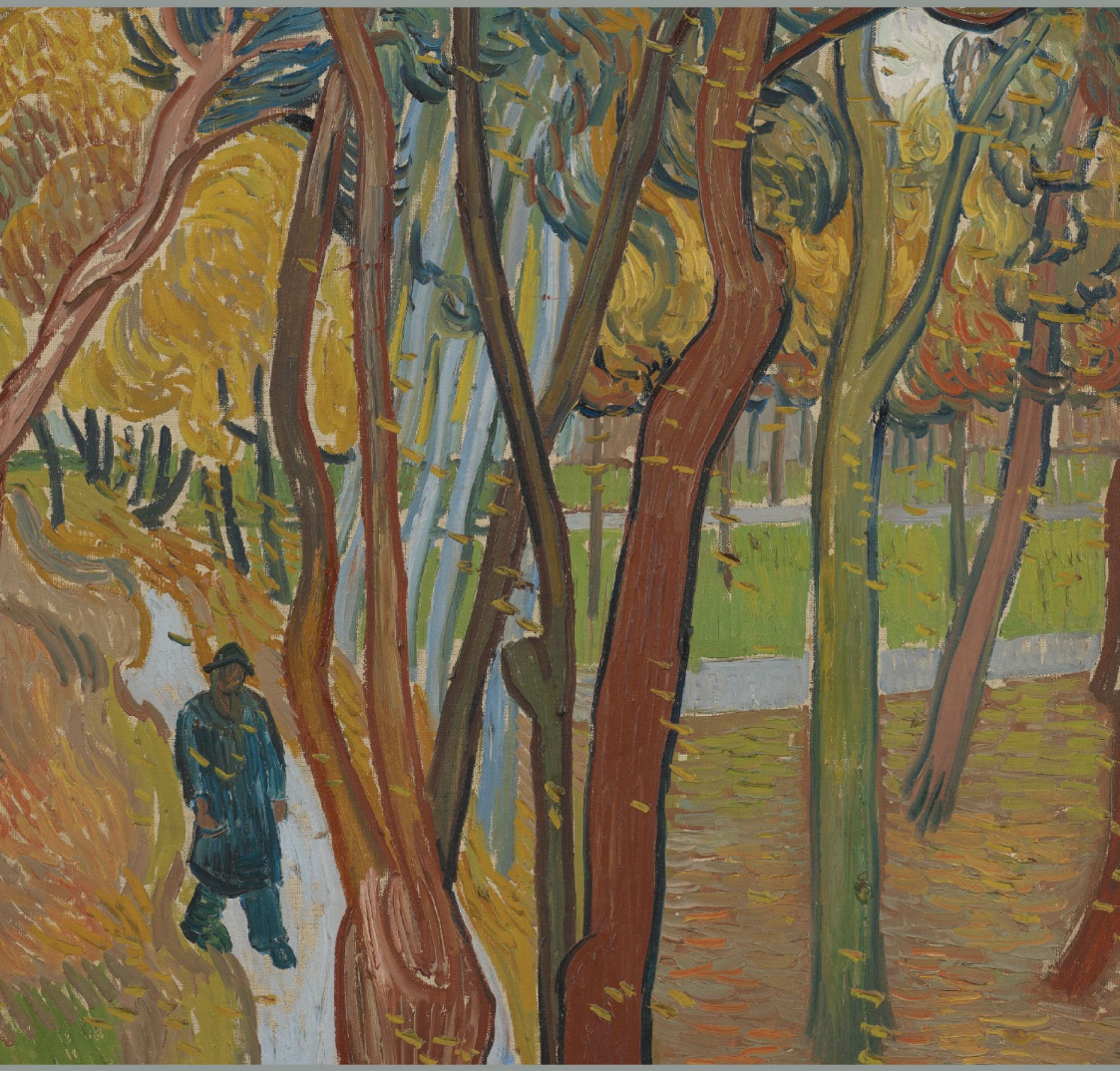
TREATMENT OPTIONS:

Their Uses and Limitations



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Treatment Options: Their Uses and Limitations

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Table of Contents

Treatment Options: Their Uses and Limitations

If you are reading this book, you probably know more than I do about treatments, having tried so many of them. Nevertheless, the summary of the tools available and some comments on them may prove useful. The good news is that we do indeed have better treatments, whatever their limitations, and research may well give us yet better ones.

Psychopharmacological Treatments

Let's start with the pharmacological. The oldest class of drugs used to treat depression is the amphetamines. These are stimulant drugs that increase the quantity of excitatory neurotransmitters in the synapses of some circuits in the brain. "Come again?" you say.

