Mrs. Ames* wasn’t doing well. Five months before, she had started to feel sad, fatigued, and disinterested in her work and hobbies. Then came difficulty getting back to sleep when she awoke at 4 AM, a gradual 15-pound weight loss, and growing thoughts about her lack of achievement, worthlessness, and an increasingly bleak future. She began to wonder if it was worth going on living. But she was puzzled. At 47 years of age, she had never experienced anything like this. And her life situation seemed good. Her husband and children appeared to be doing well, she had been promoted in her job, and she had no known health problems.

She consulted Dr. Bones, her primary care physician (PCP), an internist, who listened sympathetically to her symptoms, briefly explored her current life situation, examined her, checked out her thyroid parameters and blood counts, and prescribed an average starting dose of an SSRI. At her first follow-up appointment a month later, Mrs. Ames was slightly better. Dr. Bones encouraged her to cheer up and renewed her prescription. Two months later she was no better, so he referred her for psychiatric evaluation.

Such a familiar story! Her care in the hands of Dr. Bones, my colleague and friend, had been responsible and correct as far as it went—ruling out medical causes of depression, prescribing an antidepressant, following up at what seemed to him like reasonable intervals. She might have become much worse without it. But the leisurely pace and incompleteness of the care she received had probably cost her several months of amelioration of her suffering.

From a psychiatric viewpoint, the initial history had been incomplete. In the 15–20 minute initial appointment, Dr. Bones hadn’t discovered that, when Mrs. Ames was 5 years old, her mother had had a severe postpartum depression or that her maternal grandfather had died under mysterious circumstances. In addition, Dr. Bones had not gone beyond brief screening questions about her marital life or relations with her children. He had not addressed her passing remarks about hot flashes over the past 2 years or lack of interest in sexual relations with her husband. Nor had he explored how her thoughts evolved from the transient idea of not finding life worthwhile to pervasive feelings of hopelessness—especially, was she contemplating suicide?

The treatment had been incomplete as well. A follow-up visit within the first 7–10 days would have been more appropriate; the American Psychiatric Association (APA) Practice Guideline recommends weekly visits for monitoring pharmacotherapy in routine cases, with more frequent follow-up in more complex cases (APA Practice Guideline, p. 101). The dose of the SSRI should have been increased after a few weeks of unimpressive results, and the medication itself might have been changed or augmented after a 4–8 week trial at the higher dose (APA Practice Guideline, p. 101). In addition, Mrs. Ames had been denied half of the treatment program that scientific evidence and clinical experience show to give the best results in more severe depressions—a combination of medication and psychotherapy, rather than either one alone (APA Practice Guideline, p. 351).

What is wrong with this picture? Mrs. Ames had at least gotten some help, which put her ahead of a majority of people experiencing depression. The PCP is the front-line professional in the effort to find and treat people suffering from depression—a prime objective in the forward-looking community programs being developed by consortia of employers, insurers, government bodies, and providers, with participation by the American Psychiatric Association. Depression is the leading psychiatric disorder that causes serious losses to employers through absenteeism, reduced productivity, employee turnover, and related medical expenses. A recent study calculated that "workers with depression... cost employers an estimated 44 billion dollars per year in LPT [lost productive time], an excess of 31 billion dollars per year compared with peers without depression." A major challenge in these innovative community programs is to upgrade the quality of services that PCPs provide to depressed patients, because the limited availability of psychiatrists makes it unlikely that every new patient

*Mrs. Ames is a fictitious patient, an amalgam of many such cases seen over the years.

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can see a psychiatrist. In addition, concerns about stigma and privacy still trouble people enough to make them prefer to see their trusted and familiar physician as the first approach to getting help. But the PCP, under extreme pressure to see 4–6 patients an hour, is hard-pressed to do a thorough evaluation, let alone to probe for psychological issues or spend time patiently helping the patient understand the illness and its treatment.

Third-party payment issues often further cloud the picture. If the patient is in an HMO or PPO, a referral to a psychiatrist may entail multiple calls from the PCP’s office to 800 numbers—being put on hold and listening to elevator music—while trying to get a referral to a psychiatrist in the patient’s network, if one is available. Alternatively, the doctor may just direct the patient to make those calls him- or herself, hoping that there is still enough energy, motivation, and persistence left despite the depression to carry the patient through the gauntlet. This compartmentalization of resources by managed care carve-outs conspires to discourage the kind of working relationship between the PCP and the psychiatrist down the hall that makes for efficient referral, feedback, and collaboration on thorny problems at the interface between medical and psychiatric illnesses.

