

Psychotherapy of Mood Disorders

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Abstract: In the last decades, psychotherapy has gained increasing acceptance as a major treatment option for mood disorders. Empirically supported treatments for major depression include cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), behavioural therapy and, to a lesser extent, short-term psychodynamic psychotherapy. Meta-analytic evidence suggests that psychotherapy has a significant and clinically relevant, though not large, effect on chronic forms of depression. Psychotherapy with chronic patients should take into account several important differences between patients with chronic and acute depression (identification with their depressive illness, more severe social skill deficits, persistent sense of hopelessness, need of more time to adapt to better circumstances). Regarding adolescent depression, the effectiveness of IPT and CBT is empirically supported. Adolescents require appropriate modifications of treatment (developmental approach to psychotherapy, involvement of parents in therapy). The combination of psychotherapy and medication has recently attracted substantial interest; the available evidence suggests that combined treatment has small but significant advantages over each treatment modality alone, and may have a protective effect against depression relapse or recurrence. Psychobiological models overcoming a rigid brain-mind dichotomy may help the clinician give patients a clear rationale for the combination of psychological and pharmacological treatment. In recent years, evidence has accumulated regarding the effectiveness of psychological therapies (CBT, family-focused therapy, interpersonal and social rhythm therapy, psychoeducation) as an adjunct to medication in bipolar disorder. These therapies share several common elements and there is considerable overlap in their actual targets. Psychological interventions were found to be useful not only in the treatment of bipolar depressive episodes, but in all phases of the disorder.

Keywords: Bipolar disorder, combined treatment, dysthymic disorder, major depressive disorder, psychotherapy.

INTRODUCTION

In the last decades, psychotherapy has increasingly gained ground as a major treatment option for mood disorders. First, it has found widespread acceptance in the treatment of acute depressive episodes; then, in recent years, its scope has expanded considerably to include bipolar disorder and chronic forms of depression. While the literature contains several excellent systematic reviews and meta-analyses examining the efficacy of psychotherapy or selected psychotherapeutic approaches in specific mood disorders, there is a scarcity of papers covering the general topic of psychotherapy and mood disorders as a whole and dealing also with theoretical, clinical, and practical issues. In this paper, we take the opportunity kindly offered by the Editor to provide a broad overview of the field including not only a critical appraisal of the empirical support enjoyed by the various therapies, but also a basic description of their theoretical and practical aspects, and a discussion of specific clinical issues such as the combination of psychotherapy and medication.

UNIPOLAR DEPRESSION

In the past three decades a multitude of randomized controlled studies reported that psychotherapy is an effective

treatment for depressive disorders. Two different approaches, meta-analysis and critical review of the evidence, can be used to evaluate and synthesize this literature.

A series of meta-analyses indicated that several types of psychotherapy are effective in the treatment of depression, including cognitive behavioural therapy, interpersonal psychotherapy, problem-solving therapy, behavioural activation therapy, and short-term psychodynamic psychotherapy [1-3]. The efficacy of psychotherapy for mild to moderate depression was found to be similar to that of pharmacotherapy. Although there are indications that the effects of psychotherapy for depression have been overestimated in meta-analytical studies because of publication bias [4] and the relatively low quality of many studies in the field [5], the effects of psychotherapy remain nevertheless significant, though smaller, when adjusted for publication bias or when only high-quality studies are taken into account.

Differently from meta-analysis that combines results across studies to derive a pooled estimate of effect, critical review of the evidence puts a premium on well-designed studies in fully clinical populations that corroborate the efficacy and specificity of a given intervention. According to established criteria [6], which are similar to those used by the Food and Drug Administration to evaluate proposed drugs for approval and marketing in the United States, a therapy is considered efficacious and specific if there is evidence from at least two settings that it is superior to a pill placebo, a psychological placebo, or another bona fide

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treatment, i.e., a treatment that is credible and intended to be therapeutic. If there is evidence from at least two settings that the therapy is superior to no treatment, it is considered efficacious, though not specific. If only one or more studies from just a single setting support the therapy, it is considered possibly efficacious awaiting replication.

