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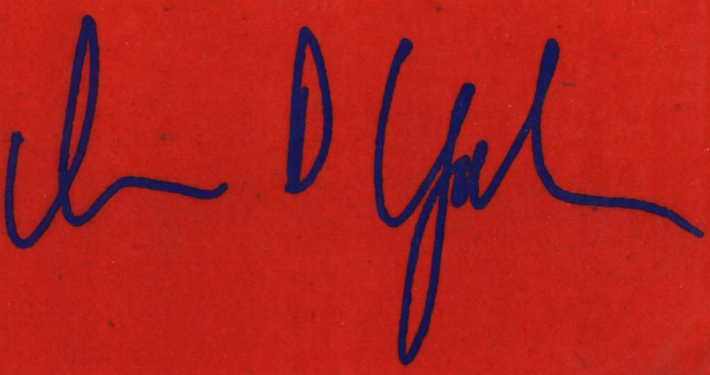

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To those patients with mood disorders who have had the courage to rise above the pain caused by the disease and gone for help. And especially to Susan Dime-Meenan, executive director of the National Depressive and Manic-Depressive Association, a group that has pioneered helping others find the way to effective treatment.

FOREWORD

At a recent meeting of clinical practitioners, a senior practitioner declared that more change had occurred in his practice of psychotherapy in the past year than in the twenty preceding years. Nodding assent, the others all agreed.

And was that a good thing for their practice? A resounding "No!" Again, unanimous concurrence—too much interference from managed care; too much bureaucracy; too much paper work; too many limits set on fees, length, and format of therapy; too much competition from new psychotherapy professions.

Were these changes a good or a bad thing for the general public? Less unanimity on this question. Some pointed to recent positive developments. Psychotherapy was becoming more mainstream, more available, and more acceptable to larger segments of the American public. It was being subjected to closer scrutiny and accountability—uncomfortable for the practitioner but, if done properly, of potential benefit to the quality and efficiency of behavioral health care delivery.

But without dissent this discussion group agreed—and every aggregate of therapists would concur—that astounding changes are looming for our profession: changes in the reasons that people request therapy; changes in the perception and practice of mental health care; changes in therapeutic theory and technique; and changes in the training, certification, and supervision of professional therapists.

From the perspective of the clientele, several important currents are apparent. A major development is the de-stigmatization of psychotherapy. No longer is psychotherapy invariably a hush-hush affair, laced with shame and conducted in offices with separate entrance and exit doors to prevent the uncomfortable possibility of patients meeting one another.

Today such shame and secrecy have been exploded. Television talk shows—Oprah, Geraldo, Donahue—have normalized psychopathology and psychotherapy by presenting a continuous

public parade of dysfunctional human situations: hardly a day passes without television fare of confessions and audience interactions with deadbeat fathers, sex addicts, adult children of alcoholics, battering husbands and abused wives, drug dealers and substance abusers, food bingers and purgers, thieving children, abusing parents, victimized children suing parents.

The implications of such de-stigmatization have not been lost on professionals who no longer concentrate their efforts on the increasingly elusive analytically suitable neurotic patient. Clinics everywhere are dealing with a far broader spectrum of problem areas and must be prepared to offer help to substance abusers and their families, to patients with a wide variety of eating disorders, adult survivors of incest, victims and perpetrators of domestic abuse. No longer do trauma victims or substance abusers furtively seek counseling. Public awareness of the noxious long-term effects of trauma has been so sensitized that there is an increasing call for public counseling facilities and a growing demand, as well, for adequate treatment provisions in health care plans.

The mental health profession is changing as well. No longer is there such automatic adoration of lengthy "depth" psychotherapy where "deep" or "profound" is equated with a focus on the earliest years of the patient's life. The contemporary field is more pluralistic: many diverse approaches have proven therapeutically effective, and the therapist of today is more apt to tailor the therapy to fit the particular clinical needs of each patient.

In past years there was an unproductive emphasis on territoriality and on the maintaining of hierarchy and status—with the more prestigious professions like psychiatry and doctoral-level psychology expending considerable energy toward excluding master's level therapists. But those battles belong more to the psychotherapists of yesterday; today there is a significant shift toward a more collaborative interdisciplinary climate.

Managed care and cost containment is driving some of these changes. The role of the psychiatrist has been particularly affected as cost efficiency has decreed that psychiatrists will less

frequently deliver psychotherapy personally but, instead, limit their activities to supervision and to psychopharmacological treatment.