It is thus very tempting for the PCP to prescribe a standard antidepressant and follow-up in a month or two, without closely monitoring the effectiveness of the medication and its side effects—which often cause non-compliance—and without titrating dosage, with consequences similar to those in the case of Mrs. Ames, or more extreme outcomes such as the occasional suicide attempt. Worse yet, the patient is denied the benefits of psychotherapy. Psychiatrists much prefer to start psychotherapy when the illness is acute and the underlying issues are closer to the surface, often concomitantly with initiating pharmacotherapy, rather than wait until medication has failed to produce an adequate response.

The evidence base for the effectiveness of several standard psychotherapeutic modalities is strong for depressed patients. Randomized, controlled, manual-based therapeutic trials have shown a therapeutic effect that is often equivalent to what medications can do and considerably better than placebo. The research trials generally focus on time-limited programs of treatment.

Cognitive behavioral therapy (CBT) sets up a systematic program for sorting through the patient’s “cognitions” to find the basic false beliefs, patterns, and automatic thoughts that are assumed to underlie the patient’s depressed mood, worthless feelings, and hopelessness. Often these affect the patient’s interpersonal relationships and skew perceptions of how others view him or her. Through daily self-charting and reporting of this homework to the therapist, the patient begins to see the effects of the maladaptive thoughts and the importance of replacing them with more positive thinking. Mrs. Ames could thus have been helped in a period of weeks if, in CBT, she had confronted her recurrent underlying assumptions that she was washed up as a woman, unappealing to her husband, and useless as a mother to children now approaching adulthood.

Interpersonal psychotherapy (IPT) was originally designed for research trials of psychotherapy in depression. In a less structured process that is closer to traditional psychotherapy than CBT, the therapist nonetheless keeps the discussion focused on current interpersonal relationships—issues such as role changes, losses and mourning, and interpersonal conflicts. IPT could have helped Mrs. Ames more quickly come to grips with her sense of loss about her children leaving home, impending menopause, and leaving a boss who was also a close friend in order to implement her promotion. Her anxiety about the demands of her new position would also have emerged, as her role shifted from trusted assistant to a supervisor with greater responsibilities.

Psychodynamic psychotherapy (PDP) comes from a long psychoanalytic tradition in which the study of mourning and melancholia was a milestone. Working in the framework of a therapist-patient relationship in which the responses of the two participants to each other contribute directly to understanding, Mrs. Ames and her psychiatrist might have come across the same issues noted above. In addition, Mrs. Ames would probably have become aware of the effects of her mother’s depression on her when she was 5 years old and the similarity to the way she was feeling and behaving now; the loss of her grandfather and the consternation in the family about his presumed suicide; her identification with his tragic, self-destructive pseudo-solution to his problems; and the rage about her losses that she was turning on herself. She might have discerned conflicting feelings within herself that left her paralyzed. Possibly some characterological issues, such as a tendency to excessive, masochistic guilt, might have come to light and become a focus of an effort to change. The therapeutic process would be less directive, less problem-oriented than CBT or IPT, but more sensitive to underlying personality patterns and issues from the remote past. More of the work would be done in the context of the relationship with the therapist, who would be less like a
teacher or sage listener and more like a participant in an active, real-life scenario reliving important issues.

Mrs. Ames started several months late in one of these healing psychotherapeutic processes. How could this delay have been avoided? In my own practice experience, early referral for comprehensive treatment is much easier if psychiatrists or other skilled mental health professionals work closely in the same facility as the PCPs. Even without that geographic proximity, establishing an ongoing consultative relationship with a few PCPs can be enormously helpful to patients and their physicians. Ending the carving out of mental health care from general medical services in third-party payer systems would also facilitate smooth and rapid entry into care without a complicated transfer from one third-party payer to another. Earlier response to treatment translates into savings for employers, through reduced disability, absenteeism, and impaired productivity, as well as savings for those who pay for treatment.

Many mental health professionals are driven from the “behavioral” managed care networks because of low reimbursement and intrusive case management, thus further reducing the availability of therapists. Psychotherapy by psychiatrists is burdened by financial disincentives that make it much more profitable to do medication management. Such inequities significantly detract from the quality of care and its results.

Psychotherapy must be seen as a fundamental part of the quality treatment of depression, to be implemented by an expert professional as early as possible. The combination of medication and psychotherapy enhances effectiveness, both acutely and in long-term prevention of relapse (APA Practice Guideline, p. 36). Better coordination between PCPs, psychiatrists, and other mental health professionals to provide such integrated treatment is vital in improving access to quality treatment of depression.

References