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# Psychotherapy and Psycho-education of Depression

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**Abstract:** Progress of anti-depressants has reduced the number of depressive patients requiring hospitalization and increased those cases that may be treated at outpatient clinic. However, the drug therapy is not necessarily effective for all cases. The importance of psychotherapy is being re-evaluated for the patients, including particularly those for whom drug therapy is not indicated. Among psychotherapies are the psychoanalytic therapy, cognitive therapy, behavior therapy, interpersonal therapy, etc., and in recent years therapies that can achieve the effects in short-term are prevalent. Interests in psycho-education are mounting because of studies that family relations influence the prognosis and of the increased importance attached to informed consent. This means that the physicians and therapists work with the patient and family to deepen understanding of the disease and to prevent its aggravation as well as recurrences. A depressive person visiting a primary care physician for the first time should be seen with a flexible attitude depending on his/her signs and symptoms without adhering to therapies of different kind. In other word, there is no need to adhere to one therapy throughout the prodromal, acute and recovery stages.

**Key words:** Mood disorder (depression); Psycho-education; Psychotherapy

## Introduction

Drug therapies are the main stream of treatments for depression and their efficacy is irrefutable as discussed in many articles. In the clinical scene, it is said that drug therapy is effective for about 80% of the patients for removing themselves from the depressive phase and it becomes more effective when combined with psychotherapy. There are, however, light and dark sides to the drug

therapy, and in cases where the drug compliance is inadequate and drug therapy is not suitable, psychotherapy should mainly be pursued.

More concretely, there may be a young patient whose parent declines the drug therapy because of uncertainty about side effects, a patient may be pregnant or planning pregnancy, a patient may easily develop side effects of an anti-depressant because he/she is elderly or because of somatic complications,

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or a patient may be extremely uneasy about the drug therapy because of the past history of allergic reaction, or a patient is resistant to the drug therapy. One should be aware that the drug therapy is not omnipotent for treatment of depression.

When suicidal ideation for death such as "I wish to disappear", "there is no use for living any longer" or "I want to die" is observed, drug therapy or an emergency hospitalization should be considered.

This paper discusses the outline and the current state of psychotherapy and psycho-education focusing on mild and masked depression seeking primary care.

### Kinds of Psychotherapy

Psychoanalytical therapy has long been relied on for treating depressive mental disorders, but its time-consuming and expensive nature have limited the number of patients. In order to overcome these difficulties, the short-term psychotherapies such as cognitive therapy, behavioral therapy, and interpersonal therapy came to be widely practiced for achieving therapeutic effects in a short period of time. These therapies differ from psychoanalytical therapy in that the therapist gives positive and definite guidance and completes the therapy on a short-term basis by setting a clear-cut objective based on discussion and consultation.

Cognitive therapy was developed by Beck *et al.*<sup>1)</sup> and hypothesizes that although depression is a mood disorder, depressive patients have peculiar distorted cognition, which deteriorates their mood. This distorted cognition is what is lately described as negative thinking. By correcting the distorted cognition, the therapy aims at improving the mood.

The behavioral therapy reinforces a person's manner of addressing things by advice, feedback, and compensation based on a hypothesis that the mood can be changed by changing behavior. According to this theory,

the reason why there are so many depressive elderly persons is because the elderly finds little pleasure in daily life. They are recommended to engage in activities that they can enjoy as much as possible (Lewinsohn *et al.*, 1974).<sup>2)</sup>

Interpersonal therapy was developed by Klerman<sup>3)</sup> and Weissman *et al.*<sup>4)</sup> from the interviews by Sullivan *et al.* focusing on the interpersonal relationship in 1930s. The therapy is characterized in that the treatment period is as short as 12 to 16 weeks and that the problem is defined by focusing on the current interpersonal relationship, not on cognition or behavior.

The problem area is grief after the loss of an object; discord involving the interpersonal roles, which is the friction in personal relationship, change in roles, and lack of interpersonal capacity. By clarifying the problem and capturing the positive and the negative emotions that generate, the interpersonal relationship of the past is understood and the alternatives are sought.

When handling grief, the patient is encouraged to express emotions at the time of the loss of an object, to reconstruct the relationship that has been lost, and to start attachments and activities anew. Discord among roles often arises out of differences in expectations toward respective roles. It should be determined whether or not to re-negotiate, whether the situation is at a standstill, or parting is unavoidable, and then solutions to the problem are prompted, gaps are clarified and grief work is performed. As for changes in the role, the patient is made to give up the role he/she has been enacting, to express anger or sense of loss, to acquire techniques required by the new role toward the society and to support building a new social network.

### Psycho-education

Psycho-education is a general term for an educational approach of assistance to offer

accurate knowledge and information about the nature and methods of treatment and addressing the disease needed for cure added with consideration for psychotherapy.<sup>5)</sup>

In the background of why psycho-education is now regarded important is that litigations against the unilateral treatment provided by medical profession have increased. As abundance of medical information passes to the patients' side, it is difficult and often chaotic to understand and deal with them adequately. A study on how the family expresses emotion influences prognosis of mental disorder suggests the importance of understanding of the disease by the family and closed. This means not only the unilateral offering of information from the medical service provider but also removing misunderstandings of the disease, improving cognition, and evaluating the manner of addressing problems surrounding the disease. Thus, it is called psycho-education, not mere education. The objects are not limited to psychiatry patients but include those suffering from cancer, AIDS, and the sequel of strokes. The important thing is that the treatment is performed not by the top-down method of doctor to patient, but by cooperation with the patient and the family.