In its efforts to contain costs, managed care has asked therapists to deliver a briefer, focused therapy. But gradually managed care is realizing that the bulk of mental health treatment cost is consumed by inpatient care and that outpatient treatment, even long-term therapy, is not only salubrious for the patient but far less costly. Another looming change is that the field is turning more frequently toward the group and family therapies. How much longer can we ignore the many comparative research studies demonstrating that the group therapy format is equally or more effective than higher cost individual therapies?

Some of these cost-driven edicts may prove to be good for the patients; but many of the changes that issue from medical model mimicry—for example, efforts at extreme brevity and overly precise treatment plans and goals that are inappropriate to the therapy endeavor and provide only the illusion of efficiency—can hamper the therapeutic work. Consequently, it is of paramount importance that therapists gain control of their field and that managed care administrators not be permitted to dictate how psychotherapy or, for that matter, any other form of health care be conducted. That is one of the goals of this series of texts: to provide mental health professionals with such a deep grounding in theory and such a clear vision of effective therapeutic technique that they will be empowered to fight confidently for the highest standards of patient care.

The Jossey-Bass Library of Current Clinical Technique is directed and dedicated to the frontline therapist—to master's and doctoral-level clinicians who personally provide the great bulk of mental health care. The purpose of this entire series is to offer state-of-the-art instruction in treatment techniques for the most commonly encountered clinical conditions. Each volume offers a focused theoretical background as a foundation for practice and

then dedicates itself to the practical task of what to do for the patient—how to assess, diagnose, and treat.

I have selected volume editors who are either nationally recognized experts or are rising young stars. In either case, they possess a comprehensive view of their specialty field and have selected leading therapists of a variety of persuasions to describe their therapeutic approaches.

Although all the contributors have incorporated the most recent and relevant clinical research in their chapters, the emphasis in these volumes is the practical technique of therapy. We shall offer specific therapeutic guidelines, and augment concrete suggestions with the liberal use of clinical vignettes and detailed case histories. Our intention is not to impress or to awe the reader, and not to add footnotes to arcane academic debates. Instead, each chapter is designed to communicate guidelines of immediate pragmatic value to the practicing clinician. In fact, the general editor, the volume editors, and the chapter contributors have all accepted our assignments for that very reason: a rare opportunity to make a significant, immediate, and concrete contribution to the lives of our patients.

Irvin D. Yalom, M.D.
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Stanford University School of Medicine

INTRODUCTION

Ira D. Glick

They had practically raised me, and now they would wonder what had gone wrong. There was no way I could possibly explain to them that I was suffering from an acute depression, that it was so intense that even when I wanted to get out of my own head and attend other people's needs—as I had so much wanted to do that day—I couldn't. I was consumed by depression and by the drugs I took to combat it, so there was nothing left of me, no remainder of the self that could please them even for a few hours. I was useless.

E. WURTZEL

Although "depression" is still not generally recognized by the public as being an illness (as opposed to being a moral failing), changing patterns of medical care are bringing increasing numbers of patients who are depressed to the attention of mental health professionals. As a result, most of us have busy practices with lots of depressed people in our caseloads. We recognize that therapists have their hands full with this population and that this is pervasive, hard work. This book aims to help by providing the specific guidelines and techniques for when to do what and for whom.

Fortunately, treating depression in the 1990s is a far more rewarding enterprise than it was up to several decades ago, when no therapies could be proven more useful than a placebo. Today, we are fortunate to have treatments that can change the life course of those afflicted with this illness.

What else has changed? First, research has begun to integrate the two developmental (and presumed etiological) pathways representing biological/genetic factors and psychosocial/environmental factors. Second, treatment outcome (how an episode is

resolved) has become a window into pathogenesis for understanding the interaction of biological and psychosocial parameters in onset and recovery. For example, the response of an adolescent who is "depressed" after a breakup with a girlfriend or boyfriend and who remits after three sessions of psychotherapy suggests this is situation related. Conversely, a patient who remits within six months of medication and no psychotherapy suggests a biologically based etiology. Accordingly, new medication and psychotherapeutic strategies have been developed to manage these illnesses in ways very different from those two decades ago. Finally, new diagnostic criteria (*DSM-IV*) identify different subtypes of depression and, by implication, effective therapies for a particular type. This book details some of the most important models for understanding and treating all of these types and subtypes.

