HANDOUTS

Strategic Therapy for Comorbid Anxiety and Depression

Presented By

Michael Yapko, Ph.D.

Thursday

8:15 a.m. Registration (continental breakfast buffet)

9:00 **Treating the Distressing Duo**

- To focus first on the anxiety or the depression
- When anxiety is primary: Clues and implications
- When depression is primary: Signs and strategies
- Core etiological patterns shared by depression and anxiety
- Thinking strategically about treatment: Pattern interruption
- Designing and delivering focused strategic interventions

10:20 Break (coffee and tea)

10:35 **Anxiety, Depression and the Meaning of Life:**
Explanations that Harm

- How global thinking affects your outlook and life skills
- Therapist skill-builders: Structuring behavioral activations
- Moving forward when you don't know where to go
- Ambiguity as a major risk factor: Being clear about uncertainty
- Exercise: Ambiguity and giving therapeutic advice
- "Better living through chemistry" isn't
- What therapy does better

12:00 Lunch (on your own)

1:30 **Special Focus: Sleep Issues**

2:45 Break (coffee, tea, soda, snack)

3:00 **Controllability as a Core Issue**

- Exercise: What's controllable?
- Illusions of helplessness and control
- Risk assessment and personal resources

4:30 Adjournment (pick up one-day certificates)

Friday

7:45 a.m. Registration (continental breakfast buffet)

8:30 **Biology and Psychology on a Collision Course**

- Family history and gene-environment correlations
- The biopsychosocial model of depression
- The social context of depression

9:50 Break (coffee and tea)

10:05 **Epidemiology as an Informant**

- Gender differences
- Coping styles - family risks for depression
- Expectations, dating, marrying, and depression
- Relational and parenting skills and trans-generational risk
- Depressed parents raising children - and vice versa

11:30 Lunch (on your own)

12:45 **Watching it Work:**
Hypnotic and Strategic Intervention

- The Case of Terri
  Ambiguity about aging as a source of distress

2:00 Break (coffee, tea, soda, snack)

2:15 **Skill Building in Treating Comorbidity**

- Crystallizing key aspects of experientially-based treatment
- The art of making key distinctions between contexts in life choices
- Compartmentalization strategies and decision-making
- The possibility of prevention requires us to shift our priorities
- Q & A summary and closure

3:45 Adjournment (pick up certificates)

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presents

Strategic Therapy for Comorbid Anxiety and Depression

with

Michael D. Yapko, Ph.D.

June 22-23, 2006

Is Depression Caused By:

- Genetics?
- A biochemical imbalance?
- Psychosocial stressors?
- Cognitive distortions ?
- A lack of environmental and social rewards?
- Social inequities?
- Cultural/familial influences?
- Mishandling key vulnerable situations?

The Biopsychosocial Model Of Depression

- Depression has a ***biological*** component (genes and biochemistry, diseases,drugs)
- Depression has a ***psychological*** component (cognitive distortions, history)
- Depression exists in a ***social*** context (social disturbances, distress, cultural influences)

Hard Questions About Defining and Diagnosing Depression

There are 227 possible combinations of symptom presentations for DSM-IV Major Depression- "a bewildering array of manifestations for a supposedly singular entity"

Is it a discrete phenomenon, like a heart attack, or a relative one?

(Pettit & Joiner, *Chronic Depression*, 2006, APA)

New Recommendations for Depression Screening

The U.S. Preventive Services Task Force (USPSTF) finds "good evidence that screening for depression in primary care practices can improve clinical outcomes in adult patients."

The method of depression screening can range from structured written questionnaires to simply asking two questions: one about mood and one about anhedonia.

USPSTF, Annals of Internal Medicine, May 21,2002, 136: 760-764

Or visit: ***www.ahrq.gov/clinic/3rduspstf/depression***

Depression is Often Co-Morbid With:

- Anxiety Disorders
- Substance-Related Disorders (especially alcoholism)
- Anorexia and Bulimia
- Personality Disorders
- Medical Conditions

Depression and Anxiety Co-Morbidity

- Approximately 60-70 percent of persons with MDD also suffer an anxiety disorder. In descending order:
- Social phobia
- Simple phobia
- Post -traumatic stress disorder (PTSD)
- Generalized anxiety disorder (GAD)
- Agoraphobia

Anxiety as a Risk Factor for Depression

Depending on the type of primary anxiety disorder, the risk for onset of secondary depression is increased 2-4x above the risk expected for subjects with no previous history of anxiety disorders. The ***number of anxiety disorders present***, the persistence of ***anxious avoidance behavior***, and the ***degree of psychosocial impairment*** are strongest factors associated with depression onset.

Wittchen et. Al, ***Acta Psychiatrica Scandinavica***, 102(406), 2000

Evidence For Etiological Overlaps

Two main areas of shared treatment success:

Pharmacological: SSRI's efficacy

Psychotherapeutic: CBT's efficacy

Concurrent resolution: Treating one disorder often leads to the remission of the other

Barlow, ***American Psychologist***, Nov.,2000

Anxiety Typically Precedes Depression in Young People

The finding that most anxiety disorders seem to occur temporally prior to depressive disorders has stimulated considerable research efforts to determine why people with anxiety disorders might be at an increased risk for developing depressive disorders.

Wittchen et al., ***Acta Psychiatrica Scandinavica***, 102 (406), 2000

Pure Anxiety and Depression Have Different Ages of Onset

Anxiety disorders are found to start predominantly in childhood and early adolescence and uncommonly after age 20. Depression increases in incidence sharply in late adolescence and continues to rise remarkably in those age 20 and over.

