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Psychotherapies for Mood Disorders

Essential Concepts

- There is a basic disconnect between symptomatic and functional improvement in many patients with mood disorders.
- Often, despite symptomatic recovery, impairment continues in work and social functioning.
- Psychotherapies and psychosocial interventions may be needed to improve functional recovery.
- Patient-run support groups are also important psychosocial interventions and are associated with improved outcomes.
- Existential despair can be misinterpreted as part of chronic major depressive episodes. The therapeutic alliance between the doctor and the patient, even if not formalized in psychotherapy sessions, can be seen as an important kind of existential psychotherapy with benefits for this despair.

In this book, the treatment chapters have focused mainly on psychopharmacology. However, some further discussion of psychotherapies and psychosocial interventions is important.

THE PROBLEM OF FUNCTIONING

We should not lose sight of the importance of psychosocial interventions for mood disorders if for no other reason than that it appears that our pharmacologic interventions often produce symptomatic benefit but not functional recovery. In other words, patients' symptoms may improve, but they often do not return to having normal lives in the sense of returning to their previous level of work or study or in the sense of resuming or maintaining their previous level of interpersonal relationships. This disconnect

between symptoms and functioning is especially evident in the treatment of bipolar disorder. There is some evidence that despite almost complete symptomatic recovery from a manic episode, only about 40% of patients recover functionally 2 years later. The majority continue to have problems at home with their spouses and family and are unable to be employed full time. Further, partial remission of symptoms, with some residual depression or cycling, generally leads to incomplete functional recovery as well.

Sometimes we cannot do better, but we should not be complacent. Patients want to be completely well, and many of them can be, and full remission of symptoms plus attention to functional outcomes is the method to getting there. What appears to be the case is that more and more medications, in part due to worsened quality of life owing to side effects and in part due to limited efficacy, may not be the means to reaching this goal. It is not unreasonable to hope that psychotherapies and psychosocial interventions may be able to fill in this gap and lead to better functional recovery in the treatment of mood disorders.

WHAT KIND OF PSYCHOTHERAPY?

When such observations are made, it is perhaps too easy to conclude that therefore all mood disorder patients should receive medications and psychotherapy, the most common kind of psychotherapy being some supportive or psychoanalytically derived approach. I think that this conclusion is both too facile and too superficial.

Psychotherapies can be, and are, studied empirically, and thus I think that we should emphasize those with some empirical evidence of benefit for mood disorders. Unfortunately, the most common varieties, the supportive and psychoanalytically oriented types, have the least amount of empirical support.

In Table 22.1, I list and describe the major kinds of psychotherapies available for mood disorders. In Chapter 8, I discussed cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) to some extent in their use for unipolar depression. They are also proven effective in some studies in the prevention of relapse in bipolar disorder, as are the other therapies listed, (family-focused therapy and psychoeducation). In my opinion, psychoeducation in particular deserves widespread use because it is not complicated to learn and because insight is such a major problem in bipolar disorder.

TABLE 22.1. Types of Psychotherapies for Mood Disorder

Type	*Empirical Support*	*Comments*
Supportive	No	Seeks to support ego defenses; provides basic caring; no specific theory
Psycho-analytically oriented	No	Seeks to interpret underlying emotions; leads to insight; based on detailed theories; often emphasizes past relationships
Cognitive behavioral	Yes	Seeks to reduce the impact of negative cognitions on mood; helps with coping skills; useful for residual depression
Interpersonal	Yes	Focuses on present relationships; seeks to reduce triggers of episodes (including poor sleep habits)
Family focused	Yes	Seeks to reduce expressed emotion
Psycho-educational	Yes	Seeks to improve insight into illness and compliance with treatment
Existential	No	Seeks to communicate empathy and maximize the therapeutic alliance

While supportive and psychoanalytically oriented approaches possess limited empirical support, I do not mean to imply that they should not be used. The mere fact that so many therapists are trained in these approaches makes them often the only practical choices. However, I think that if other approaches are available, they should be preferred.