The cells of the nervous system—the neurons—including the brain, don't quite connect with each other. The gap between them is called the synapse. Chemicals—neurotransmitters—go across the gap and transmit information to the cell (the post-synaptic neuron in technical terms) across the gap. These chemicals can be uppers (excitatory) or downers (inhibitory). All the antidepressants act on these neurotransmitters. The stimulant ones, like the amphetamines, pump out excitatory neurotransmitters from the presynaptic (before the synapse) neurons. Since the neurochemical correlative (maybe or maybe not the cause) of depression is diminished availability of excitatory neurotransmitters resulting in slowed down transmission of information in certain brain circuits, increasing the availability of these chemicals (neurotransmitters) is a perfectly logical treatment for depression. Stimulant drugs do indeed alleviate depression, so we have *the*, or at least *a*, cure—no? Unfortunately, no. Why not? The nervous system quickly habituates to drugs like amphetamines, necessitating raising the dose. At higher doses, they have all sorts of baleful side effects, including anxiety and jumpiness. A drug you need more and more of is an addictive drug. So these days psychopharmacological stimulants are rarely used alone in the treatment of depression. They are sometimes used to supplement other antidepressant drugs and you may have had them prescribed with that purpose. Sometimes their addition results in a treatment response when there was a weak one or none at all.

The psychostimulants have largely been supplemented by antidepressants. They work differently than the stimulants. Instead of increasing the quantity of excitatory neurotransmitters, they prevent their reuptake. What does that mean? Well, once the excitatory chemical is in the synapse it would continue to jazz up the post-synaptic neuron forever and serve no useful purpose since it is the difference in the rate the neurons "fire" that conveys the information that it is the nervous system's job to carry. "Fire" in this context means setting off an electrochemical reaction that acts as a signal. To prevent this, the neurotransmitter, so to speak, is sucked up back into the neuron before the synapse—*reuptake* is the technical term. One class of antidepressants slows this reuptake, making more excitatory transmitters available. Since depression is down and excitatory transmitters are up, they have the potential to lift depression.

There are several types of antidepressants. The oldest are called tricyclic because there are three rings in their molecules. Elavil is the most frequently prescribed tricyclic. It is quite effective, especially for severe, acute depression. Unfortunately, there is a price tag on everything and Elavil and its relatives have problems. The neurotransmitters antidepressants are supposed to work on are primarily serotonin and norepinephrine. The tricyclics unfortunately also act to depress a neurotransmitter called acetylchlorine. This "anti-chlorinergic effect " is hard to live with, causing dry mouth, constipation, and sometimes urinary retention, among other things. These side effects are intensely uncomfortable and feel invasive. In common with other classes of antidepressants, the tricyclics can lose their effectiveness over time so they aren't much prescribed these days. They're usually used when other drugs don't work.

The most commonly prescribed antidepressants these days are SSRIs, that is, selective serotonin reuptake inhibitors, which increase the availability of the excitatory neurotransmitter serotonin in the synapse. SSRIs are called selective because they target particular neurotransmitters, usually serotonin, sometimes serotonin and norepinephrine while not affecting neurotransmitters like acetylchlorine in ways that cause the unpleasant side effects that the older tricyclics did. The first of them was Prozac, a billion-dollar seller. One day I came home to have my wife tell me, "The doctor put Priscilla on Prozac." Priscilla was a German shepherd, who, so far as I could tell, was not in the least depressed. Oversold, perhaps, yet Prozac and its cousins helped many and still do help many people. Other commonly prescribed SSRIs include Zoloft and Cymbalta. Cymbalta differs from Prozac, Zoloft and, to name another popular one, Lexapro, in that it affects the reuptake of norepinephrine as well as the reuptake of

serotonin. In fact, it is believed to act primarily on norepinephrine. It is a drug worth trying if you've gotten minimal or no response from one of the serotonin reuptake blockers. It gives you another option.

What about the down side of the SSRIs? There are quite a few. They don't work for everyone or for all depressions; they often lose their effectiveness over time; they take roughly six to eight weeks to be fully operative; they commonly result in weight gain, particularly in women; and they can have sexual side effects. Women may have trouble getting aroused and have difficulty or find it impossible to orgasm. Men may have problems with achieving and maintaining an erection and/or in coming. When people are maximally depressed, they don't care much about sex, but if they get an antidepressant effect from their SSRI they do care and this becomes a not trivial side effect, leading to non-compliance, that is, going off the drug. The same phenomenon happens with weight gain. Additionally, some people are anxious or jumpy on SSRIs, especially when they first go on them. Most, but not all, accommodate and become less anxious.

What if you have a "treatment-resistant" depression that doesn't respond to stimulants or SSRIs and a trial on a tricyclic doesn't work either? Well, there's yet another class of antidepressant that might be worth trying called MAO inhibitors. Incidentally, "treatment-resistant" is meant to refer to your depression, not to you, but it is often heard that way and unfortunately sometimes the frustrated prescriber unwittingly thinks of you as the agent resisting treatment. MAO inhibitor means monoamine oxidase inhibitor. When one of those excitatory neurotransmitters like serotonin are out in the synapse they are not only reuptaken, they are chemically degraded—rendered inoperative by chemicals, enzymes that are also in the synapse. They do their work by oxidizing the neurotransmitter, that is, they facilitate the combination of the neurotransmitter with oxygen, in effect burning it up. Those enzymes contain one amine group in their molecule, hence are called monoamine oxidases (MAOs). This type of antidepressant inhibits the action of the enzyme that degrades excitatory neurotransmitters, resulting in a greater availability of those excitatory neurotransmitters: serotonin, norepinephrine, or both.