Following these criteria, the treatments with greater empirical support are cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT). The available studies suggest that CBT, and especially cognitive therapy (CT), is efficacious and specific in the treatment of major depressive disorder (MDD). There are consistent indications that it has a lasting effect that is both efficacious and specific in relapse prevention and efficacious with respect to the prevention of recurrence. With regard to IPT, the efficacy of the approach appears to be well established when implemented by well-trained therapists; IPT seems to be efficacious and specific in reducing acute distress and may prevent both relapse and recurrence as long as it is maintained. Behavioural therapy has substantial empirical support, too. The available studies indicate that it is efficacious and specific in the treatment of MDD. The evidence is stronger for the contextual approaches, such as behavioural activation and contingency management, which were put to the test against other efficacious interventions in fully clinical samples. Support for problem solving therapy is less strong, as the corroborating studies were carried out on recruited volunteers or general practice samples. Overall, when provided by competent and experienced therapists, CBT (especially CT), IPT, and some forms of behavioural therapy are as efficacious as medications and specific in the treatment of MDD. Other psychological treatments have been less studied. While early trials of dynamic psychotherapy by advocates of other approaches yielded negative results, more recent studies by investigators with expertise in this approach provided limited support. Based on the current state of knowledge, a fair conclusion is that short-term dynamic psychotherapy is possibly efficacious with respect to acute response and prevention of relapse and recurrence. Although marital and family problems are frequent in depression and may play a role in its aetiology and may make treatment more difficult, the studies of traditional marital and family therapies are too few and the findings too mixed to draw well-founded conclusions. Experiential-humanistic interventions have also been little studied, although later studies performed by advocates suggested possible efficacy [7].

The following subsections provide a description of the psychological therapies that enjoy reasonable empirical support and are most frequently used with patients with unipolar depression, namely cognitive and behavioural therapies, interpersonal psychotherapy, and psychodynamic psychotherapy. Further subsections are devoted to specific clinical issues, such as working with patients affected by chronic depression, treating adolescent patients, and combining psychotherapy and medication.

Cognitive Behavioural Therapies

Cognitive behavioural therapy (CBT) is not a single form of treatment but rather a family of interventions based upon a combination of basic behavioural and cognitive principles

and research. All versions of CBT share the premise that there are important relationships between situations, thoughts, and emotions. Although there are differences between the various CBT approaches, there is a general emphasis on changing thoughts and behaviours, and using specific techniques or exercises to help patients make such changes. All CBT approaches share a theoretical perspective, which assumes that internal covert processes called 'thinking' or 'cognition' occur, that cognitive events affect behaviour, and thus that cognitive change may mediate desired behaviour change [8].

Historically, CBT is rooted in the work of classical philosophers such as the Stoics and Epicureans, and grew out of traditional behaviour therapy, from which it differs by its incorporation of the mediational perspective. This incorporation occurred mainly in the late Sixties and early Seventies, through the work of influential theorists such as Ellis, Beck, Meichenbaum, and Mahoney, who explicitly identified themselves as cognitive-behavioural in orientation. In later decades, CBT underwent further theoretical development and diversification. Most approaches acknowledge the importance of the therapeutic relationship and the fact that patients' private worlds are most formatively developed and revised in the context of affective relationships. Also, to different degrees, CBT approaches came to acknowledge the role played by unconscious processes in human experience. In some approaches, there is only limited (e.g., automatic thoughts) or intermediate (e.g., cognitive schemata) acknowledgment of the operation of processes outside of conscious awareness, while in other approaches (i.e., the constructivist approaches) tacit processes are viewed as central to all knowing activity and have been elevated to the level of a cardinal tenet. Indeed, constructivist perspectives adopt a more proactive view of cognition, emphasize the operation of tacit ordering processes, the complexity of human experience, and the merits of a developmental, process-focused approach to knowing [9-10]. These perspectives underline the complex interactions of many systems (e.g., biological, interpersonal, social, cultural) that contribute to the construction of meanings and the development of personality and identity.

Independent of differences in principles and procedures, all CBT approaches provide patients with a collaborative, problem-focused treatment that takes into account the way they construe and interpret situations and events, their attitude toward themselves and the world, and the skills and activities by which they interact with the world. CBT approaches are by nature either explicitly or implicitly educative and, as compared with other approaches, they focus more on the 'here and now' than on the past. While research-based therapy protocols are usually time-limited and last from 12 to 16 sessions on a weekly basis, in clinical practice the therapy can be tailored to patients' needs by increasing or decreasing the frequency and number of sessions.