So what are the key issues for clinicians treating depression? The aim is to find the best combination of therapies for a particular individual, given his or her life circumstances, developmental phase, and particular type of depression. Our text aims to be helpful (1) when one uses medication alone, (2) when one uses psychotherapy alone, and (3) when one combines them.

This volume covers six approaches. For each, we spell out what it is (a definition of the therapy), how to do it (the model and process), and whom to do it with (indications) and present the data to support its efficacy.

We begin with the modality most recently developed—family therapy. The family is not only where depression plays out but, as it happens, also the crucial system for the long-term management of this disorder. Carol Anderson and her co-workers discuss the *psychoeducation model* as it applies to patients with depression and their families. This model has two formats—group and individual—and you will want to use them differentially in your practice.

Next, we present three models of individual therapy. The significant change in this field is the development of specific "brands" of individual therapy, which for the most part are now

manualized and have been tested in controlled trials. Michael Thase discusses *cognitive-behavioral therapy*. Holly Swartz and John Markowitz discuss *interpersonal psychotherapy*, and Jules Bemporad discusses *psychodynamic psychotherapy*. Each of these modalities works somewhat differently, and obviously they have overlapping spheres. We outline for whom each model is indicated and how each technique can be applied.

Finally, Joan Luby discusses *group psychotherapy* for the depressed patient. This modality has reached full flowering with the recognition that, for some patients, a group setting is ideal for working out interpersonal problems consequent to their illness—such as maintaining a relationship—and in part caused by the often lifelong residue of the illness (lowered mood, irritability, oversensitivity).

We conclude by presenting the treatment modality that has been shown in controlled studies to be most beneficial for this disorder—psychopharmacotherapy. As presented by Charles DeBattista and Alan Schatzberg, this chapter also examines how to combine medication with psychotherapy for *which* patients under *what* circumstances. Because the most common treatment mix is combining medication with psychotherapy, hand in hand, Michael Thase and I devote another entire chapter to this modality.

We are also concerned throughout this book with how the conscientious and caring therapist can deal with issues raised by managed care. Here, we recommend a proactive stance based on principles elucidated in each chapter. The therapist first formulates a careful diagnosis of relevant issues of not only the patient but also the family. Second, a treatment plan based on one or more models of intervention presented here is laid out. Third, the case is presented to the new "member of the treatment team"—a managed care supervisor.

From our perspective, the major goal is quality, rather than limitations to treatment. The practitioner should not be sidelined by the attempts to cut costs as a by-product of managed care. We emphasize educating the payer and taking charge of the treatment plan.

What we are hearing more and more is that HMOs and MCIs are realizing that "quick and dirty" costs them more in the long run—in expensive hospitalization, residential treatment, and other costly emergency interventions. So, managed care supervisors are becoming more open and flexible about necessary outpatient treatment as preventive early intervention. This flexibility requires the therapist to be adept at persuasion and negotiation. It also requires a willingness to provide the required paperwork—treatment plans, progress notes, utilization reviews, even outcome data—that can help make the case. And it means thoroughly understanding the internal structure of the insurer so that the proper appeals can be initiated if necessary. New trends in managed care, moreover, seem to favor a capitation rather than fee-for-service approach, which means that many therapists will be working in groups, practices, networks, and clinics that contract to provide all necessary services for a predetermined total fee. This group work means we decide how much of what to do, without external approvals or review. Overall, however, we want to take a more work-together, pragmatic approach.

Finally, let's summarize the current treatment of depression. At this point, the symptoms and severity can be reliably rated, and as mentioned, particular subtypes can be defined. The severity of symptoms can also suggest the intervention: severe depression requires medications. The psychotherapeutic models may be more appropriate for the mild to moderate depression—that is, dysthymia, grief, or subsyndromal levels of the symptoms. At the same time, the following warning from a clinical social worker is relevant:

> Therapists need to be careful not to misdiagnose the dysthymic patient as suffering from a personality disorder or a depression that is simply a reaction to personal problems. Misdiagnosis may lead the therapist to mistakenly treat this illness with psychotherapy alone. Since dysthymia is often due to abnormalities in brain biochemistry, it is best to treat it with

> antidepressants. Medication should not be reserved solely for depressed patients suffering gross impairments in functioning.

However, not every "depressed" patient needs medication.