Wittchen et al., ***Acta Psychiatrica Scandinavica***, 102(406),2000

Anxious Children

- 8-10% of American children and adolescents are seriously troubled by anxiety.
- More than 3 million children suffer one or more of the eight anxiety disorders.
- Anxiety is the most prevalent psychiatric diagnosis in those 16 and younger
- Anxious children are 2-4 times more likely to develop depression.

Dacey & Fiore, *Your Anxious Child*, Jossey-Bass, 2000

Central Patterns Reflecting Anxiety/Depression in Kids

- They find it harder than other children to calm themselves when they're in a stressful situation.
- Although many are above average in creativity, they seldom use their ability when making plans to cope with their anxiety.
- Even when they do have a good plan, they tend to become discouraged with it after a short while and quite trying.

Continued……

Central Patterns Reflecting Anxiety/Depression in Kids

- Even when making progress in reducing their anxious feelings, they fail to recognize their success.

Dacey & Fiore, *Your Anxious Child*, Jossey-Bass, 2000

Cognitions of Anxious Children

Anxious children:

- ❑ interpret ambiguous situations negatively
- ❑ report more dysfunctional cognitions
- ❑ judge ambiguous situations as dangerous

Bogels & Zigterman, ***J of Abnormal Child Psychology***, 28(2), 2000

What Does the High Rate of Co-Morbidity Mean?

Anxiety disorders may:

- constitute an early manifestation of MDD
- represent alternative manifestations of MDD
- increase the hazard for MDD onset
- be unique conditions which are highly co-morbid due to shared risk (genetic or environmental) factors

Kaufman & Charney, ***Depression & Anxiety***,12(Suppl.),2000

The Cognitive Cornerstones of Depression and Anxiety Co-Morbidity

Negative thoughts involving an:

***Over*estimation of danger**, threat and fear

and an

***Under*estimation of one's abilities** to cope with threats

This is true both for adults and children

Bogels & Zigterman, ***J of Abnormal Child Psychology***, 28(2), 2000

Differences in Somatic Symptomatology

Depressed patients have more conspicuous vegetative symptoms, such as anorexia, weight loss and diminished libido

Anxious patients have symptoms more closely associated with sympathetic nervous over-activity, such as tachycardia, sweating, and symptoms induced by hyperventilation.

Maser et al., in ***Handbook of Depression***, 1995

Depression & Physical Symptoms

In an international study of medical clinics conducted in 14 countries on 5 continents, somatic symptoms were common – in fact, an average of 69% of patients with MDD presented only with somatic symptoms (e.g., headache, constipation, back pain, chest pain dizziness, weakness and musculoskeletal complaints).

Simon et al., New England J. Of Medicine, 1999, vol. 341, pp. 1329-1335

Four Key Factors to Consider in Determining a Primary Diagnosis

- Predominant mood
- Sleep pattern
- Psychomotor change
- Response to exercise

Clayton, ***J of Clinical Psychiatry***, (Suppl.11),1990

Overlap Symptoms of Depression/Anxiety

- Dysphoria
- Sleep disturbance
- Appetite disturbance
- Impaired concentration
- Fatigue
- Irritability
- Non-specific somatic complaints

Clayton, ***J of Clinical Psychiatry***, (Suppl.11),1990

When the Anxiety Disorder is Primary

- Anxious mood
- Initial insomnia
- No psychomotor change
- No significant therapeutic response to exercise

Clayton, ***J of Clinical Psychiatry***, (Suppl.11),1990

When the Depression is Primary

- Depressed mood
- Terminal insomnia
- Psychomotor agitation or retardation
- Positive response to exercise

Clayton, ***J of Clinical Psychiatry***, (Suppl.11),1990

Global Cognitive Style as a Key Factor

When you can't see the forest for the trees…

Global Thinking ***in the Symptom Context*** Virtually Precludes the Ability to:

- Compartmentalize (contain anxiety)
- Think linearly, sequentially
- Maintain good boundaries
- Make key discriminations

Therapeutic Technique ***Does*** Matter

"…recent data indicate that psychological treatments require considerable clinical expertise and a strong therapeutic relationship to maximize efficacy…specific strategies that experienced therapists choose to undertake when confronted with a variety of different patient styles contribute to the determination of outcome."

Barlow, D. *American Psychologist*, December, 2004, p.874

Learning to Think Strategically

1. What are the goals in concrete terms? What is the order of priority?
2. What specific resources (abilities) will the client need in order to accomplish the goals? Can you identify them and create a learnable linear sequence for applying them?

Learning to Think Strategically (continued)

3. Does the client already have these resources and they are in some way dissociated? Or, does the client need to be trained to develop the requisite resources?
4. How will contextualization be accomplished? Through hypnosis? Task assignments?

Pattern Interruption Strategies

- Alter the rate or frequency of the symptom pattern
- Alter the duration
- Alter the time (hour, day, week)
- Alter the location
- Alter the intensity
- Alter the sequence

Part 2: Ambiguity and Meaning

The Projective Hypothesis

When you encounter an ***ambiguous stimulus***, you project meaning onto it using your own frame-of-reference

Attributional Style Affects Your:

- Mood
- Health
- Productivity
- Sociability/Likeability

The consequences for adopting the arbitrary life perspective one holds are ***not*** equivalent in people

Ambiguity is a Risk Factor

- People strive to understand and make "meaning"
- Ambiguity raises, while certainty lowers, anxiety; projection as a coping device
- Cognitive distortions represent efforts to reduce, eliminate ambiguity
- A therapeutic goal is to learn to both RECOGNIZE and TOLERATE ambiguity

Attributional Style

- Purpose: To identify the client's characteristic patterns for self-explaining the events of life
- Describe the event in objective terms ("Here's what happened.")
- State perceptions of the major cause of the event ("I think it happened this way because...")