Personally, I also tend to emphasize the provision of existential psychotherapeutic methods to most of my patients. By *existential methods,* I mean the effects of simply "being there" for patients, not only providing an ongoing empathic connection but also constantly valuing and promoting the therapeutic alliance as a key ingredient to any treatment. As Ronald Pies has suggested, one might even view the therapeutic alliance as a mood stabilizer. The constant presence of the psychopharmacologist, being available for quick appointments during periods of instability, or perhaps a short phone call with a medication change at times is a-features of the therapeutic alliance that helps to stabilize patients. In the case of bipolar disorder, one can conceive of pharmacologic mood stabilizers as providing a kind of coarse mood stabilization, reducing the severity and frequency of full mood episodes. The patient is often left with residual, less severe mood instability, and it is the psychotherapeutic interventions that may be able to act as fine-grained mood stabilizers.

To some extent, the problem of functional impairment in mood disorders is a problem of residual symptoms (often depressive) that might improve with psychotherapeutic interventions. To some extent, functional impairment even persists with almost no symptom impairment. In such cases, other factors, such as long-term cognitive impairment as a result of mood episodes, need to be examined. Also, patients sometimes become so used to being ill that once their mood symptoms are improved pharmacologically, they are unable to cope with the demands and needs of a nondepressed, nonmanic lifestyle.

These are the types of issues that require the careful assistance of well-trained psychotherapists. Pills are not enough in these circumstances.

THE PROBLEM OF DESPAIR AND CHRONIC SUBSYNDROMAL DEPRESSION

As noted previously, with our best current treatments, many patients are left with mild to moderate chronic depressive symptoms. These symptoms in fact may reflect leftover depressive illness. Another possibility is that they reflect a psychological reaction to years of suffering—a kind of existential despair. Even after the biologically based mood episodes are controlled with medications, many persons with bipolar disorder appear to suffer from a sense of despair at having lost so much for so long. In such cases, an existentially oriented psychotherapy can be useful; even the therapeutic alliance between doctor and patient can be seen as an

existential treatment in this setting. Essentially, the therapeutic alliance acts as a kind of "mini-mood stabilizer" that can improve the low-level despair that hangs over the life of those who finally have improved from their severe mood episodes with medications. More medication frequently is not the answer: I commonly tell my patients that our medications are like sledge hammers—when they are severely ill with acute depression or mania, our medications can improve those severe mood swings, but when they have only mild depressive symptoms, our antidepressants either fail to work or just cause mania or more mood cycling. We need tuning forks in such circumstances, not sledge hammers, and sometimes a strong therapeutic alliance or existential or other psychotherapies can be those tuning forks that can make all the difference between full remission (and complete recovery) versus partial remission (and continued functional impairment).

OTHER PSYCHOSOCIAL INTERVENTIONS

Psychotherapy can be provided by psychiatrists, but also by social workers, psychologists, and nurse practitioners. Social workers and psychologists may be particularly well placed to provide psychotherapy because, increasingly, they often have more formal training in psychotherapies than do psychiatrists and nurses. Other psychosocial interventions are also relevant, however, many of which are related more closely to the field of social work. These include residential assistance, such as halfway-house living or structured day-treatment programs. These settings lead to better medication compliance as well as improved functioning. Vocational rehabilitation is important to begin the process of retraining patients for work settings appropriate to their state of symptomatic recovery. Vocational counseling is also relevant in teaching patients how to go about the basics of advancing a career. Family therapy is also quite important in terms of assessing and maximizing support networks for patients.

SUPPORT GROUPS

Perhaps the newest psychosocial support networks for patients with mood disorders are the patient- and family-run organizations that have developed in the last two decades. Examples are the National Alliance for the Mentally Ill

(NAMI) and the Depressive and Bipolar Support Alliance (DBSA). It is often the case that a person gets the most help from peers who have those conditions rather than from authority figures like medical professionals. Family members also find these support groups to be helpful as they cope with these serious illnesses. Persons who are regularly involved in these support groups tend to be more compliant with treatment and to have better outcomes. Cause and effect is unclear but the association is informative.

I think that it is important that patients become aware of these support groups and that clinicians work closely with these groups to help persons with mood disorders. In the long run, the more alliances that exist between patients, treaters, and families, the better are the outcomes.