According to the classical CBT model of depression, individuals prone to suffer from depressive disorders develop a disposition to view situations and circumstances in habitually negative and biased ways, which leads them to habitually experience negative feelings and emotions as a result. Depression would be caused by a combination of dysfunc-

tional thought processes and maladaptive behaviours motivated by these processes. The model emphasizes that depressed individuals tend to have negative thoughts not only about themselves but also about the future and the world. These negative thoughts would increase depressive feelings. Depression would lead to a decrease in activity and social interactions, resulting in further worsening of depressive symptoms [11]. CBT approaches share the common assumption that such thoughts and behaviours can be changed, and provide a consistent focus on changing dysfunctional cognitions and helping patients learn new, more adaptive coping skills, with the aim of eliminating the vicious cycle of negative automatic thoughts, depressed affect, decreased motivation, and decreased activity that characterizes depression.

Different versions of CBT place varying emphasis on the cognitive and behavioural components of treatment. Also, the cognitive component may focus mainly on maladaptive schemas and cognitions, such as in Beck's or Ellis' approaches [11, 12], or on core ordering processes by which individuals organize and construct meaning for reality and construct and maintain a sense of self in a social field, such as in constructivist approaches [10, 13, 14]. In a constructivist perspective, vulnerable individuals are postulated to find it difficult to identify and understand the connections between motivations, thoughts, affects, actions, events, and situations. They can experience a particular event or series of events (e.g., conflicts, losses, disapproval from others, personal mistakes and failures) as a confirmation of a feared impossibility of living a dignified existence [15]. In clinical practice, the therapy focuses on meanings rather than being aimed at directly alleviating symptoms or at training patients to better manage their problems. More than on cognition and behaviour, the emphasis is on the relationship between affects and real or imagined situations. To explore the patient's experience, non-directive techniques (e.g., empathic listening, supportive acknowledgement) and, mostly, directive techniques (e.g., targeted questions, interviewing, moviola, circular questions, confrontation, and clarification) are used. These techniques, which differ from interpretation, aim at challenging the way the patient gives meaning to his or her experience, and at helping him or her untangle the web of connections linking motivations, thoughts, emotions, actions, and events. This emphasis on the construction of meanings reveals the social and relational character of constructivist therapy [10, 14].

The following description mainly refers to Beck's cognitive therapy, which has been the most empirically researched approach. The classical cognitive model postulates the existence of structures called schemas, that are thought to develop in childhood as the result of early experiences, and are defined [16] as 'structures used for screening, coding, and evaluating the stimuli that impinge on the organism'. Within schemas reside various cognitions, which relate to a central theme or meaning concerning the self, the world, or the future. At any given moment, particular cognitions may or may not be accessible to conscious awareness, and individuals are often unaware of important cognitions that shape the way they react to experiences.

Cognitions are hierarchically organized [17]. Core beliefs, which are considered to be the deepest category of

cognition, are fundamental assumptions that influence how individuals view the world and themselves. People get so used to thinking in these core ways that they do not notice or question them anymore. While schemas refer to cognitive structures in which the beliefs reside, core beliefs refer to the content of a schema and represent the theme or meaning of the related schema (e.g., 'I am unlovable', or 'I am inadequate and inferior'). Intermediate beliefs are less central cognitions that derive from core beliefs, such as attitudes (e.g., 'It is terrible to be unloved'), conditional assumptions (e.g., 'If I please everyone then people will love me'), implicit rules (e.g., 'I should never get angry with others'), and central goals (e.g., 'Being loved is of the utmost importance'). The most situation-specific and less central cognitions derived from core beliefs are automatic thoughts, which are evaluative cognitions that occur in response to a particular situation. They are called automatic because they are not the result of deliberate extended thinking or logical reasoning, but rather are reflexive thoughts that occur spontaneously and effortlessly, more or less all the time, and usually are not questioned. Most of the time, individuals are unaware that they are occurring, not so much because they are unconscious in nature but rather because they are so used to them that they do not notice them anymore. Automatic thoughts influence emotions and behaviours and can induce physiological responses.

Although the biologic, environmental, and behavioural bases of depression are acknowledged, the therapy is mainly based on a cognitive vulnerability model. The original version of this model, put forth by Beck [11, 18], argues that depression is the result of negative schemas of the self, world, and future. In individuals prone to depression, schemas involve themes of loss, inadequacy, interpersonal rejection, and worthlessness. Under stressful circumstances that may resemble those that produced the negative schemas, vulnerable individuals engage in negative automatic thinking, which is mainly driven by these schemas and the related beliefs, rather than by the concrete aspects of their experience as judged by an external observer. For instance, if a friend does not promptly reply to a message, an individual prone to depression might automatically think 'He is not answering my message because he hates me', rather than considering alternative explanations such as 'He must be really busy today'. As a result of these negative automatic thoughts, feelings of depression would build and deepen, and individuals would engage in maladaptive behaviours, such as social withdrawal.