Attributional Style Patterns to Identify

- Internal or external ("It's me/ It's them.")
- Stable or unstable ("It will always be this way/ It will change.")
- Global or specific ("It affects everything/ It affects only this.")

Stable Style Predicts Whether the Client Will be Prone to :

- seek treatment
- progress quickly or slowly
- actively participate in treatment
- experience a partial or complete recovery
- relapse

Adopting a Frame as the Predictor of Response

Example: Dealing with an upset child

- He's just upset right now. He'll get over it.
- He's been traumatized. He needs help.
- He's a hyperemotional wimp.
- I was just like that when I was his age.
- He's such a sensitive child, probably going to be a poet or something artistic.
- I must be a terrible parent.

One of the most powerful social forces operating today is the push to comply with a biological interpretation of depression

Is Antidepressant Efficacy Overblown?

- "Published medical evidence fails to support a clinically meaningful benefit of antidepressant therapy…selective presentation of data from drug trials explain the benefits that are claimed."

Moncrieff & Kirsch, July 16 (2005), *British Medical Journal, 331*, 155-157.

The Decline of the Serotonergic Hypothesis of Depression

"For the last 40 years, medical science has operated on the understanding that depression is caused by the lack of serotonin…the theory is appealingly simple: Sadness is simply a shortage of chemical happiness. The typical antidepressant – like Prozac or Zoloft – works by increasing the brain's access to serotonin. If depression is a hunger for neurotransmitter, then these little pills fill us up.

Unfortunately, the serotonergic hypothesis is mostly wrong…

cont'd on next slide

The Decline of the Serotonergic Hypothesis of Depression

…After all, within hours of swallowing an antidepressant, the brain is flushed with excess serotonin. Yet, nothing happens; the patient is no less depressed. Weeks pass drearily by. Finally, after a month or two of this agony, the torpor begins to lift

But why the delay?"

Lehrer, "The Reinvention of the Self," Seed, Vol. 2 (3), Feb/March, 2006, p. 63

Antidepressants, Trophic Factors and Neurogenesis

"…a range of antidepressants trigger a molecular pathway that has little, if anything, to do with serotonin. Instead this chemical cascade leads to an increase in the production of a class of proteins known as trophic factors. Trophic factors make neurons grow…If the relief from depressoin was due to changes in serotonin, then halating neurogensis with radiation should have had no effect.

But it did…If there is no increase in neurogenesis, then ADMs don't work in rodents."

Lehrer, "The Reinvention of the Self," Seed, Vol. 2 (3), Feb/March, 2006, p. 63

Therapy as Enrichment: A Catalyst to Neurogenesis?

Animal studies but no human studies yet, make it clear that neurogenesis is critical to recovery from the effects of trauma and deprivation. Elizabeth Gould, the neuroscientist credited with discovering neurogenesis, said: "My hunch is that a lot of these abnormalities [caused by stress] can be fixed in adulthood. I think there's a lot of evidence for the resiliency of the brain."

Lehrer, "The Reinvention of the Self," Seed, Vol. 2 (3), Feb/March, 2006, p. 67

Life Experience Changes Brain Chemistry

Psychotherapy results in brain changes visible on PET scans

(Schwartz & Begley, **The Mind and the Brain: Neuroplasticity and the Power of Mental Force**. New York: HarperCollins, 2002.)

When placebos work, they do so by changing brain chemistry

(Mayberg et. al, **Am J of Psychiatry**, 2002, 159(5): 728-737.

Suggesting a drug will cure depression misses the inescapable point…

...Depression is more a ***social*** than medical problem.

No Amount of Medication Can Change Your:

- Coping style
- Explanatory style
- Relationship style
- Cognitive style
- Problem-solving skills
- Support network
- History

Part 3: Sleep Disturbances

Depressed and anxious because you can't sleep? Or, can't sleep because you're anxious and depressed?

Deep Sleep and Mental Health

- Activity in parts of the brain that control emotions, decision-making processes, and social interactions is drastically reduced in deep sleep, suggesting that deep sleep may help people maintain optimal emotional and social functioning while awake

Sleep Disturbances

More than 90% of patients in major depressive episodes report sleep difficulties, making it the single most frequent complaint of depressed patients.

Depressive sleep is shortened, shallow, fragmented, and REM sleep is altered, based on subjective reports and empirically confirmed with polysomnographic (PSG) studies.

Szuba et.al, ***Depression and Anxiety***, December, 2000

Sleep Disturbances and Depression's Severity

- ❖ Persistent sleep disturbance is associated with refractoriness to antidepressant treatments
- ❖ Sleep disturbance constitutes a risk factor for chronic depression
- ❖ Patients with recurrent depression have more severe REM sleep disturbances than patients in their first episode

Szuba et.al, ***Depression and Anxiety***, December, 2000

Sleep Disturbances Have Serious Clinical Implications

Sleep disturbances can:

- disrupt the timing of neurotransmitter and neuroendocrine release
- exacerbate a negative mood
- bring about a poor performance
- disrupt social schedules that regulate biological rhythms

Thase, ***J of Clinical Psychiatry,*** (Suppl.11),2000

Does Sleep Disturbance Predict Depression's Onset?

In a prospective study of non-depressed subjects from the general population, complaints of persistent sleep disturbances were risk factors for the onset of depression within 1 year.

Thase, ***J of Clinical Psychiatry,*** (Suppl.11),2000

Sleep Disturbance Increases Risk for Alcohol-Related Problems

Using prospective data from the ECA program, researchers assessed the risk of alcohol-related problems among individuals with self-reported sleep disturbances because of worry. Survey respondents who reported sleep disturbances, more than 12 years later, had twice as high a rate of alcohol-related problems.

