A Melancholy Breach

Science and clinical tradition clash amid new insights into depression

By BRUCE BOWER

In the past decade, psychiatrists, psychologists and others dealing with depressed patients have experienced an odd mix of optimism and unease.

Their optimism stems from a growing confidence in various combinations of talk therapies and drug treatments to allay mild to extreme forms of depression. Their unease emanates from a harsh exchange between two clinical camps over how best to subdue the sometimes life-threatening symptoms of "major" or severe depression.

An increasingly powerful, research-oriented camp trumpets scientific data supporting a marriage of antidepressant drugs with short-term psychotherapy aimed at altering depression-inducing thoughts and behaviors. A second group of mental health workers, with a perspective grounded in Freudian psychoanalysis, eschews the pursuit of scientific data. Instead, they rely on decades of clinical experience with long-term "psychodynamic psychotherapy" focused on unconscious conflicts and emotions. These therapists grant medication a supporting role at best.

A lawsuit launched in 1982 epitomized this rift. A former patient at a prestigious mental hospital in Rockville, Md., sued the hospital for negligence because it had failed to treat his severe depression with antidepressant drugs. Hospital clinicians had offered the man only intensive, four-times-a-week psychodynamic psychotherapy. The case, known as *Osheroff v. Chestnut Lodge,* achieved considerable notoriety in the mental health community before an out-of-court settlement in 1987, for an undisclosed amount of money, staved off a jury trial.

Friction between biologically and psychodynamically oriented therapists shows no signs of dissipating in the 1990s, especially as insurance dollars for mental health care dwindle. Another ongoing and related dispute — involving both mental health workers and organizations of mental patients and their families — concerns whether major depression and other serious mental disorders primarily represent diseases or stem in critical ways from social and emotional factors.

As these issues continue to generate heated debate, two new investigations shine some precious light on depression's causes and treatments.

Women suffer from all forms of depression at twice the rate of men largely because of cultural and social factors rather than biological predisposition, concludes the National Task Force on Women and Depression in its final report, released last December. The 20-member task force, commissioned by the American Psychological Association (APA), spent three years reviewing research and synthesizing the findings.

Some investigators maintain that the depression gender gap reflects women's greater ease in talking about emotional distress and contacting mental health workers. The APA report, however, accepts the gap as genuine and characterizes it as a product of several risk factors — predominantly social and cultural ones — that promote depression among women. Those factors, according to the report, include physical and sexual abuse, unhappy marriages, poverty and a culturally sanctioned tendency for women to dwell on feelings of depression rather than act to overcome them. Researchers often neglect social factors that influence depression among women, says report coauthor Bonnie R. Strickland, a psychologist at the University of Massachusetts in Amherst.

In addition, hormonal changes related to reproductive events, including menstruation, pregnancy, childbirth and infertility, may further influence women's depression, according to the report. In the case of major depression, the task force grants culture and upbringing equal power with female physiology.

Bouts of major depression last for at least two weeks. Some people suffer only one or a few such episodes, while others spend years dipping in and out of a dark well of melancholy. Typical symptoms include a loss of interest and pleasure in virtually all activities, feelings of helplessness and hopelessness, sleep and appetite disturbances, loss of energy, and thoughts of suicide. An estimated 15 percent of severely depressed people kill themselves, and many more attempt suicide. A recent survey by the National Institute of Mental Health indicates that recurring, severe depression afflicts about 2.5 million men and women in the United States.

According to the task force report, scientific studies show that two forms of short-term psychotherapy — usually lasting a few months — provide help to women suffering from mild to severe depression. Interpersonal therapy examines how conflicts with others and disturbed relationships contribute to depression. Cognitive-behavioral therapy attempts to correct the distorted thinking, attitudes and behaviors that characterize depression.

Many clinicians treat severely depressed people with long-term psychodynamic psychotherapy, but the task force asserts that virtually no scientific studies have charted the effectiveness of this approach, leaving its supporters to take guidance from clinical reports and experience.

Antidepressant medication proves "at least partially effective" for women with major depression, according to the report, particularly when physicians carefully monitor individual doses of these powerful drugs.

However, the task force charges that much antidepressant research suffers from a "gender-related blind spot." Comparisons of men's and women's responses to the drugs rarely appear, and few studies examine the effects of tailoring women's antidepressant doses to the menstrual cycle — a strategy that may improve medication effectiveness, according to the report's authors.

Regardless of gender, continued high daily doses of imipramine — a commonly used antidepressant — quell most recurrences of major depression with remarkably few side effects, according to a new study reported in the December 1990 ARCHIVES OF GENERAL PSYCHIATRY.

Short-term psychotherapy, combined with generous doses of imipramine or chemically related antidepressants, pulls many individuals out of the depths of depression, says study coauthor David J. Kupfer, a psychiatrist at the University of Pittsburgh School of Medicine. When depression lifts after a few weeks or

months, treatment with the same amount of medication for at least three years usually keeps mood on an even keel, he contends.

Most clinicians currently reduce the prescribed antidepressant dose or stop drug treatment altogether once an individual under their care sheds the cloak of depression.