According to the model, the thoughts of depressed patients typically involve a number of cognitive distortions, such as catastrophizing (always anticipating the worst possible outcome to occur), filtering (focusing on negative while ignoring positive aspects of an experience), personalizing (automatically blaming oneself when something bad occurs even when having no real responsibilities), overgeneralizing (viewing isolated troubling events as evidence that all following events will become troubled), polarizing ('all or nothing' thinking that assigns either 'all good' or 'all bad' labels, rather than looking to the 'gray areas' or complexities of the situations), and emotionalizing (allowing feelings about an event to override the logical evaluation of what occurred during the event).

Treatment commonly begins with a psychoeducation component in which the nature of depression and its maintaining factors (i.e., thought patterns and behavioural tendencies) are outlined. The therapist teaches patients about the interplay between cognitions and affect and about the self-perpetuating vicious cycles of inaction and increased depression. Psychoeducation also helps prepare patients for the active role they are expected to play in treatment [19]. Just from the outset, the therapist works to form a therapeutic alliance with the patient, who is encouraged to act as active partner in the therapeutic process. To this purpose, throughout the course of therapy the work completed during sessions is often complemented by home practice assignments. Between-session 'homework' may consist of instructions to keep a log of thoughts, behaviours, and moods, or may involve practicing the techniques learned during therapy sessions as well as new cognitive and behavioural skills outside the therapeutic context.

The first phase of treatment focuses on symptom relief, emphasizes behavioural change, and aims at engaging again patients in their daily activities and restoring psychosocial functioning. Basically, the behavioural aspect of CBT involves monitoring behaviour and using these data to help motivate patients to make positive behavioural changes by replacing behaviours that may be contributing to depression with healthier ones, with the aim of increasing mood directly.

This treatment component heavily borrows from behavioural therapy, which is an effective treatment for depression in its own right. The evidence is most compelling for the contextual approaches based on functional analyses, such as contingency management and behavioural activation, which focus on changing observable, problematic behaviours, and use functional analysis to modify the contingencies that shape and maintain the depressed patient's behaviour [7, 20]. Behavioural activation, which involves the assignment and scheduling of weekly activities, helps patients return to activities they have discontinued and engage in new activities. Patients are taught to monitor their daily activities and rate their level of enjoyment from each experience by keeping an activity log. In this way, they learn to recognise the link between their behaviour and their mood, and they collect information on activities that enhance their mood as opposed to those that impair it. The therapist will then devise strategies for helping patients to increase the number of pleasant activities, and will also carefully look for any skill deficit that might play a role in maintaining depressed mood, inaction, passivity, and problematic behaviours.

If the patient seems to have skill or coping deficits, the therapist educates the patient in missing skill sets. To this aim, the therapist may use techniques such as assertiveness training, modeling, and role-playing, and may also assign the homework of practicing new behaviours outside the therapy sessions. Problem-solving techniques can be used to help patients make choices when they are faced with decisions they find difficult to make. The therapist may teach the patient how to break complex and seemingly insurmountable tasks into smaller, more manageable components, which can help decrease the patient's avoidance and anxiety and result in more rewarding success experiences that improve mood.

Distraction and refocusing is used to assist patients when they have difficulty concentrating or are experiencing an overload of emotion. Patients can also be taught basic relaxation techniques, including imagery exercises, to decrease intense emotions and to relax [21].

As well, the therapist and patient work together on setting behavioural goals in important life domains. The patient is encouraged to set realistic short- and long-term goals, and to describe the steps needed to achieve these goals, which are defined in terms of behavioural rather than emotional outcomes. Then, the patient gradually tackles each goal while paying specific attention to patterns of avoidance and replacing them with active coping.

In the middle phase of treatment, the focus shifts to cognitive restructuring, which involves identifying, disputing, and modifying the patient's maladaptive cognitions and cognitive distortions. It should be emphasized that, although patients may hold beliefs that are dysfunctional and may seem irrational and distorted to an external observer, such beliefs do make sense to them in light of their history, experiences, and personality organization. Also, distorted though they may be, these beliefs are all patients have to help them make sense out of the events that happen to them, so they should be treated with respect and any attempt at challenging them should be made with great caution.