Crum et al., *Am J of Psychiatry*, July, 2004, 161(7):1197-1203

CBT vs. Ambien

- 63 young and middle-aged adults with chronic sleep-onset insomnia (one hour or more) received CBT, Ambien, combination therapy, or placebo. Primary outcome measure was sleep-onset latency based on sleep diaries and secondary measure was sleep efficiency (amount of time spent asleep divided by the total time allotted for sleep.
- CBT resulted in the greatest number of normal sleepers after treatment as measured by subjective and objective sleep-onset latency of 30 minutes or less. CBT maintained therapeutic gains at long-term (one year) follow-up.
- Combined treatment offered no advantage over CBT alone.

Jacobs, *Archives of Internal Medicine*, 2004; 164; 1888-1896

CBT vs. Ambien for Sleep: CBT Should Be First- Line Approach

"Our results suggest Cognitive-behavior therapy (CBT) should now be considered the first line of treatment for (sleep onset) insomnia…Sleeping pills are the most frequent treatment for insomnia, yet CBT techniques clearly were more successful in helping the majority of study participants become normal sleepers"

Study lead author Gregg Jacobs, Ph.D.
Beth Israel Deaconess Medical Center, Boston, MA

Forms of Insomnia

- Initial (primary); least common in MDD
- Middle
- Terminal; most common in MDD

Insomnia is most likely in so-called "agitated" depressions

Pre-Sleep Cognitive Activity and Insomnia

Cognitive arousal, dysfunctional cognition, and fear of insufficient sleep are sleep-inhibiting factors. In self-report, insomniacs were 10 times more likely to cite cognitive arousal as central to their sleep difficulties, compared with somatic arousal. The need to aim for minimal cognitive processing, drive, effort and affective load are treatment goals.

Harvey (2000) ***British J of Clinical Psychology***,39(3),275-286

Teaching people self-soothing skills and strategies for managing rumination is critical to enhancing their sleep

Some Relevant Websites to Visit

- American Academy of Sleep Medicine
- www.aasmnet.org
- American Sleep Disorders Association
- www.asda.org
- Medscape
- www.medscape.com
- National Institute of Mental Health
- www.nimh.nih.gov
- National Sleep Foundation
- www.sleepfoundation.org
- SleepNet
- www.sleepnet.com

Part 4: Helplessness and Perceiving Controllability

Hopelessness is the most powerful factor in depression

Helplessness is the second most powerful factor in depression

Extreme Perceptions Regarding Controllability

- ***Learned Helplessness***: Learned expectations that one's efforts will have *no* effect on the outcome
- ***Illusion of control***: Learned expectations that one's efforts are the *sole* determinant of the outcome

Exercise in Assessing Controllability

Task: Attach a specific numerical percentage of perceived controllability to the following vignettes, ranging from **zero** (no control) to **100** (total control).

Day Two

Part 1: Biology and Psychology on a Collision Course

Depression Runs in Families...

But not for the reasons you might assume...

What Are Genes?

Genes are functional segments of the long, double-stranded DNA molecules that make up chromosomes. They generate proteins by transcribing their codes onto single stranded RNA molecules, which serve as templates for protein construction.

What Are Genes For?

Although the genetic age has brought incessant reports about genes “for” homosexuality, risk-taking, shyness, anxiety and more, the only thing a gene is actually “for” is a protein…A gene is an instruction.

"No single gene appears to be responsible for any mental disorder. Rather, small variations in multiple genes contribute to a disruption in healthy brain function."

Dr. David Satcher
Former U.S. Surgeon General
December 13, 1999
www.surgeongeneral.gov

Gene Correlations With The Environment

- Passive Correlations
- Evocative Correlations
- Active Correlations

Passive Correlations

Parents transmit genes that promote a certain trait, like depression, and then construct a child-rearing environment likely to support the child's genetic predisposition (e.g., hypercritical)

Evocative Correlations

The presence of the genetically acquired predisposition to particular traits evokes reactions from others that reinforce these traits (e.g., a child predisposed to depression displays depressive behaviors like irritability that cause others to ignore or exclude him/her).

Active Correlations

People actively seek out experiences that fit with their genetically influenced traits (e.g., a depressed person expecting rejection seeks out difficult relationships that are more likely to fail).

Reasonable Conclusions About Genes and Depression

- Complex experiences like depression are almost invariably a product of genes ***and*** environment, and not either factor alone.
- Genetic influences can account for anywhere from as little as 11% to as much as 50% of the variance in depression; significant, but not overwhelming
- The genetic evidence has been ***at least*** as powerful in pointing to environmental influences on depression as it has genetic influences

Reasonable Conclusions About Genes and Depression (continued)

- It is as inaccurate to state that depression is *not* heritable as to say that it is.
- Any genetic influences will operate through specific personality, psychological and cognitive features, not a global entity called depression
- A gene-environment correlation means variations in genetic expressions are systematically associated with varying environmental circumstances

Part 2: Epidemiology, Coping, Relationships

A World Health Organization (WHO) Prediction

- Depression is currently the FOURTH most significant cause of suffering and disability worldwide (behind heart disease, cancer and traffic accidents)

and, sadly,

- It will be the SECOND most debilitating human condition by the year 2020

What Does the WHO Prediction Suggest to You?