MAO inhibitors are not often prescribed, and for good reason. They are dangerous. The person taking them must totally avoid a rather long list of foods, certain cheeses, for example, that contain amino acids that are acted on by the MAO inhibitors. Such interaction sends blood pressure skyrocketing, thereby radically increasing the risk of a disabling or fatal stroke. If you've been on a MAO inhibitor, you

know how careful you must be. To be on one would make a nervous wreck of me, but people on them have to be careful and serious complications are rare. Yet, if nothing else has worked, an MAO inhibitor is worth a try. As with all antidepressants, not everyone responds, effectiveness may lessen or cease over time, and there are probably side effects of which I am unaware. The most widely prescribed MAO inhibitor is Parnate.

Welbutrin is another antidepressant that doesn't fit easily into any class. It is a sort of entity unto itself. It, too, is a reuptake blocker. However, it blocks the reuptake of two neurotransmitters: norepinephrine and dopamine, a combination not targeted by other anti-depressants. Dopamine, which plays many roles in the nervous system, is the key neurotransmitter in the pleasure centers of the brain. It therefore makes sense that a treatment that increases the availability of dopamine, thereby further stimulating the pleasure centers, would he helpful to someone who is depressed. Welbutrin is most often prescribed in conjunction with another antidepressant. It has a number of advantages. It does not have sexual side effects and it does not promote weight gain. It does, however, make some people nervous, and like all antidepressants, it is prone to failure, or at least radical diminution of its effectiveness over the course of time. As far as I know, it is not addictive. So Welbutrin offers another possibility for psychopharmacological treatment.

Psychiatrists, psychopharmacologists, and primary care physicians who are the ones that actually do much of the prescribing for depression often have to play with dosages and with competing SSRIs (these days, there's a slew of them) trying to find an effective treatment. This is more empirical than scientific, sort of trial and error, though there are rationalizations for using one rather than another of the SSRIs to treat a given symptom profile of a depression. However, they aren't very convincing. If you've been living with depression for a long time, you have probably gone through a lot of such juggling and you know how extraordinarily frustrating it can be. Nevertheless, it is most certainly worth playing around this way to try to get a response, especially if a drug that worked for you has ceased to do so.

There's yet one more psychopharmacological strategy for treating intolerable depression, that is adding an antipsychotic to the regimen. The heavily advertised drug Abilify is just such an antipsychotic. Sometimes this works, at least for a while. The down side of adding an antipsychotic is that there is some risk of developing tarpe dyskinesia, an irreversible movement disorder, especially if you stay on it for a

long time or you are female. I'm not certain what the risk is, and it is probably fairly low, but unfortunately, there are other side effects of antipsychotics. Again, if nothing else has worked for you, the addition of a drug like Abilify may be worth a try. Although this is a book about unipolar depression (i.e., depression without manic episodes), I should mention a common and effective treatment for bipolar depression, lithium carbonate. It must be monitored carefully because lithium can cause kidney damage. The so-called mood stabilizers (originally developed as anti-seizure medications) such as Tegretol are also used in the treatment of bipolar disorder.

What do I conclude from all this? Psychopharmacology is good stuff, albeit oversold. Over the past generation it has offered hope to the hopeless and permitted many to recover from or mitigate their depression. But if you are reading this book, you are no longer one of those who radically benefits from psychopharmacology of your depression. Of course you don't know how much worse it could be if you were off your drug regimen, and new drugs keep coming down the pike. So my advice is to stay with whatever helps, however partially, and put yourself in the hands of a psychiatrist (if you aren't already there) who assiduously keeps up with the latest advances in the chemical treatment of depression.

I should mention once again another bit of bad news. There's a phenomenon called "kindling" in which earlier depressions act as kindling for later depressive episodes, making them worse. So it is wise to do anything possible, including psychopharmacology, not only to attenuate present pain, but to mitigate the possibility of recurrence of severe episodes.

On the skeptical response side to antidepressants, there are several studies that show that cognitive psychotherapy of depression is at least as effective, if not more effective, than drugs for the treatment of mildly and moderately severe depression. These studies go back to one reported by the founder of cognitive therapy, Aaron Beck, twenty years ago. However, it is not so clear at this time if the more severe, chronic depression you suffer is better treated with some forms of psychotherapy than with medication. At this stage of the game, you're probably staying with medication because you have little to lose, but you are pretty damn frustrated because it isn't helping you all that much.

There is an association between alcohol use, especially alcohol abuse, and depression. Lots of people self-medicate depression with alcohol. It is the wrong antidepressant and only makes matters

worse. Being an anesthetic, booze gives temporary relief from the pain of depression; being a central nervous system depressant, it actually exacerbates it. The use of stimulant drugs like cocaine is similarly futile. True, there is a pleasurable rush, but then a terrible crash. Don't be your own psychopharmacologist with "recreational" drugs. They won't help and just create a new problem. In the course of your chronic depression, you may have found this out for yourself.