### Current State in Clinical Medicine

Although psychotherapy and psycho-education were discussed by distinguishing them as in textbooks, it is quite difficult to differentiate the cognitive therapy, the behavioral therapy, and the interpersonal therapy in clinical medicine.

A therapy mainly focusing on thoughts such as cognition may utilize the aspect of behavioral theory and the reverse is also possible. When an interpersonal issue is taken up, an interpersonal therapeutic approach is naturally applied. According to Elkin *et al.*<sup>6)</sup>, the difference in their efficacy as evaluated by the psychological evaluation scale is not so clear. Even though they do have their own unique

features, the issue is not about which one is superior to others. Treatment should be provided by utilizing the features of respective therapies adroitly. It is not necessary to adhere to the therapy chosen at the start. It is necessary to cope with the patient's conditions by observing the phases of depression.

As the phases of depression, there are the prodromal stage, the depressive stage, and the recovery stage. In the prodromal stage, it is difficult to detect and intervene for a patient who has developed the disease for the first time. For a recurrent patient, the same signs as those at the time of the first onset appear often, enabling intervention at an early stage. These are called the warning signs. Once a warning sign is recognized, attempts should be made as soon as possible to remove stresses by encouraging the patient to share the work load with others, decrease the overtime work, and take the paid leave.

In the depressive stage, psychotherapy and psycho-education are effective for mild to medium degree morbidity. For the grave cases, drug therapy and electro-shock therapy must be considered. At the first examination of a depressive patient, Kasahara's minor psychotherapy<sup>8)</sup> is often relied; the author learned the technique while still an intern. According to Kasahara, it is important to explain that (1) this is a illness, not laziness, (2) respite is the best remedy, (3) the illness is bound to be cured, (4) the patient should promise not to commit suicide, (5) the patient should not make an important decision of life during this period, (6) the patient's conditions fluctuate during treatment, and (7) side effects should be explained and the importance of medication should be emphasized.

When suspecting depression at the time of primary care examination, the physician should sympathize with the patient on painfulness of the current situation and explain the causative disease. If the patient is feeling uneasy because the cause was not uncovered by examinations at the departments of ortho-

pedics, internal medicine, and otolaryngology, he/she will feel secure if the cause is precisely explained. On the other hand, the term "depression" does sound as if it is incurable and the patient may show rejection when informed. After the patient is told of the name of the disease, he/she should be explained fully about its general course and high probability of successful cure. The patient should also be explained that depression is rather a common disease that anybody may catch.

In the acute phase, physical respite is naturally called for. But after a while, the patient calms down. Lying down at home is not necessarily restful for all, and he/she should be told to do what he/she like such as listening to music or reading and take mental respite. These would be approaches of behavioral therapy. However, depression has long been considered to be a state where one has exhausted energy, and recovery may be delayed by consuming energy for such activities. The patient should be recommended to save energy for the following day.

How much he/she should save energy is proportional to his/her degree of recovery. The patient is asked to measure to what percentage he/she has recovered by deeming his/her usual state as 100%. When he/she has recovered by 60%, he/she is asked to conduct only 60% of his/her usual activities and save 40% for the following day.

The patient may be anxious to return to work and may be preparing for work without the physician's awareness. Preparing for work is not what the patient wants to do but is something he/she feels must do, and therefore does not remove stresses. Preparation for work may prolong the leave of absence when the patient is feeling strongly uneasy about returning to work.

Since people around him/her cannot easily see abnormality or injury as in the case of bone fracture and there is no apparently valid excuse for leave-taking, the patient is often found blaming himself/herself for being lazy.

He/she cannot persist even if he/she wants to or his/her problems are not resolved by perseverance. One should be careful because encouraging the patient to persevere may aggravate the conditions.

Giving such information will considerably relieve the patient and will be enough as intervention in the first stage. Except where the case is mild, cognitive or behavioral therapy may induce confusion if attempted in the very early stage. It is the same for psycho-education. Information should be given to the family first while the patient is still unsettled and discussion of how to deal with the patient within the family should be held.

In the recovery phase, the patient has somewhat recovered energy and may be able to conduct some complex work in terms of behavioral therapy. At this point, psycho-education is most useful because of few side effects and low rate of dropouts. The focus should be placed on preventing recurrences. It is a good opportunity to consider with the physician and the family how to best address the problem that has been causing stresses.<sup>9)</sup>

## Conclusion

Psychotherapy and psycho-education for depression were discussed. Very few patients visit the psychiatrist at the onset as they visit clinics of other somatic medicine. In this context, the role of a primary care physician is quite important.

There are two types of primary care administered to depressive patients. One is that the physician does not realize there is depression because the patient complains mainly of physical discomforts. Another is that the primary care physician readily refers the patient to the psychiatrist. In the former case, depression should be diagnosed first to find out why symptoms do not alleviate after many tests and drug therapies and then an antidepressant, etc. as well as psychotherapy should be administered. Listening to the

patient alone may lead to cure. In the latter case, the psychiatry department is not so easily accessible and referral without preliminaries may shock the patient and the family. To facilitate treatment by a specialist, sufficient time should be spent on explanation.

Even psychiatrists may not be well versed in cognitive therapy, behavioral therapy or interpersonal therapy. If the physician takes the position of viewing things at the same eye level as the patient and try to work out countermeasures with the patient and the family, this may lead to successful psycho-education. In the old days, general practitioners must have been good psychiatrists.

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