- Depression is already a pervasive and debilitating condition
- Depression is growing in prevalence around the world
- Most of the people who need help don't receive it
- Depression will impact individuals, families and cultures in unpredictable ways
- Depression's growth is more likely to be socially transmitted than by other means

Depression's Epidemiology in the United States

- Nearly 23 million Americans suffer symptoms of major depression at a given time; it's the most common mood disorder in the U.S.
- Average age of onset is mid-20's and dropping
- Prevalence is highest for 25-44 year olds

Depression's Epidemiology in the United States (continued)

- Adolescents are the fastest growing age group of sufferers
- Only about 25% of sufferers receive treatment
- About twice as many women are diagnosed as men
- 1.5 to 3 times more common amongst first degree biological relatives

Depression is Largely a Social Phenomenon

Mood is contagious, as are socialized values

Recall the seminal research of Schachter & Singer on the contagion of mood?

What to make of adrenaline-induced physiological changes?

Psychological Review, 1962, 69, 379-389.

Issues vs. Patterns

- Breakdown of family
- Technology
- Nuclear destruction
- Self-fulfillment
- Geo mobility
- Television
- Helplessness
- Low frustration tol.
- Hopelessness
- Personalization
- Less social skill
- Global thinking

Stress Generation Patterns

- The presence of depression and/or anxiety seriously compromises these individuals' stress coping resources. Minor aggravations become major problems.
- Poor problem solving skills lead to poor choices, which aggravate negative circumstances.

Hammen, Journal of Abnormal Psychology, 1991
Harkness & Luther, Journal of Abnormal Psychology,2001

The Stress Generation Model of Depression

"Depressed people contribute to the occurrence of their own stress, which, in turn, maintains or exacerbates vulnerability to depression."

Hammen, *The Interactional Nature of Depression*, 1999

Depression and Stressful Life Events as Reciprocal

- Negative life events precipitate the onset of major depressive episodes (see Mazure, Clinical Psychology: Science and Practice, 1998)
- A growing body of evidence shows the reverse causal relationship: Depression generates stressful life events.
- Individuals with co-morbid anxiety and dysthymia experience higher rates of events that were at least partly dependent on their own behavior.

Harkness & Luther, *Journal of Abnormal Psychology*, 2001

Stress Generation: Active vs. Intentional

Depressed people may ***actively*** generate negative life events, but this is not ***intentional***; some of their behaviors have the unintended consequence of making life more stressful.

What keeps depression going? People actively generate future life events that, in turn, become the basis for more future depression.

Coping Styles

- Primary Control Coping:
  - The individual strives to enhance a sense of personal control over the environment and/or self (i.e., change)
- Secondary Control Coping:
  - The individual strives to adapt
- Disengagement:
  - The relinquishment of efforts to achieve either primary or secondary control

Compas et.al., Children of Depressed Parents, 2002 p.230

Coping Styles

- Approach (direct) problem-solving
- Avoidant coping
- Ruminative coping

Avoidance and rumination are highly correlated with depression

Approach, Avoidance and Depression

"Coping strategies involving approach as opposed to avoidance, such as direct problem-solving and seeking information from others, can buffer people against the depressogenic effects of negative life events…close support in families leads to more approach coping in the members of such families."

Holahan, Moos & Bonin, *The Interactional Nature of Depression,* 1999

Action Oriented vs. Ruminative Coping Styles

It is no coincidence that the therapies with the greatest empirical support all emphasize **ACTION** in treatment; clients may ***feel*** better in merely supportive therapy, but they will ***do*** better in treatment with direction.

Ruminative Responses

- Expressing to others how badly one feels
- Pondering on why one feels badly
- Thinking about the possible consequences of one's symptoms

Nolen-Hoeksema, *J of Abnormal Psych,* 1991

Does Rumination Predict Depression?

Ruminative responses to depressive symptoms predict:

- higher levels of depressive symptoms over time (after accounting for baseline levels)
- depressive disorders, including new onsets
- chronicity of depressive disorders
- anxiety symptoms

Nolen-Hoeksema, ***J of Abnormal Psychology***, March, 2000

Rumination Impairs Problem Solving

"Even when a person prone to rumination comes up with a potential solution to a significant problem, the rumination itself may induce a level of uncertainty and immobilization that makes it hard for them to move forward."

Nolen-Hoeksema, *Monitor on Psychology*, Nov.,2005, 36(10), p.38

Common Characteristics of Ruminators

Ruminators typically:

- believe they're gaining insight through it
- more often have a history of trauma
- perceive they face chronic, uncontrollable stressors
- exhibit personality characteristics such as perfectionism and excessive relational focus

Nolen-Hoeksema, *Monitor on Psychology*, Nov.,2005, 36(10), p.39

The Social Cost of Rumination

Although ruminators report reaching for others' aid more than non-ruminators, they receive less of it. Many report more social friction. People might respond to a ruminator compassionately at first, but their compassion wears thin if the rumination persists. They get frustrated, even hostile, and pull away, giving the ruminator more to ruminate about.

Nolen-Hoeksema & Davis, *J of Personality and Social Psychology*, 77(4), 801-814

Why Do Women Have Higher Rates of Depression?

- Women are much more likely to suffer sexual abuse in childhood as well as lifelong sexual harassment/discrimination
- Economic deprivation (living at poverty level, inequitable divorce settlements)
- Socialized dependency; ruminative coping
- Hormonal changes related to reproductive cycle/events

A Key Report on Women'sDepression

Summit on Women and Depression: Proceedings and Recommendations

Published in 2002 by the American Psychological Assn.,it reflects the research of 35 internationally renowned experts from a variety of disciplines. Copies are available online. Go to:

www.apa.org/pi/wpo/women&depression.pdf

NIMH Strives to Raise Awareness of Men's Depression

The goal is to reduce the stigma of men seeking help for depression. The website encourages men to seek help, explains treatment options, and encourages families and friends to provide support.

http://menanddepression.nimh.nih.gov

Or toll free (866) 227-6464

Men's Depression

- Increased interpersonal conflict
- Conflict between gender role related expectations and accomplishments
- Work-related problems and conflicts
- Hypersensitive to perceived threats to self-esteem and self-respect
- Increased levels of alcohol and other drug abuse and dependence

Cochran & Rabinowitz, *Professional Psychology: Research and Practice,* April, 2003, pp.132-140.