Let's close by reviewing some of the basic epidemiology of depression—putting aside "grief" and the normal "ups and downs" with which all people suffer.

> Depressive illness is a very common condition affecting at least 5 percent of the general population over 18 at some point in their lives. It is more common in women than men. Depressive illness is severely disabling, adversely affecting working capacity and disrupting family and social life. The disability found in major depression exceeds that of most severe medical illnesses, such as diabetes and hypertension. Depressive illness can be lethal. At least 15 percent of patients with depressive illness have a lifetime expectation of committing suicide, a figure which has scarcely changed since the introduction of antidepressants unless systematic long-term treatment has been used.

Psychotherapeutic and rehabilitative strategies, with and without medication, can profoundly benefit the patients and families that therapists see daily. So we hope this book provides the specific guidelines and concrete methods for successful treatment of this very large and difficult population.

ACKNOWLEDGMENTS

I am especially grateful to our editor, Alan Rinzler, who has been crucial to the coherence and readability of this work. In addition, I wish to acknowledge the efforts of those researchers in the field of mood disorders who have done the hard work of finding the "facts" underlying the understanding and treatment of these diseases.

NOTES

P. xiii, *E. Wurtzel:* Wurtzel, E. (1993). *Prozac nation: Young and depressed in America, a memoir.* New York: Houghton Mifflin.

P. xvi, *impairments in functioning:* Quinn, B. (1994). Chronic depression: The danger of misdiagnosis and inadequate treatment. *NAFDI News,* 7, 1.

P. xvii, *long-term treatment has been used:* Task Force of the Collegium Internationale Neuro-Psychopharmacologicium (CINP). (1993). Impact of neuropharmacology in the 1990s: Strategies for the therapy of depressive illness. *European Neuropsychopharmacology, 3,* 153–156.

CONTENTS

CHAPTER

1

FAMILY THERAPY

Carol M. Anderson, Sona Dimidjian, and Apryl Miller

Those who have major depressive disorders or chronic dysthymias, almost regardless of their attitude and temperament prior to becoming ill, tend to view themselves and their relationships in a negative and sometimes hopeless way. Withdrawn, amotivated, lacking in energy or interest—it's as if they are wearing dark glasses that color their view of the world around them. As they selectively attend to negative events and feelings, their sensitivity to criticism, feelings of worthlessness, and compromised self-esteem make it difficult for them to accept positive feedback and support. In fact, their depression often makes them more frustrated and irritable when support is offered.

It is not surprising, then, that families of depressed patients are almost always distressed. Depression acts like a magnifying glass, highlighting all of the normal problems of families and family members, making these issues seem more serious, and adding stressful and worrisome troubles of its own. Anyone who has observed the struggles of depressed patients and their families knows there is a powerful and complicated relationship between depression and family life. Although biology and genetics may play a significant role in the etiology and course of depression, a variety of psychosocial issues, especially family variables, is also crucial. Families have an influence over the onset and course of the disorder, and the ways in which they respond to depression influence both the lives of the individuals and each family as a whole.

Living with Depression

Most family members report that it's extremely difficult to live with someone who is depressed—so difficult, in fact, that over time their own mood and well-being are compromised. These complaints by family members are supported by observations of researchers that depression has a dramatic negative impact on those who come into contact with it even briefly. For instance, a limited telephone conversation with a depressed person can influence the mood of a nondepressed listener. Given such findings, it is not surprising that depression places great stress on family members and intimate relationships.

Trying to Cope

The way in which family members cope changes over time. Initially, many attempt to deal with the symptoms of depression by accommodating, adapting, and gradually centering their lives around their relative in an effort to help. They become highly attuned to needs and moods, attempting to protect the depressed person from criticism and life stress. They try to be reassuring or, by using logic, to make a case that life is not as bad as the depressed person perceives it to be. The husband of a thirty-five-year-old depressed woman responded to her repeated complaints about feeling depressed, isolated, and overwhelmed with household and child-care chores by listing all the people who cared about her and all the labor-saving devices she had that had not been available in their parents' generation. As other patients frequently report, this strategy did not help. When a depression is severe—as hers certainly was—such logic and reassurances only cause the depressed persons to feel alienated, to believe that their family members simply don't understand, don't want to hear about their troubles, or don't take their pain seriously.

Coping can be especially difficult for partners of adults who are depressed, because the disorder almost always compromises the spouses' ability to meet the responsibilities of their family