Somatic Treatments

The somatic treatments we will consider here are of three types: electroconvulsive treatment (ECT), transcranial magnetic stimulation (TMS), and vagal nerve stimulators. ECT, colloquially referred to as "shock treatment," has a bad rep, and indeed is an invasive procedure with significant risk. It can also be a lifesaver in severe suicidal depression. The response to it is often dramatic. On psychiatric hospital wards, patients who one day were slumped into withdrawn, almost catatonic lumps, are seen after a few treatments walking around conversing cheerfully. So ECT has its uses. In the past it was often misused to treat conditions it could not help, such as schizophrenia, and in assaultive ways for too-long courses of treatment, delivering too many shocks to the brain. This is no longer done. The ways it is administered have also evolved. Today, the shock is usually delivered to only one side of the brain and muscle relaxants and anesthetics eliminate such adverse effects as broken bones in the course of the ensuing convulsion. The most pernicious side effect, a troublesome, potential debilitating one, memory loss, is minimized. When using modern ECT protocols, not only is memory disturbance minimized, but recovery with restoration of normal cognitive functioning is far quicker. Having said this, ECT is still somewhat analogous to starting a stuck engine by banging on it with a hammer and a crude method for shaking things up and getting them working again.

You may have had ECT and hopefully it helped you. It is clearly useful in acute, dangerous, severe depression that does not respond to psychopharmacological treatment and is not accessible to talk therapy. When it works, it alleviates the worst symptoms. It is *not*, however, a cure for depression, which more often than not recurs. Additionally, memory loss, although this does not usually occur, can indeed persist. So ECT is a heroic treatment to be used only in situations calling for heroic interventions. It has little or nothing to offer for the type of chronic depression we are discussing.

On the other hand, a newer treatment, Transcranial Magnetic Stimulation (TMS), may have something to offer you. Apparently it works somewhat like ECT while being minimally invasive. Instead of delivering a shock to the brain it infuses it with magnetic energy, a painless procedure that does not involve either loss of consciousness or loss of memory. To go back to my analogy, if ECT acts somewhat like the use of a hammer to jump start a stalled engine, TMS is more like shaking the engine while bathing it in warm water.

TMS's effectiveness is not well established; empirical evidence supporting its use in the treatment of depression is weak. However, I do know two psychiatrists I greatly respect who report some striking successes with hitherto intractable depression using this method. That doesn't mean it works for everybody or that it would work for you.

There are some down sides. It is a time-intensive treatment requiring four sessions of approximately two hours, four days a week, for six weeks, and in all probability a reduced maintenance schedule thereafter. It is expensive. Insurance companies tend to be highly resistant to paying for TMS, but after a protracted struggle, some of them do. If nothing else has helped you, TMS is worth investigating.

Vagus nerve stimulators were developed at Duke University as a treatment for intractable depression. The vagus nerve carries messages to and from the brain to a wide variety of internal organs, stimulating smooth muscle. It does so in the stomach, for example, and also plays a major role in regulating the heart. In this treatment a pacemaker type of device is implanted in the neck to send a message up to the brain, stimulating certain brain circuits. The initial results were promising. The stimulator was surgically implanted, the device regulating the frequency and pattern of stimulation of the vagus nerve adjusted, and some extremely depressed people were responsive. I don't know how this treatment has stood the test of time, but once again, if all other treatments have failed you, vagal stimulation is worth investigating.

Psychotherapeutic Treatments

Let's take a look at the psychotherapeutic possibilities. They fall into three broad categories:

psychodynamic, cognitive, and interpersonal, and each has an etiological subtext. That is, the treatment is intrinsically intertwined with a theory about causality. As a therapist, if you believe that depression is caused by genetically transmitted vulnerability to less than optional neurotransmitter balance and function, then you would treat psychopharmacologically to redress the balance. That is what psychopharmacologists do. As a therapist, if you believe that this is only partly true and that this vulnerability only becomes manifest after traumatization, then you would prescribe psychopharmacology and psychotherapy. If you believe that depression is powerfully triggered by loss, by overidentification with and internalization of the lost object, by anger turned against the self, and by events precipitating massive loss of self-esteem, you would engage in psychodynamic psychotherapy. If you as a therapist believe that depression is a result of irrational thinking, then you would prescribe cognitive therapy, and if you as a therapist believe that the cause of depression, or at least the cause of the depression continuing, is disturbed relationships with other people in the present, then you would prescribe interpersonal psychotherapy. Although there are more extreme advocates who claim exclusivity for their particular approach, the truth is that they are not mutually exclusive.

There is an historical dimension here as well. If we asked a medieval or Renaissance physician, he would cite the imbalance of the humours, discussed above, with the predominance of one of them (black bile) being the cause of melancholia. We moderns have a different metaphor. Instead of speaking of the humors, we talk about the neurotransmitters. If you think about it, the two aren't all that different. Perhaps instead of describing people and their personalities as sanguine or phlegmatic, terms derived from the humour theory, we will start describing people as serotonic or norepinephric, a gain for science but a loss for poetry.

Clearly we have too many causes here, leading us somewhere between the blind man and the elephant and "Dear Officer Krupke." Amazingly, they can all be true, applied to different people and different types of depression and/or the same person in different phases of depression. We human beings have neurotransmitters and we have relationships. We have memories and we process current reality. We have genetically transmitted structures and patterns and we suffer loss and trauma. All of these factors interact. To cite a rather sad example, trauma alters neurochemistry for the worse so that trauma is doubly registered as memory and as altered brain function. So an openness by both therapists and sufferers to a multiplicity of treatment approaches makes the best sense. As a victim of chronic

depression, you know that none of the above have completely done the trick for you, even if they have helped. Yet they probably haven't been totally useless. Or perhaps, sadly, they have been.