Depression's Social Effects... Depressives Have:

- fewer social skills
- fewer close relationships
- less elaborate social networks
- less rewarding relationships
- fewer social contacts

Depressions' Social Effects…(continued)

- less social support
- more marital problems
- more family arguments
- more pessimism about the future of their relationships

Keltner & Kring, Review of General Psychology, 9/98

The Depressed Person's Social Presentation

- Distant
- Apathetic
- Shy
- Hostile
- Clingy

How do others evaluate and react to depressed people? How does that serve to exacerbate depression?

Negative Expectations and Social Components of Depression

- Predict rejection< >Shyness
- Predict conflict< > Avoidance
- Predict loss< > Withdrawal
- Predict criticism< > Apathy
- Predict being burdensome< > Suicidality

Maladaptive Mate Selection

- The choice of a mate is a strong determinant of stress level and overall family adjustment
- Poor self-concept and perceived limited choices
- Similarity and familiarity with "damaged" partners
- Family "re-enactment"
- Complementarity in seeking "excitement"

(Hammen, *The Interactional Nature of Depression*, 1999)

Self-Verification Theory of Depression

"…people are motivated to confirm their firmly held self-views out of a desire to bolster perceptions of prediction and control…(and) to preferentially solicit self-confirming feedback…and to impute more credibility to feedback that fits with their self-views…They also choose interaction partners who view them as they view themselves."

Giesler & Swann, *The Interactional Nature of Depression,* 1999

Interpersonal Patterns That Maintain Depression

- Negative feedback seeking (seeking out information that confirms their already low self-concepts)
- Excessive reassurance seeking (desiring and repeatedly asking for reassurances as to their worth while rejecting positive input)
- Interpersonal conflict avoidance

Areas of Interpersonal Difficulty in Couples with a Depressed Partner

- Quality of life
- General family functioning
- Family problem solving
- Family affective responsiveness
- Family affective involvement
- Behavior control within the family
- Social support
- Global marital distress
- A history of distress within family of origin
- Marital problem-solving communication
- Marital affective communication
- Problematic internal relationship attributions

Areas of Interpersonal Difficulty in Couples with a Depressed Partner

- BOTH members of these couples reported so many difficulties in each domain

Hickey et al., April, 2005, *J of Marital & Family Therapy, 31*, 2, 171-182.

Expectations and Marital Satisfaction

How well your partner lives up to your expectations determines your degree of marital satisfaction.

But, what happens if the expectations aren't realistic?

How much of the anger, hurt, and disappointment people experience in their relationships is a product of their own unrealistic expectations?

Especially when combined with low frustration tolerance, poor impulse control, and an external attributional style

Marriage and Depression

- Are marital discord and depression clinically linked?
- Do poor marriages predict increased vulnerability?
- Does marital discord predict later depression?
- Does marital discord "cause" depression and vice-versa?
- Can marital therapy relieve depression?

THE ANSWER IS "YES" TO ALL!

Depressive Distortions of Others' Attributes

- Humor
- Generosity
- Frugality
- Reserve
- Stable
- Confidence
- Concern
- Consideration
- Affectionate
- Cruelty
- Wastefulness
- Withholding
- Lack of feeling
- Boring
- Arrogance
- Intrusive
- Weakness
- Dependent

Depression as a Family Issue

"When an adult is depressed, it is likely to signal that the spouse and children are involved, either as contributors to the current distress or as unwitting targets of the consequences of the mood disorder and its underlying caused. Thus, to break the cycle of intergenerational transmission of depression, it is often necessary to treat the entire family, or at least to evaluate the children's own mental health and functioning, and to educate the affected parents about the potential effects of their disorders on their children."

Hammen, Children of Depressed Parents, 2002 p. 193

Depression Intensifies From One Generation to the Next

The first such study following *3 generations of high-risk families* and has taken more than 2 decades to complete showed most of the prepubescent grandchildren with a 2 generation history of depression developed anxiety disorders that developed into depression as they aged into adolescence.

Weissman et al., *Archives of General Psychiatry*, January, 2005

Depressed Parents and Their Babies

"Depressed parents perceive more difficulty in caring for their infants and regarded their infants as more bothersome than did non-depressed parents."

Cummings & Davies, *The Interactional Nature of Depression*, 1999

Mom's Mood, Infant's Mood

Infants as young as 3 months old have been shown to ably detect their mother's mood and to modify their own responses accordingly

Dennis, *Journal of Clinical Psychiatry*, 65:9, September, 2004

Mood and Cortical Activity

The prefrontal cortex is a primary site regulating emotional and social behavior.

Left frontal lobe lesions tend to result in depression and catastrophic reactions; left frontal activation occurs during the expression of "approach" emotions such as joy and interest;

Right frontal lobe lesions tend to result in apathy or euphoria; right frontal activation occurs during the expression of "withdrawal" emotions, such as distress and fear.

Ashman & Dawson in Children of Depressed Parents; 2002, p 38-9

Shaping Neural Circuitry and Functions

The protracted developmental course of the prefrontal cortex, extending throughout infancy, childhood and adolescence, allows for many opportunities for experience to shape the development of frontal lobe neural circuitry and functions, a process called ontogenetic sculpting.