Typically, the therapist uses a non-confrontational method called 'Socratic questioning' to help the patient examine his or her thought patterns [11, 22, 23]. This method utilizes a progression of questions to assist the patient in identifying faulty beliefs, evaluating them, refuting them, and restructuring them into more adaptive cognitions. Through this method of guided discovery, the patient is led to his or her own conclusions about the accuracy of beliefs and thoughts. First, the patient is guided to discover his or her thought process in relevant situations. To this purpose, the patient completes thought records in which he or she reports the occurrence of unpleasant events and situations, and identify and label the feelings and automatic thoughts elicited by these events. In addition to self-monitoring, guided discovery and role-play of situations during the sessions may also be used to help the patient identify beliefs and automatic thoughts. Subsequently, the patient is taught to critically evaluate beliefs and automatic thoughts by treating thoughts as hypotheses rather than facts, and by examining the evidence and logic for and against these and alternative thoughts. To this purpose, the therapist teaches the patient to systematically ask and answer a set of questions such as 'Is there any evidence for this belief?', 'What is the evidence against this belief?', 'What are possible alternative ways of thinking?', 'Is this belief helpful?', 'What is the worst that can happen if I give up this belief?', 'What is the best that can happen?'. After some sessions, the patient learn to monitor his or her own thoughts and to perform the disputing process outside of therapy sessions. In addition to the Socratic method, role-play, colourful metaphors, imagery, and stories are also common tools for cognitive restructuring [19].

The final phase focuses on maintenance of treatment effects and on relapse prevention [21]. The patient is encouraged to conduct planned experiential activities designed to

obtain new information called 'behavioural experiments'. These experiments aim at testing the validity of the patient's core beliefs so that the dysfunctional ones can be modified. Also, the client performs a behavioural analysis of dysfunctional coping mechanisms and alternative problem solving strategies. Finally, the therapist and patient set future goals, anticipate possible obstacles, and think of ways to overcome them [24].

Interpersonal Psychotherapy

Interpersonal psychotherapy (IPT) [25] is a form of psychotherapy that was initially developed as a time-limited, focused treatment of adult outpatients with major depressive disorder and was subsequently adapted also for other disorders. Its theoretical roots can be traced in works of authors such as Harry Stack Sullivan [26], John Bowlby [27], and Adolf Meyer [28]. The basic assumption of IPT is that the interpersonal relationships between the depressed patient and significant others have a major influence on the onset, course and outcome of depression, as the development of the disorder occurs in a social and interpersonal context.

As compared with psychodynamic therapy, IPT focuses more on current relationships than past ones, and on interpersonal processes rather than internal psychic processes. Also, the use of the therapeutic relationship is more limited in IPT than in psychodynamic therapy. For instance, while negative feelings are understood as transference phenomena, they are not dealt with using a psychodynamic perspective. Patient-therapist interactions are examined only when the patient's feelings about the therapist are hampering progress, or to elucidate an interpersonal process that the therapist feels may be occurring in relationships outside the therapy room and influencing the depression.

The main aims of treatment are to decrease depressive symptoms, educate patients about the reciprocal link between their depression and the quality of their interpersonal relationships, and promote and enhance skills for addressing interpersonal problems that may exacerbate or contribute to depression. Although the therapist takes an active stance, the responsibility for change is with the patient. The therapist may make suggestions but is careful not to tell the patient what to do. The emphasis is constantly on improving patients' ability to solve their own problems and pursue their own goals and interests.

The IPT model conceptualizes four general areas in which a person may be having relationship difficulties: interpersonal disputes, role transitions, grief, and interpersonal deficits. The therapy usually concentrates on one of these areas.

The term 'interpersonal disputes' refers to a situation occurring in the marital, family, social, or work setting, in which the patient and a significant other have diverging expectations and the ensuing conflict is severe enough to lead to significant distress. In such circumstances, IPT would aim to identify the dispute and determine its stage, detect sources of misunderstanding via ineffective communication, explore how nonreciprocal expectations contribute to the dispute, examine how the quarrel is perpetuated, develop alternative solutions for the dispute, and promote the development of

skills needed to negotiate future interpersonal conflict. The therapist would use techniques such as problem solving and communication training to help the patient choose a plan for action and modify the communication or expectations.

