

# Psychotherapeutic Approaches to the Treatment of Anxiety and Depressive Disorders

Robert Michels, M.D.

Psychotherapy, both alone and in combination with pharmacotherapy, is one of the most prevalent treatments for depression and anxiety. Research data are sparse, but there is ample evidence that several psychotherapies are effective for acute affective and panic disorders. The best data are for interpersonal and cognitive-behavioral therapies, with only early reports on the more common psychodynamic psychotherapies. There has been less study of more chronic disorders, but once again the suggestion is that appropriate psychotherapy is effective. Treatment should be active and focused on the patient's symptoms and current problems, not on character pathology or developmental psychodynamics. *(J Clin Psychiatry 1997;58[suppl 13]:30-32)*

The dramatic advances in the treatment of depression that have revolutionized the profession, its relationship to the public, and its value to society have largely come not from gains in psychotherapy but from advances in pharmacotherapies. However, most of the depression seen by American clinical psychiatrists today is chronic or recurrent, frequently complicated by comorbidities, particularly Axis II personality disorders, and is generally treated with a combination of pharmacotherapy and psychotherapy. In most American psychiatrists' offices, the psychotherapeutic component of that combined therapy is not one of the two psychotherapies that have been extensively evaluated by modern research techniques, but rather some variant of psychodynamic psychotherapy that was learned in residency programs. Most cases of depression, of course, are not even seen by psychiatrists in our country, but are handled by other physicians or nonmedical mental health specialists.

Notwithstanding this clinical reality, most of the existing research data are available for acute syndromes of patients with limited comorbidities who are treated with monotherapies. On the other hand, for patients who have been treated with psychotherapy, most of the research has been done on interpersonal or cognitive-behavioral or re-

lated short-term focused therapies. This paper is based not only on the systematic knowledge that we have accumulated regarding the pharmacotherapy of chronic depressive disorders, but also on inferences, extrapolation, and clinical intuition.

In this evolutionary process, the systematic study of the efficacy and effectiveness of the treatment of these chronic disorders is only beginning. We are beginning to expand clinical research on treatment in this area, extending it to the more common clinical problems: chronicity and comorbidity, with which we are familiar from our office practices, both with other Axis I disorders and with Axis II disorders.

These changes of focus on the chronic, the complex, and the comorbid will lead to a recurrence of interest in new forms of psychotherapy. We have enough early hints to recognize that just as the pharmacotherapies of 30 years ago—bromides, sedatives, or stimulants rather than the more specific antidepressants available today—are no longer the treatment of choice, so the psychotherapies of 30 years ago appear not to be the treatment of choice for these disorders.

We have learned, contrary to many predictions, that psychotherapy is a valuable treatment in depression.<sup>1-6</sup> It is more effective than placebo, and, for many patients, its effectiveness is comparable to the pharmacotherapies. As with the several available pharmacotherapies, there is no clear front-runner among the several psychotherapies for depression that have been evaluated scientifically.<sup>1,3,4,6</sup>

Similar to the situation of the serotonin selective reuptake inhibitors (SSRIs) a few years ago, the most popular psychotherapy in this country, psychodynamic psychotherapy, is widely used but not yet tested. Of course, the SSRIs were brand new, and psychodynamic psychotherapy is 100 years old. Our impression is that the tradi-

---

*From the Department of Psychiatry, Cornell University Medical College, New York, N.Y.*

*An earlier version of this paper was presented at the symposium "Advances in the Management of Chronic Depressive and Anxiety Disorders," May 7, 1996, New York, N.Y., sponsored by the American Psychiatric Association and supported by an unrestricted educational grant from the Roerig Division of the U.S. Pharmaceuticals Group, Pfizer Inc.*

*Reprint requests to: Robert Michels, M.D., Cornell University Medical College, 525 East 68th Street, Box 170, New York, NY 10021.*

tional modes of psychotherapy are not the right treatment for these patients, but that if we shift from nonspecific to specific therapies, we can provide effective treatment.

How does one treat patients with depression psychotherapeutically? My first advice would be to consult a manual for either cognitive-behavioral therapy or interpersonal therapy. We know that these treatments work. My impression is that most American psychiatrists who are more than 5 years out of training do not, in fact, do that. They continue to use variants of their more familiar psychodynamic psychotherapy.

What can we infer from the therapies of known efficacy about how we should modify our more traditional psychodynamic psychotherapies? First, as in any psychotherapy, we must set a goal. The goal in treating a patient with depression is to resolve the depression. That platitudinous statement is perhaps one of the most important ideas we must include in a discussion of the psychotherapy of depression.