The Psychodynamic Approach

Let's start with the psychodynamic approach. Here, too, there is a range of approaches from the classical psychoanalytic five times a week on the couch to once a week face-to-face meetings. Psychodynamic treatment for depression generally is once or twice a week face to face. Sigmund Freud wrote a great paper, "Mourning and Melancholia," which has shaped the analytic-dynamic treatment of depression ever since. In it he contrasts a normal phenomenon, mourning, with a pathological one, melancholia, which we call depression. In both he hypothesizes there has been a loss (of a person or an ideal or a job or a valued place in the world) resulting in little or no interest in the outside world. There is diminution of the capacity to love and painful affect. In mourning, what is lost is painfully conscious; in melancholia it often is not. In most cases of melancholia it is a mystery to both sufferer and observer what is being mourned, while it is obvious to all that the melancholic is mourning something. In Freud's account of it "successful" mourning requires intensely emotionally recalling memory after memory of the deceased until the photo album, so to speak, is exhausted. Mourning differs from melancholia in that the mourner, as well as the observers, knows perfectly well what loss is being mourned. The intensity of the emotional connection to each memory breaks that emotional bond, somewhat like stretching a rubber band beyond its capacity snaps it. Just as the snapping rubber band inflicts pain as it recoils, the hyperemotional memory inflicts pain as it snaps. The end of a long process, the last tie—the final memory—is snapped, and mourning comes to an end. Reality has won, the loved one is no longer here, and reason dictates that we move on. But it's been a hard fight, absorbing all of the mourner's energy as he or she engages in what Freud called "the mourning work."

Melancholia is different. Not only is what has been lost mysterious, but the process is baffling as well. Depressions are characterized in many ways. One of the most familiar and useful distinctions is between endogenous and exogenous depression. If someone tells you that he is deeply depressed, goes on to say that he has been fired, diagnosed with HIV, and his wife ran off with his best friend, we are not puzzled about his being depressed. This is an exogenous depression. On the other hand, if someone tells us she was walking home from work and started sobbing uncontrollably for no apparent reason, is only

able to get home with tremendous effort, has felt helpless and hopeless ever since, and keeps telling herself what an evil, worthless person she is, this is an endogenous depression and we are at a loss to understand or explain it. Chronic depressions are most often a mix, with the endogenous element predominating.

Mourning comes to an end (normally) while melancholia (at least in the form of chronic depression) does not. Further, the melancholic suffers a precipitous loss of self-esteem not present in the mourner. Further, as you know all too well, a depressed (melancholic) person reviles him- or herself with the most vicious self-accusations. True, the mourner experiencing "survivor guilt" does something of the same thing. But if the mourner's self-accusations persist, going beyond a certain point, he is no longer simply mourning: he is depressed.

Freud tells us in a strange poetic way that in melancholia "the shadow of the object fell on the ego." What does this mean? Well, to start with "ego" here means self and the object is what is lost: a loved one, an ideal, status, whatever. But the melancholic, the depressed one, has poor boundaries, so the lost object and the self get confused and indeed the lost one is now part of the self. The internalization of the lost object in this process is totally or largely unconscious. In Freud's language, "an object relation" (that is one between two separate people) becomes an "identification" (that is, now there is only one person, the self fused with the other). That's bad enough, but things get worse. The lost loved one is experienced as having abandoned the self and there is rage at that abandonment. Since the self and object are fused, rage against the abandoning other or abandoning value becomes rage against the self. That is one mechanism explaining depression as anger turned against the self. What follows are the terribly tormenting self-accusations you know only too well.

Freud has much of this right. There is indeed an intimate relationship between mourning and melancholia-depression. In fact, some have hypothesized that one cause of depression is failure to mourn. This is congruent with my clinical experience. An important psychodynamic treatment of depression is facilitating belated mourning for old losses. Painful as that process is, it helps. Psychodynamic treatment does in general pay more attention to past wounds than other treatment modalities. This is never mere history; the past is only of therapeutic interest if it continues to influence the present, for example, by fueling depression. Since the unmourned losses are largely unconscious,

dynamic psychotherapy works to make them conscious. This form of treatment also addresses the blurred or fused unconscious boundaries and seeks to make them both conscious and more focused and distinct. Rendering anger more conscious and getting it out front, rather than turned against the self, is an important part of this process.

Psychodynamic treatment also puts loss of self-esteem into strong focus and works to raise it. Analysts who followed Freud emphasized this loss of self-esteem as a central dynamic in depression and zero in on it in their treatments.

Trauma is also central in the etiology of depression. So psychodynamic therapists, who are used to taking into account the influence of the past on the present, naturally turn to old, perhaps unconscious, trauma and try to bring it into the present so it can be worked through. The relationship between trauma and depression is complex. Depression is a symptom of trauma; repressed, unaddressed trauma causes depression; and depression is itself traumatizing. I shall return to the role of trauma in depression in the next chapter on the rehabilitation approach when I elaborate on the centrality of memory in mourning chronic depression.

