# Defeating Depression: The Healing Power of the Therapeutic Relationship

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> The greatest degree of inner tranquility comes from the development of love and compassion. The more we care for the happiness of others, the greater is our own sense of well-being.
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> —*Tenzin Gyatso, the 14th Dalai Lama*

Major depressive disorder is common, affecting about 7% of the population at any given time and with an estimated lifetime prevalence of 16.2%. Onset is often during adolescence, with young adults and females most commonly affected. The course is often one of a chronic pattern of recurrence. The disorder has underpinnings in family genetic history and neurobiological changes (1, 2). The cost of depression for the individual, family, and society is enormous—estimated at $83.1 billion in the United States in 2000 (3).

Investigators have demonstrated that the therapeutic alliance, the collaborative bond between clinician and patient, is a potent factor in determining a positive response to the treatment of depression. This has been found to be true for specific psychotherapies as well as across theoretically and technically different psychotherapies, pharmacotherapy, or both (4–9). This strong relationship suggests that a positive rapport confers healing qualities, and without this rapport, even pharmacotherapy is less effective (4).

A positive doctor-patient relationship has also been shown to improve treatment adherence. This is particularly salient in the treatment of major depressive disorder. Guidelines set forth by the American Psychiatric Association and the Agency for Health Care Policy and Research recommend continued treatment with antidepressants for at least four to nine months after depressive symptoms resolve to prevent relapse (10, 11). Despite these guidelines, up to 68% of patients have been reported to discontinue antidepressant medication within three months of starting treatment. More frequent visits and higher quality of the doctor-patient relationship may improve longer-term adherence, thus improving prognosis. Effective physician-patient communication that included a frank discussion about adverse medication effects throughout treatment decreased the likelihood that medication was prematurely discontinued (12–14).

## Building Rapport With Depressed Individuals

The symptoms complex that is associated with depression—including neurovegetative and somatic symptoms, guilt, shame, and anhedonia—poses a challenge to the formation of an optimal therapeutic relationship. Depressed individuals most often initially present to their primary care physician, frequently with a chief complaint of somatic symptoms (discomfort, lethargy, sleep difficulties, appetite changes, and forgetfulness) or specifically with complaints of depression (11). Patients may be reluctant to fully disclose depressive, suicidal, or other crucial symptoms because of issues of stigma, feelings of vulnerability, or fear of being judged. In this scenario, forming a doctor-patient relationship that feels "safe enough" to disclose very personal information is the basis for therapeutic rapport building.

A second challenge to optimal therapeutic communication with a depressed individual is the lethargy, lack of motivation, and anhedonia that is often part and parcel of the disorder. Providing empathic understanding while concomitantly encouraging activation—encouraging the patient to actually push him- or herself to do things that he or she feels too depleted to do—is another challenge to the therapeutic alliance. A depressed individual may lack the motivation or ability to collaborate optimally in his or her treatment planning. A depressed individual may feel misunderstood if a simple solution (for example, exercising) is proposed, without a full appreciation of how impossible that may feel to an individual who finds just getting out of bed to be a challenge. Alternatively, waiting for the patient to provide active input into a treatment plan may also be unrealistic and not optimally engaging. A panoply of engagement tools is used by the skilled clinician in the engagement of a depressed individual in his or her treatment (15).

Enhancing the therapeutic alliance is of utmost importance for improving treatment outcomes for patients with depression. This is best done by honestly and sensitively presenting the engagement challenge up front, ensuring optimal education about the disorder and treatment options, providing attuned listening, and using strength-based approaches to identify assets and resiliencies that may be

enhanced, in addition to identifying and treating the disabling symptoms (5).

### Clinical Vignette

Ms. Jones slumped as she entered the mental health section of the University Health Center. Her black hoodie was pulled over her head, with only thin wisps of limp, oily hair protruding to attest to the neglect of her hygiene. Her skin was sallow and her eyes displayed the dark circles of one who is not sleeping well. Her fingernails were gnawed short and shabbily adorned with chipped black nail polish. Dr. Scott knew that Ms. Jones' chief complaint was depression, but she was taken aback by how completely dejected Ms. Jones appeared.

"Hello, Ms. Jones," Dr. Scott said, greeting her new patient with a warm smile. The smile was not returned—only the fleeting eye contact and a limp handshake acknowledged that she heard the greeting. Ms. Jones sat morosely in the office chair, her answers to Dr. Scott's queries slow and deliberate. Dr. Scott asked the usual questions—history, symptoms, risk assessment. All were answered, but Dr. Scott knew that she and her patient had not yet connected. Dr. Scott paused and thought. The pause lasted long enough that Ms. Jones looked up.

"What's the matter?" she asked warily.