Ashman & Dawson in Children of Depressed Parents, 2002 p 41

Maternal Depression is Associated With:

- Poor mother-infant interaction
- Delayed infant development
- Increased emotional problems
- Increased behavioral problems
- Delayed verbal development

Negative effects amplified in adolescent mothers? (More than a million a year…)

Deal & Holt, *American Journal of Public Health*, Feb'98

Parents' Mood vs. Parents' Skill

"…depressed mothers receiving treatment often reported improved mood even though their interactions with their infants remained significantly less positive than those of non-depressed controls.Therefore, intervention strategies should include both symptom relief, through medication or psychotherapy, and specific help with the stresses and problems of parenting."

Lyon-Ruth et al., Children of Depressed Parents, 20002 p.112

The Risks to Children of Depressed Parents

- The risks seem to be greatest when parental depression is accompanied by personality disorder
- The risks are at least as high when the parent has a unipolar depressive disorder as when he or she has a bipolar affective disorder
- The risk for conduct disorders, anxiety disorders and substance abuse disorders, not just depression, increases at the same rate as depressive disorder when a parent is depressed.

Silbert & Rutter, in Children of Depressed Parents, 2002

Clues Suggesting Depression in Children

- Change in personality; irritable, whiney
- Lethargy, loss of energy,somatic complaints
- Loss of interest in friends,play,activities
- Self-condemnation (e.g., “I’m dumb, ugly”)
- Difficulty concentrating, distractible
- Passive, helpless, gives up easily
- Sleep, appetite problems

Four Factors Affecting Children’s Depression

1. Parental depression, which is distressing to children.
2. Ongoing stressors that typically accompany depressive disorders such as economic, relationship, and work problems.
3. Episode life events of the parent that may affect the child
4. The child’s own episodic stressful life event

Hammen, Children of Depressed Parents, 2002

Part 3: The Case of Terri

Anxiety about the vulnerabilities of aging

Available on www.zeigtucker.com

This session involves the use of hypnosis in order to help absorb Terri in a mindset where she can better ***recognize and tolerate ambiguity***

All the things one would say to be helpful to someone can, of course, be said without hypnosis…

But hypnosis makes for a focused experience of multi-dimensional experiential learning

Empowering people is the best treatment and prevention strategy

Part 4:
Discriminations and Prevention

Global Thinking *in the Symptom Context* Virtually Precludes the Ability to:

- Compartmentalize (e.g., contain anxiety)
- Think linearly, sequentially
- Maintain good boundaries
- Make key discriminations

Remember the so-called "Executive Monkey" research?

It highlighted the detrimental effects of an inadequate discrimination strategy

Criteria of Distinction

Your criteria of distinction determine what, out of a wide range of possibilities, you will focus on and respond to

Most of the problems we treat come about directly as a result of the client ***employing criteria that are ineffective*** and thereby give rise to their problems

Making Social Discriminations; How do You Distinguish…

- **When to "hold on" from when to "let go?"**
- **What you are and are not in control of?**
- **What you are and are not responsible for?**
- **When you can and cannot "trust your guts?"**
- **What is from what is not personal?**

Making Discriminations; How do You Distinguish…(continued)

- **What you want from what you need?**
- **What has been from what can be?**
- **Someone who can from someone who can't meet your needs?**
- **Realistic from unrealistic expectations?**
- **What you know from what you believe?**

Making Discriminations; How do You Distinguish…(continued)

- **When you should or shouldn't "butt into somebody else's business?"**
- **Someone who can from someone who can't "do" intimacy?**
- **Who can from who cannot be trusted?**

Developing Discrimination Criteria in Social Contexts

Criteria:

- 1. The expectations are specific for the circumstances
- 2. You have assessment skills and enough information to judge meaningfully
- 3. The person has the salient value and belief systems to support the desired response
- 4. The person has the salient personal skills and characteristics to support the desired response
- 5. The person has the salient motivations to provide the desired response

Types of Prevention Strategies

- **Primary prevention**: Prevention of the onset of the initial episode of the disease/disorder
- **Primordial prevention**: Prevention of a risk factor
- **Secondary prevention**: Prevention of further episodes of the disease/disorder

Kaplan, *American Psychologist*, April, 2000

Categories of Prevention

- **Universal**: Target the general population without focusing on sub-populations that may be at risk
- **Selective**: Target populations identified as at risk
- **Indicated**: Target individuals who already display low levels of symptoms

Cardemil & Barber in *Professional Psychology: Research and Practice*, August, 2001

The Foundation of Prevention is the Ability to ***Think Ahead***

Emphasize the Skill of Foresight

Seligman's Prevention Program

Two distinct parts: 1)Cognitive therapy and, 2) social problem solving using:

Comic strips
Role playing
Games
Discussions
Videos

see *The Optimistic Child*

Prevention: Gottman's "Emotion Coaching"

1. Become aware of the child's emotion;
2. Recognize the emotion as an opportunity for intimacy and teaching;
3. Listen empathetically, validating the child's feelings

Prevention: Gottman's "Emotion Coaching"

4. Help the child find words to label the emotion he is having;
5. Set limits while exploring strategies to solve the problem at hand

John Gottman

Raising an Emotionally Intelligent Child

Dr. Tiffany Field's Coaching

Depressed mothers and mothers at risk were given direct coaching on appropriate parenting behavior while interacting with their babies and toddlers

The period between 3 and 6 months appears to be the most crucial in terms of effects of mother's depression on the baby

T. Field et al., *Development and Psychopathology*

Teaching Foresight to Children

- "Before" and "after" examples (e.g., shoes after socks)
- Story building (e.g., "what do you think will happen next?")
- Asking, "What might happen if…?"