A unique aspect of psychodynamic therapy is that it utilizes the relationship between patient and therapist, or in technical terms, the transference and countertransference, to re-create the conflicts that brought the patient to treatment and, so to speak, bring them into the room. In that way, the past becomes the present and can be reworked and re-experienced.

Disagreeing with the cognitive therapists, Freud argued that melancholics' self-accusations were only apparently irrational; in fact, they contained more than a grain of truth. So arguing with the depressed one that his or her thoughts are irrational, which he knows isn't true, would only make matters worse. Here the clash between the two schools couldn't be clearer. Can they both be right? I doubt it, but maybe there is a time to confront and a time to confirm.

Freud also pointed out that the depressive's worldview, at least until it becomes overtly delusional, may well be more congruent with reality than that of the normal person. The only problem is that it is unlivable. We need a little Pollyanna to survive with a modicum of happiness, and, as you know, chronic depression isn't exactly Pollyannaish.

Many psychodynamic therapists believe that sadness is an effective treatment for depression so they try to get their patients to stay with their conscious sadness in therapeutic doses. I heartily endorse this.Psychodynamic therapists also look at the possible defensive purposes of depression—is it a place to hide out—a security operation? This can sound accusatory and elicit an angry response, yet it is worth looking at to see if any such dynamic contributes to your depression.

Freud thought that the most recalcitrant force driving chronicity was the sufferer's belief that he or she doesn't deserve to recover, and that the painful symptoms are just punishment for sins real or imagined. Depression is a perfect whip for such self-flagellation; ironically (and tragically) depression can serve as a punishment for being depressed. Contemporary psychodynamic practitioners explore the ways in which conscious and unconscious guilt perpetuates the illness This is another dynamic worth looking at. Irrational guilt is so much a part of depression as both cause and effect that it may very well be contributing to your misery.

To summarize psychodynamic treatment of depression: it focuses on making unconscious loss conscious; unconscious trauma conscious; firming up boundaries, conscious and unconscious, between self and other; raising self-esteem; and getting anger and aggression out front.

Cognitive Therapy

Cognitive therapy takes a different tack. Aaron Beck and Albert Ellis are the big names here. It has little, if any, interest in the past or in the reasons the patient became depressed. Rather, the whole focus of the treatment is on the irrational, unrealistic beliefs that keep the depressed person depressed, for example, the belief that he is the worst person in the world, or that she is worthless, or that only getting by getting straight A's will she be lovable. Cognitive therapy challenges these clearly counterfactual beliefs, some of them self-accusations, some of them unreasonable, unfulfillable expectations. Its tools are confrontation, demonstration (of irrationality), and reeducation. Cognitive therapy importantly expands the depressed person's experience of the possible. It is all about getting out of the self-imposed trap that constrictive, distorted thinking imposes. For example, the cognitive therapist would challenge the chronically depressed person's belief that things are hopeless, that the only light at the end of the tunnel is the locomotive. On the contrary, there are possibilities that the depression has blinded the depressed

one to. In our example, you could lie flat on the center of the tracks, let the locomotive pass over you, or climb the ladder on the wall depression had blinded you to while the train passes, and then walk out of the tunnel. Or to change the example, you might be convinced that girls with B+ averages find love too, and thereby lose your main reason for being depressed.

The concept of learned helplessness as an explanation for depression isn't primarily cognitive but is related. In a famous experiment Martin Seligman placed dogs on a floor that could be electrified. When the shock was turned on the dogs were able to jump over a barrier and escape. When they relaxed in apparent safety, Seligman shocked them again. They then jumped back to the other side and were shocked again. Then they gave up and just sat there and whimpered. Then the conditions changed. There was no shock on the other side of the barrier and they could escape their pain. But they didn't even try. They had acquired what Seligman called "learned helplessness," which he argued was an analog of human depression. Damned if you do and damned if you don't, so why try? Seligman then had an assistant drag the dogs over the barrier to safety, then return them to the shock side. It took ten interventions before the dogs spontaneously jumped over the barrier to escape the shock and arrive at a safe place. From this Seligman argued that therapists treating depressed patients need to be highly active, dragging those dogs to safety and demonstrating that the possibility does indeed exist. Cognitive therapists are extremely active; they do it verbally and symbolically but they too drag those dogs over the barrier to safety.

Cognitive therapy has a very good record in treating acute depression. But its efficacy in treating the kind of depression you suffer is much less certain, indeed, highly questionable. Nevertheless, if you have no experience of cognitive therapy you have nothing to lose by trying it.

Interpersonal Therapy

Interpersonal psychotherapy also works with the present, but rather than trying to modify irrational beliefs, it examines and tries to modify the multidirectional interactions between the depressed person and his or her significant others. It postulates negative feedback loops that perpetuate or exacerbate the depression. For example, the depressed person infuriates his loved ones, who are, in effect, his caretakers, by refusing to take his antidepressant medications. They yell at him and call him a

stubborn fool who is sabotaging himself despite them, all of which may be true. Their accusations confirm his self-accusations and make him feel even more hopeless, leaving him with no reason to take the meds. By now he's sure he's hopeless and that they won't help anyway, and besides, he can at least get a mini-jolly by upsetting mother and father. They, in turn, get even angrier and their accusations grow nastier. Round and round we go in an ever-declining spiral. The interpersonal therapist seeks to disrupt this negative feedback system by making it conscious through interpretation, confrontation, and demonstration, let us say by role-playing of alternate ways of communicating.