If we expand the goal beyond resolving the depression to resolving all of the patient's unconscious conflicts or to curing the patient's personality disorder, it is highly likely that the psychotherapy will be experienced as yet another failure in the patient's life, and, therefore, the treatment for depression will result in further demoralization. Furthermore, it is difficult to evaluate the need for treatment for personality disturbances or other life problems in depressed individuals because the depression itself may mimic the appearance of chronic underlying difficulties.

Therefore, in the psychotherapeutic approach to patients with depression with comorbid chronic personality disturbances or pathology, treat the depression, cure it, take a break, and then decide whether further treatment for the other comorbid condition is indicated. It is an error to start to analyze or to initiate long-term intensive psychotherapy for chronic personality disturbances in a patient who, when first seen, is simultaneously depressed and in whom that depression has not been adequately treated.

The issue of dosage in psychotherapy is similar to the issue of dosage in pharmacotherapy. Once again, the goal is to treat the depression, to aim for the dose that will be effective without excessively promoting dependence on the therapeutic relationship. There is some suggestion that a higher dosage (e.g., twice a week) may be required for patients with chronic depression, while patients with acute depression may do well with once-a-week treatment.

How do we modify the traditional strategies of dynamic psychotherapy? First, the therapist must be present and active when treating these patients. The therapist's presence and activity must counter the patient's mood. Variations of the "blank screen" approach, such as encouraging the patient to shape the therapeutic experience while the therapist behaves as a detached nonparticipant, are depressogenic experiences for nondepressed patients and can powerfully aggravate clinical depression.

Secondly, much of the strategy of dynamic psychotherapy is designed to help people recognize, accept, and take responsibility for problems that they have perceived as happening to them, rather than being shaped or caused by them. This is the appropriate strategy for many personality disturbances or neurotic conflicts. However, it can aggravate depressive psychopathology because it is easily translated, with a little masochistic elaboration by depressed patients, into feeling that not only are they no good, but that their very disorder is their own fault and they are responsible for it. The effective psychological treatments for depression do not suggest that the depression is the patient's fault or the patient's responsibility.

Thirdly, the therapist must maintain the focus with these patients. Unstructured, free-floating approaches fail to deal with the ego deficits that are part of the core phenomenology of depression. Depressed patients lack the capacity to provide the focus that is essential for an effective goal-directed therapy. Such focus must come from the therapist—without the therapist suggesting that the need for this reflects a resistance or an act of avoidance on the patient's part. Once again, that suggestion would amount to a form of blaming the patient.

What are the subject areas of effective treatments? Symptoms, interpersonal relationships, the patient's avoidance of various life roles and pleasures, compliance with conjoint therapies, self-defeating patterns of cognition, and conscious or immediately preconscious psychodynamic constellations that lead to pain and suffering are all useful themes. In general, any exploration of early life determinants or genetics is best deferred unless they are conscious and used only as ancillary rhetorical tools in explaining patterns to the patient to help him or her understand current relationships.

The therapist's failure to advocate optimism and anti-pathologic patterns of activity by the patient may feed a transference fantasy that the therapist thinks the depression is an appropriate and justified, rather than an exogenous, ego-dystonic syndrome, for which the patient should be treated. Traditional psychodynamic treatment sees dysphoric moods as a sign of conflicts to be explored. It subtly suggests that they are the patient's fault. Effective treatments of depression, on the other hand, view dysphoric moods as target symptoms, not caused by the patient, to be treated with the recognition that various behavior patterns of the patient that may have adapted to these symptoms may aggravate or potentiate them. The therapist should recognize that exploring the underlying deep psychological conflicts is slow, painful, and depressing for patients and that the results are uncertain. Therefore, one should deal with immediate psychological infrastructures and the ways in which the symptoms have become integrated into the psychic economy.

The goals of the psychotherapy of depression are largely the same as the goals of the pharmacotherapy of

depression. They are not the same as the goals of the psychotherapy of long-standing personality disorders. This modification of approach is in some ways analogous to the way the profession a decade or two ago rejected the concept of the schizophrenogenic mother. I am now suggesting that we must also reject the concept of the depressogenic patient.

What about combined therapies, that is, combinations of psychotherapy and pharmacotherapy? They can be used, of course, either initially or in sequential trials. In general, psychotherapy, when combined with pharmacotherapy, tends to enhance compliance with the pharmacotherapy. Indeed, this is often one of the most valuable roles of combined therapy.