Thank you for coming!

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A Brief List of Suggested Readings Regarding Depression

**** A "Top Ten" Pick From Michael**

SOCIAL/CULTURAL ISSUES

Pipher, M. (1996). The shelter of each other. New York: Ballantine.

Culbertson, F. (1997). "Depression and gender." American Psychologist, 52, 1, 25-31.

Lynch, J. & Kilmartin, C. (1999). Overcoming masculine depression. New York: Hayworth Press.

Real, T. (1997). I don't want to talk about it: Overcoming the secret legacy of male depression. New York: Scribner.

Simonds, S. (2001). Depression and Women: An integrative treatment approach. New York: Springer.

BIOLOGICAL ISSUES

Dubovsky, S. (1997). Mind-body deceptions. New York: W. W. Norton.

Whybrow, P. (1997). A mood apart. New York: Basic Books.

Antonuccio, D., Danton, W., & DeNelsky, G. (1995). "Psychotherapy versus medication for depression: Challenging the conventional wisdom with data." Professional Psychology: Research and Practice, 26, 6, 574-585.

MARITAL/FAMILY ISSUES

Beach, S. (Ed.)(2001). Marital and family processes in depression: A scientific foundation for clinical practice. Washington, D.C.: American Psychological Association.

Golant, M. & Golant, S. (1996). What to do when someone you love is depressed. New York: Villard.

Goodman, S. & Gotlib, I. (Eds.)(2002). Children of depressed parents: Mechanisms of risk and implications for treatment. Washington, D.C.: American Psychological Association.

Jacobson, N., Dobson, K., Fruzetti, A., Schmaling, D., & Salusky, S. (1991). "Marital therapy as treatment for depression." Journal of Consulting Clinical Psychiatry, 57, 5-10.

**Joiner, T. & Coyne, J. (Eds.) (1999). The interactional nature of depression. Washington D.C.: American Psychological Association.

Seligman, M. (1995). The optimistic child: How learned optimism protects children from depression. New York: Houghton Mifflic Co.

Weissbourd, R. (1996). The vulnerable child: What really hurts America's children and what we can do about it. Reading, PA: Addison-Wesley.

**Yapko, M. (1999). Hand-me-down-blues: How to stop depression from spreading in families. New York: St. Martin's.

TREATING DEPRESSION WITH PSYCHOTHERAPY

Arieti, S. & Bemporad, J. (1994). Psychotherapy for severe and mild depression. Northvale, NJ: Jason Aronson.

Beck, A. (1967). Depression: Causes and Treatment. Philadelphia: University of Pennsylvania Press.

Beck, A., Rush, J., Shaw, B., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Clark, D., Beck, A., &Alford, B. (1999). Scientific foundations of cognitive theory and therapy of depression. New York: John Wiley.

Clarkin, J., Pilkonis, P., & Magruder, K. (1996). Psychotherapy of depression. Archives of General Psychiatry, 53, 717-723.

Martell, C., Addis, M. & Jacobson, N. (2001). Depression in context: Strategies for guided action. New York: Norton.

**O'Connor, R. (1997). Undoing depression. New York: Little, Brown & Co.

O'Connor, R. (2001). Active treatment of depression. New York: Norton.

Weissman, M., Markowitz, J.,& Klerman, G. (2000). Comprehensive guide to interpersonal psychotherapy. New York: Basic Books.

Yapko, M. (1992). Hypnosis and the treatment of depressions. New York: Brunner/Mazel.

Yapko, M. (1997). Focusing on feeling good. An audio program for self-management of depression. Fallbrook, CA: Yapko Publications..

Yapko, M. (2001). Treating depression with hypnosis: Integrating cognitive-behavioral and strategic approaches. Philadelphia, PA: Brunner/Routledge.

Yapko, M. (Ed.) (2006). Hypnosis and treating depression: Applications in clinical practice. New York: Routledge.

SELF-HELP RECOMMENDATIONS

**Burns, D. (1999). Feeling good: The new mood therapy (Rev.ed.). New York: Avon.

Copeland, M.(2002). The depression workbook: A guide for living with depression and manic depression. (2nd ed.). Oakland, CA: New Harbinger

**Greenberger, D. & Padesky, C. (1995). Mind over mood: A cognitive therapy treatment manual for clients. New York: Guilford Publications.

**Yapko, M. (1997). Breaking the patterns of depression. New York: Doubleday.

OTHER SIGNIFICANT RELEVANT READINGS

Chang, E.(Ed.) (2001). Optimism and Pessimism: Implications for theory, research and practice. Washington, D.C.: American Psychological Association.

Gillham, J. (Ed.)(2000). The science of optimism & hope: Research essays in honor of Martin E. P. Seligman. Philadelphia, PA: Templeton Foundation Press.

**Goleman, D. (1995). Emotional intelligence: Why it can matter more than IQ. New York: Bantam.

**Hillman, J. & Ventura, M. (1992). We've had a hundred years of psychotherapy and the world's getting worse. San Francisco: Harper Collins.

Jamison, K. (1999). Night falls fast: Understanding suicide. New York; Vintage.

Kirsch, I. (Ed.) (1999). How expectancies shape experience. Washington, D.C.: American Psychological Association.

**Seligman, M. (1990). Learned optimism. New York: Alfred A. Knopf.

**Solomon, A. (2001). The noonday demon: An atlas of depression. New York: Scribner.

Yapko, M. (2003) Trancework: An introduction to the practice of clinical hypnosis (3rd edition). Philadelphia: Brunner/Routledge.