In interpersonal psychotherapy, the past is not completely ignored. These counterproductive interactive feedback loops no doubt were operative at some level before the depression occurred and to some extent were etiological in its coming to be. That, too, can be interpreted, made conscious, and worked through.

If your family is anything like the family I described above, an interpersonal therapist might be just the ticket. He or she probably won't cure your depression but could help mitigate the factors and communication systems that are exacerbating it. Often interpersonal therapy is most effective in dealing with the secondary consequences of the depression and less so, at least in the kind of chronic depression we're talking about here, in curing the depression itself. It nevertheless brings a powerful new lens to the understanding of any particular depression.

Back to Ron Smith

How did this apply to Dr. Ron Smith whom we met in the last chapter? The psychodynamic therapist would view his or her first task as the establishment of rapport. Building the *relationship* between patient and therapist and using it therapeutically is at the core of psychodynamic treatment. Of course all therapists need to establish rapport with their client-patients, but the psychodynamic approach puts the relationship at the center of the treatment. How is this accomplished? Essentially by empathic, attentive, non-judgmental listening and engagement, by what the counseling theorist Carl Rogers called "unconditional positive regard." This would be particularly salient working with Ron Smith, who is so filled with shame and has experienced so many high-volume condemnations, especially, but not only, after his breakdown. The therapeutic alliance between patient and therapist provides

safety, hopefully a sufficiently secure sense that the therapist's office is a safe place for the patient, here Dr. Smith. This feeling of being in a safe place makes it possible for the patient to experience and share extremely painful memories and equally painful stuff occurring in the present. The whole idea is to open things up, thereby opening up Ron and relieving the constriction that became so emotionally disabling after he descended into the depressive pit. Along the same lines, Ron suffered horribly from isolation, aloneness, and loneliness, as well as feelings of not being part of the human race. Establishing a strong therapeutic alliance provides a form of community and Ron's experience is no longer solely that of a loner.

In the psychodynamic approach the relationship is used in yet another way. In the course of time, many of Ron's conflicts would be enacted in the therapy and his maladaptive defenses made manifest. This could be commented on (interpreted) by the therapist and worked on. For example, Ron exacerbates his loneliness by pushing people away and/or avoiding them. An instance would be his not responding to holiday greetings from old army buddies. The therapist would certainly call this to his attention, but better yet, Ron might enact his avoidance behavior, motivated by fear and shame, by missing the session immediately after a particularly emotionally connective one. The technical term for this reenactment is *transference*. The therapist would interpret the transference something like this: "Ron, you told me that you were feeling close to me after I connected with your despair during your breakdown in our last session two weeks ago. Then you didn't call and didn't show last week. I think there's a connection there. You're so hungry for some human understanding. Yet when you get it you flee. That's worth talking about." After such an intervention, all kinds of things—feelings—might open up, like Ron's wish for yet fear of closeness and the feelings of worthlessness and shame that make him flee.

The psychodynamic approach deals more with the past than the other approaches do, although it certainly doesn't neglect the present. It is particularly interested in trauma and loss. We know that depression is a symptom of trauma and that depression itself further traumatizes. And we know that ancient traumas, long secreted away from consciousness, can continue to depress. Of course loss can be traumatic and often is the central trauma in people's lives. The psychodynamic approach isn't interested in the past as history; it *is* interested in the past when it continues to influence or even determines the present. The psychodynamic therapist seeks to increase conscious awareness using all of the tools available. One such tool is dream interpretation. Patients are encouraged to report and explore their

dreams, hopefully opening up new avenues of awareness. Depression itself powerfully influences what and how we dream. Just as depression can constrict conscious life, it can also impoverish and constrict the unconscious life expressed in dreams. At first Ron Smith reported few dreams. It was only over a period of years that his dream life became available for us to work with.

The psychodynamic therapist would at one point challenge, or at least probe, Ron's reportedly happy childhood. There was just too much disturbance in his family: witness the suicide of one sibling and the drug overdose death of another for that to be entirely credible. Depressed people are often accused of "seeing through a glass darkly," retrospectively distorting and/or exaggerating their negative experiences, particularly their childhood ones. There is some empirical evidence that this is true. Nevertheless, my experience is rather the opposite, namely that people who suffer chronic depression engage in what I call *retrospective idealization*. Actually the proclivity towards distortion of memory works both ways, perhaps exaggerating the horrors of the past while paradoxically just as frequently repainting it with rose-colored paint. Psychodynamic therapists, including me, would be suspicious of those who see through rose-colored glasses. The reason all of this is important is that confronting real historical pain can indeed lighten or ameliorate depression. Ron's depression was softened by our reimagining his childhood in more realistic and darker terms.

There is also evidence that "depressives," at least up to a point, actually see the world more accurately than the non-depressed. There was a bumper sticker around a few years ago that read, "Shit, more shit, then you die." This does indeed encapsulate one aspect of reality, one that really exists and that the depressed person focuses on. Of course that's not the whole story.