There is a great deal of discussion in the psychotherapeutic literature about the relative virtues and disadvantages of single or double therapists when we use combined therapies.<sup>7</sup> My own view is that there is no problem with a single therapist conducting both therapies with the possible exception of the combination of a pharmacotherapeutic regimen and classical psychoanalysis. However, this arises only infrequently. Combined therapies are most likely used when monotherapies fail, when compliance is a problem, when there are important Axis II comorbidities (although, as discussed above, it is not the time to focus on the Axis II issues), and when the depression is chronic.

Thus far, my primary model for discussion has been chronic depression, but most of the conceptual scheme will also apply to chronic panic or other anxiety disorders. The chronic disorders are more likely to have comorbidities, particularly Axis II comorbidities. However, nonspecific therapies aimed at character pathology do not usually help these syndromes.

The model for both chronic panic and chronic depression is one of treating and resolving the syndrome and the episode, preventing its recurrence, and dealing with comorbidities, residual adaptive deficits, and rehabilitation. In general, pharmacotherapy is quite valuable in treating and resolving the syndrome. For both depressive and panic disorder syndromes, psychotherapy is, for many patients, of equal value.

In terms of preventing recurrence, the data are less clear for psychotherapy. Pharmacotherapy has a role in preventing recurrence. Psychotherapy may have an important adjunctive role, particularly in enhancing compliance. There is some suggestion that psychotherapy used in the initial episode may lead to more stable recovery than pharmacotherapy in the initial episode<sup>1,2</sup> if the treatments are discontinued upon remission.

Generally, in dealing with Axis II comorbidity, psychotherapy is frequently the treatment of choice for the Axis II disorder. In dealing with the residual adaptive deficits, the

chronic demoralization, and the need to rehabilitate patients, once again psychotherapy is frequently the treatment of choice. In panic disorder with agoraphobia, one can conceptualize agoraphobia as a secondary phenomenon that must be dealt with in many patients if they do not respond fully to the pharmacologic treatment of panic, and that often requires psychotherapeutic interventions.

Combining goals in treating comorbid Axis I and Axis II disorders is relatively simpler in patients with anxiety disorders than those with depressive disorders, since psychotherapy tends to make people depressed more than it makes them anxious. Psychotherapy actually tends to reduce anxiety, although there may be chronic problems of promoting dependency, a particular risk in many patients with panic agoraphobic symptoms.

In summary, systematic research in psychotherapy is several decades behind that in pharmacotherapy regarding the treatment of patients with affective disorders. However, the existing data show that it has significant promise.<sup>3,4,8-10</sup> They also suggest that we must alter the content of our psychotherapy, just as our nonspecific stimulants or sedatives of three decades ago had to evolve to more specific pharmacologic agents before they were really helpful for depressed patients.<sup>5,6,9,10</sup> Our psychotherapies of a few decades ago that worked for some patients, but not many, are giving way to more specific, focused psychotherapeutic approaches that are effective for patients with anxiety and/or depression.

## REFERENCES

1. Shea MT, Elkin I, Imber SD, et al. Course of depressive symptoms over follow-up: findings from the National Institute of Mental Health treatment of depression collaborative research program. *Arch Gen Psychiatry* 1992;49:782-787
2. Weissman MM, Klerman GL, Prusoff BA, et al. Depressed outpatients: results one year after treatment with drugs and/or interpersonal psychotherapy. *Arch Gen Psychiatry* 1981;38:51-55
3. American Psychiatric Association. Practice Guideline for Major Depressive Disorder in Adults. Washington, DC: American Psychiatric Association; 1993
4. Treatment of Major Depression (Clinical Practice Guideline Number 5). In: *Depression in Primary Care*, vol 2. Washington, DC: US Dept of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research; 1993
5. Beck AT. *Cognitive Therapy of Depression*. New York, NY: Guilford; 1979
6. Jarrett RB, Rush AJ. Short term psychotherapy of depressive disorders: current status and future directions. *Psychiatry* 1994;57:115-132
7. Roose SP. Use of medication in combination with psychoanalytic psychotherapy or psychoanalysis. In: Michels R, ed. *Psychiatry*, vol 1. Philadelphia, Pa: JB Lippincott; 1995:1-8
8. Crits-Cristoph P. The efficacy of brief dynamic psychotherapy: a meta-analysis. *Am J Psychiatry* 1992;149:151-158
9. Gabbard GO. Psychodynamic psychotherapies. In: Gabbard GO, ed. *Treatment of Psychiatric Disorders*, vols 1 and 2. 2nd ed. Washington, DC: American Psychiatric Press; 1995:1205-1220
10. Thase ME. Reeducative psychotherapies. In: Gabbard GO, ed. *Treatment of Psychiatric Disorders*, vols 1 and 2. 2nd ed. Washington, DC: American Psychiatric Press; 1995:1169-1204