"We can now tell people, 'The dose of antidepressant that gets you well keeps you well,'" says psychologist Ellen Frank, also of the Pittsburgh School of Medicine, who directed the investigation.

Frank and her colleagues studied 230 people who had experienced recurring periods of major depression for an average of 12.5 years. All participants entered the study during an episode of depression. For the first 17 weeks, they received a relatively high daily dose of imipramine – about 200 milligrams – and sessions of interpersonal therapy every week or two. This approach eased depression for 98 women and 30 men. The rest of the participants left the study, mainly due to a lack of response to the treatments or intolerable side effects from imipramine.

The remaining volunteers received one of five maintenance treatments for the next three years. Twenty-eight participants stayed on the same daily imipramine doses that helped spur their recovery; 23 received daily placebo capsules; 26 attended monthly interpersonal therapy sessions; 26 got interpersonal therapy and placebos; and 25 got therapy and the full daily dose of imipramine.

Of the 53 participants who stayed on imipramine, 41 remained free of depression for the entire three years. The combination of interpersonal therapy and imipramine showed no clear advantage over imipramine alone, probably because the drug's effects proved so successful that psychotherapy added little over the long haul, Kupfer says.

Only one-fifth of the placebo-only group avoided depressive episodes during the maintenance period. Volunteers who went without imipramine but received monthly interpersonal therapy fared better, with about half remaining well for the entire three years. Interpersonal therapy may thus offer a "window of wellness" to many women who wish to discontinue antidepressants during pregnancy, Frank notes.

No statistically significant difference emerged between the responses of men and women in the maintenance study.

Imipramine and chemically related antidepressants can cause a number of side effects, including dry mouth, blurred vision, weight gain, drowsiness, lowered blood pressure, constipation and impotence. But of the 22 volunteers who dropped out of drug treatment during the maintenance period, only four cited medication side effects as the reason, Kupfer observes.

He notes that general practitioners – who see the bulk of severely depressed patients – often refrain from prescribing antidepressants out of fear that individuals in the throes of melancholy will take intentional overdoses. Yet no suicides, and only one attempted suicide, occurred among participants in the Pittsburgh study, Kupfer says.

With careful blood monitoring of high-dose antidepressants, presumably including the new and widely touted fluoxetine (Prozac), "the danger of suicides and overdoses isn't what primary-care physicians have been led to believe," Kupfer maintains.

Despite the growing evidence of antidepressants' benefits and the absence of scientific data to back psychodynamic therapy as an effective treatment for major depression, psychodynamic proponents and their critics continue to skirmish in the aftermath of the *Osheroff* case. Two psychiatrists at the center of the debate squared off in the April 1990 AMERICAN JOURNAL OF PSYCHIATRY.

APA/Thorina Rose

Psychiatric patients have a right to treatments with a scientific stamp of approval, which psychodynamic therapy lacks, contends Gerald L. Klerman of Cornell University Medical College in New York City. Klerman, a co-developer of interpersonal therapy, believes substantial evidence exists for treating severe depression with a combination of antidepressant drugs and short-term therapy.

"The issue is not psychotherapy versus biological therapy, but rather opinion versus evidence," he maintains.

Alan A. Stone of Harvard University in Cambridge responds that psychodynamic psychotherapy promotes gains in self-knowledge and emotional awareness not captured by stringent scientific studies. Many mental health workers still rely on the psychodynamic approach to treat mild to major depression because the therapy passes clinical, if not scientific, muster, he says.

Most scientific studies of treatments for mental disorders remain preliminary and should not "dictate to clinicians the clinical standards of care," he adds.

Some clinicians say the *Osheroff* settlement has already cast a pall over patient care. "It seems that if we so much as inquire whether a depression might be related to the stresses or losses of life before blasting it with a chemical, we are virtually guilty of malpractice," writes psychiatrist Matthew P. Dumont in the October 1990 AMERICAN JOURNAL OF ORTHOPSYCHIATRY.

Dumont, medical director of the Chelsea (Mass.) Community Counseling Center, charges that psychiatry "should openly declare its identity as an arm of the drug industry." Pharmaceutical money now underwrites most of psychiatry's academic research, professional journals and scientific conferences, he argues. What's more, psychiatrists and other physicians each receive thousands of dollars' worth of logo-inscribed reprints, coffee mugs, pens, calendars and other gifts annually from drug company representatives, creating a clear conflict of interest when it comes time to write prescriptions, Dumont says.

His argument echoes testimony at a Dec. 11 hearing convened by the Senate Labor and Human Resources Committee. Some participants, including a former public relations official for a pharmaceutical firm, claimed that drug companies devise expensive giveaways to bribe physicians into prescribing their products. Representatives of the pharmaceutical industry and the American Medical Association denied the charge, pleading the importance of quick communication between drug companies and physicians concerning the rapid advances in drug treatment.

Many psychiatric leaders defend their profession's ties to major drug companies as a boon to research on mental disorders such as major depression.

Meanwhile, back at the front lines of depression treatment, optimism and unease hang tough. □