Back to Ron. It may be that before his breakdown his hapistat—that hypothetical entity some theorists think is "preset" to an equilibrium point by heredity—was naturally high, giving him immunity to whatever in his childhood home doomed his two siblings. But I doubt it. There was simply too much depression in the family and Ron's long history of depression has to be connected to some pretty grim stuff early in his life.

Our hypothetical psychodynamic therapist would certainly want to know about those childhood enemas and the feelings and fantasies associated with them. My guess is that they were traumatic and

that the adolescent self-administered enema was an attempt to master that trauma by reliving it, turning a passive experience into an active one. Such an interpretation, typical of dynamic therapy, would serve to normalize or at last explain the source of shame and self-loathing, thereby softening one of the consistent and most punishing elements of Ron's depression. I could go on, but you get the idea.

Cognitive therapy stays in the present. Cognitive therapists would confront, challenge, and demonstrate the irrationality of many of Ron's present beliefs, beliefs that had gotten him depressed and are keeping him there, for example, his conviction that he is "worthless" or that his life has been a "complete waste." The cognitive therapist would try to convince Ron that such beliefs are counterfactual, at variance with reality. Take worthlessness. "Were you worthless when you were helping your outpatients in the army? How about the help you gave the inpatients before you got sick? What about the way you supported your mother during her declining years? How about the courage you showed when you repeated your first year of graduate school and went on to a doctorate?" Ron would no doubt argue, but the cognitive therapist would keep at it. "You generalize, distorting reality. Your life hasn't been a complete waste—look at the things you've accomplished. You yourself told me that you were a good therapist. How about that?"

The therapist might go on: "If you broke your leg and couldn't run a four-minute mile because of that, would you hate yourself? Depression is a disease and its effect on you is much like an injury. Just like the broken leg would slow you down, depression does the same thing. To blame yourself for being sick—for having a disease—is irrational. It makes things worse than they have to be."

Cognitive therapists also assign homework, teach coping strategies, encourage action, educate about depression and its causes, and persistently, gently, and determinedly challenge the irrational thoughts maintaining the depression. They use techniques like "thought-stopping," that is, instructing a patient to "talk back" to the inner voice telling him he's worthless, literally saying "shut up, leave me alone," role-playing non-depressed behaviors, and suggesting other ways of thinking. It all helps. Unfortunately, it's most helpful in acute depression. Still, it has something to offer in chronic depression. If it "only" loosens one obsessive self-hating thought, it has done something significant. Then you would be, to some extent, less deeply depressed.

The interpersonal approach encourages examining here-and-now interactions with other people that contribute to maintain depression. If Ron had consulted an interpersonal therapist during the period when he was having his breakdown, the therapist would have zeroed in on his relationships with his commanding officer, with his peers, with other hospital personnel, and with his patients. What sort of negative feedback loops were operating? For example, as Ron started feeling depressed he chose to work with the sickest patients, who frequently confirmed his growing belief that he was inadequate at best and useless at worst as a therapist. His already vey sick patients then being treated by a self-doubting depressed psychologist would be even less likely to improve, confirming Ron's belief that he was useless. Panic was not far behind.

The interpersonal therapist would make manifest this negative feedback loop and seek to disrupt it, perhaps by telling Ron that he needed to work with patients with better prognoses if he wanted to feel better, and then help him work through these fears of being inadequate with higher functioning patients so he could get some positive feedback.

Interpersonal therapy looks at the internalized feedback loops, the interpersonally destructive tapes imprinted by past experience that both cause and maintain depression. But its focus is on the present, including the interplay with the therapist. If Ron had consulted an interpersonal therapist after he returned home from the service and was subjected to relentless criticism for "laziness and malingering," the therapist might have suggested family therapy and helping Ron see the angry, "passive-aggressive" component of his nonfunctioning, while helping the family to see that they were just making things worse by berating Ron and telling them that if they backed off he might do better. Their rage at Ron's disease had become rage at him, and if they could see that dynamic, some improvement might have been possible.

All three psychotherapeutic approaches have their uses. All of them are helpful with the right patient at the right time. None of them "cure" chronic depression, although they may make it more tolerable. I believe that regardless of "school" or "technique," the most important predictor of therapeutic success is the relationship. I advise you to be in therapy; it helps, even if it doesn't cure. So don't give up. There is some professional out there who can be a force for good in your life and that is worth having. Depression is a bio-social-psychological phenomenon. Biological vulnerability, inborn or acquired

through traumatization, including the traumatization of major depression itself, interacts with the social surround that often contributes depressive forces, perhaps in response to the depressed one's behavior, such as rejection, unrealistic expectations and demands, and lacerating criticism, which in turn interact with internal saboteurs, self-hating self-concepts, and overidentification with now gone and/or malignant people in the sufferer's present or past life. All of these continually reinforce each other, resulting in either continuing plunging into the darkness or keeping you stuck there. No wonder you feel awful. You just can't find anything that you can do to make it better. Any decent treatment of chronic depression addresses each and every contributing factor enumerated above with appropriate means: pharmacological, somatic, social, and psychological.