"Oh," Dr. Scott replied. "You look so sad and depleted. I really want to be helpful. But it doesn't seem that we are quite connecting—you know, as humans. That's important."

There was another pause. "I'm sorry," Ms. Jones began. "I didn't mean to make you feel bad."

"I'm not trying to guilt-trip you. When someone is depressed, they often feel too exhausted to really engage. That's part of the disorder. I am hoping we may find a way to better connect to help you. How about talking about things that you enjoy—or even things that you used to enjoy, before you got so down. I see you have a Nirvana hoodie. Do you like music?"

Ms. Jones went on to discuss how she had been in a band—she was a singer and songwriter. Her boyfriend was the drummer. Her best friend was the guitar player. "We were pretty good—I mean we got some gigs around town, and it was a good time, a little extra money—ya know." Dr. Scott's eyes softened as she listened. A lonely tear began to trickle down Ms. Jones' cheek.

"Then . . . my best friend stole my boyfriend. Can you believe that?" Ms. Jones blurted, her eyes momentarily fiery prior to glossing over again.

"Wow. I am really sorry that happened to you. No wonder you are so sad and mad."

"I was mad at first, but not anymore. I probably deserved it anyway. I'm basically a loser. A lonely loser. And my ex-boyfriend and ex–best friend are having the time of their lives without me."

"I'm glad you came here today," Dr. Scott replied empathically. "I can understand that you must feel very hurt and lonely. But as for being a loser—no, definitely not. That is your depression talking." They discussed how being upset and depressed is a normal reaction to such an upsetting event. But then it can "take on a life of its own" with all of the symptoms she was experiencing—poor sleep, no energy, no interest, falling grades, and loss of appetite.

"But therapy and meds won't bring Joe back to me, so what's the use?" Ms. Jones asked, her face becoming stony.

"You're right. But maybe it can bring you back—the talented, smart, spunky young woman that is hiding beneath your shroud of depression."

"Hey, maybe I'll use that in a song—shroud of depression—I think maybe you could be a songwriter, Dr. Scott," quipped Ms. Jones.

Dr. Scott smiled, "I think I'd better stick to the shrink thing. But I'd love it if you started to write and sing again." A glint of hope entered Ms. Jones' eyes for the first time that day.

After reviewing issues of safety and making a safety plan, it was agreed that Ms. Jones was safe to go home, and a second appointment was made for later that week. They discussed medications, potential side effects, and the evidence base for therapy and medication.

"I've heard of that medication on TV," Ms. Jones noted.

"Don't you love how the colors around her get brighter after she starts the medication?" Dr. Scott smiled. "Ah, I knew you had a sense of humor under your hoodie shroud."

They both laughed spontaneously. "Do you feel like we are connecting yet?" Ms. Jones asked tentatively.

"Absolutely!" Dr. Scott replied.

"Yeah, me too," Ms. Jones said, as she left the office.

### Tips for Enhancing Engagement With a Depressed Individual

An individual with depression presents with self-deprecation, lack of motivation, feelings of helplessness, hopelessness, and social withdrawal—all potential barriers to forming a beneficial therapeutic alliance. Considerable therapeutic skill is required for the physician to engage an individual in the midst of a major depressive episode. Techniques that promote activation and provide realistic hope for recovery are especially helpful. The patient may need a great deal of reassurance and an extended period of trust-building before truly engaging in the therapy. Establishing a collaborative, mutual partnership in which the therapist and patient work together to set goals and complete treatment tasks is particularly important—both for resolution of symptoms and for ongoing adherence to medication for the recommended period of time.

1. Listen carefully to the patient's presenting complaints, and refer to these as the most salient issues that the patient wants to be sure are addressed.
2. Identify open and collaborative communication as a goal. Identify that this is often a challenge for individuals who are in the depths of depression.
3. Tailor one's communication style to the patient's needs and capacities, explaining symptoms in understandable terms and demystifying the disorder.

4. Normalize concerns and symptoms to help decrease embarrassment or concerns about being judged. For example, "Many individuals I treat who have depression complain of a lack of sex drive. Have you noticed that?"
5. Identify and optimize strengths, interests, assets, and resiliencies.
6. Provide realistic hope.
7. Discuss treatment options and evidence regarding these to help each individual become educated and increasingly in control of the treatment planning. Bring in evidence about what works, including the need to take medication even after the depression clears. For individuals who are too depressed to take it all in, provide simple handouts or written instructions.
8. Use humor when appropriate. It is a great engagement tool, diagnostic tool, and one of the truly human attributes.
9. Use a collaborative team approach among primary care physician, psychiatrist, patient, family, and therapist (if the psychiatrist is not the primary therapist as well), as appropriate. Set regular and specified methods of team communication with each other and integrate the patient into these discussions whenever possible.

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