Role transitions are conceptualised as situations where the patient has to adapt to a major change in life circumstances. Some of these transitions imply an actual loss, such as when a person becomes chronically ill or disabled. Other transitions, such as getting married or divorced, being promoted or demoted, moving to a new city, or becoming a parent are experienced as losses by the person who develops depression [29]. Another life event associated with increased risk for depression that involves several actual or perceived losses is migration, which has a substantial impact on several cultural and social roles and may also imply separation from loved ones [30]. In IPT, the patient with role transition difficulties is helped by the therapist to reappraise the old and new roles, to identify sources of difficulty in the new role, and to generate and implement solutions for these difficulties. The treatment goals are to mourn and accept the loss of the old role, promote a more positive view of the new role, and help the patient achieve a sense of competence and mastery in the new role. To these purposes, the therapist may use interventions such as linking the patient's affect to the role transition, clarifying the advantages and disadvantages of the new situation with respect to the old, identifying the skills required to feel more confident and successful in the new role, practicing these skills and applying them to interpersonal relationships.

Grief, defined in IPT as loss through death, is considered abnormal if it is delayed, distorted, or takes a chronic form. The therapist, while maintaining an empathic listening stance to help facilitate the mourning process, seeks to reconstruct the patient's relationship with the deceased, helps to address unresolved issues in this relationship, and guides the patient to recognize the link between depression and the feelings for the deceased. A primary aim of the grief work is to help the patient build new relationships and increase his or her social support system.

The fourth problem area, 'interpersonal deficits', is diagnosed when the patient reports impoverished interpersonal relationships, social withdrawal and impairments in social and communication skills in the absence of a clearly identifiable stressful event or situation. In many such cases, during therapy the focus needs to be placed on both old relationships and the relationship between the patient and therapist. When focusing on the former, common themes should be identified and linked to current life circumstances. On the other hand, the therapeutic relationship would facilitate the identification of problematic interpersonal processes, such as excessive dependency, fear of intimacy, difficulties in starting or maintaining relationships, or hostility. Using the therapeutic relationship as a template for further relationships, the therapist would then aim at modifying the maladaptive interpersonal processes within the therapeutic framework and helping the patient practice novel approaches to developing and preserving new personal relationships, the creation of which is a major therapeutic objective [29].

All sessions have a similar general structure, regardless of the treatment phase. At the beginning, the therapist and

patient review the depressive symptoms and the patient is asked to rate symptoms on a 10-point scale. Then, noteworthy interpersonal events that occurred over the past week are identified and linked to changes in depressive symptoms. The rest of the session focuses on the tasks that are specific to the current phase of treatment.

During the initial 'formulation' phase, the focus is on psychiatric assessment and depression diagnosis, psychoeducation about the disorder, exploration of the patient's significant interpersonal relationships, and identification of the problem area to be focused on during treatment. Psychoeducation involves providing the patient with information about the nature and causes of major depressive disorder, treatment options, the basic principles and aims of IPT, and the potential for improvement and recovery. To reduce feelings of guilt, the therapist often encourages the patient to adopt a 'sick role' [31], which has both privileges and responsibilities. The key benefit is that the patient is excused for being depressed and from blame for missing activities because of symptoms, as having an illness is not one's own fault. At the same time, the sick role entails the responsibility to be compliant with therapy and to actively work to get better and recover the healthy role.

A critical component of the initial phase is the 'Interpersonal Inventory', which involves a thorough examination of the patient's significant relationships, focusing mostly on the current relationships but including past relationships. For each significant relationship, information is collected about interactions, expectations, satisfactory and unsatisfactory aspects, and desired changes. This inventory is the cornerstone of IPT case formulation, as it provides a collaborative framework for understanding the social and interpersonal context of the onset and maintenance of depressive symptoms and allows the collection of the necessary information to identify the interpersonal problem area to focus on during the middle phase. When the patient presents with difficulties in several problem areas, the therapist should identify a primary and possibly a secondary problem area for which to develop a treatment plan, in agreement with the patient.

The individual's acceptance of the interpersonal formulation marks the beginning of the middle phase of treatment. During this phase, the therapist and patient explore the interpersonal problem areas in detail and identify the links between current symptoms and recent interpersonal experiences relevant to the focus area. Both directive and non-directive exploratory techniques are used. The former comprise targeted questioning and interviewing, while the latter include supportive acknowledgment, extension of the topic being discussed by the patient, and receptive silence [32].

Communication analysis is used to identify ways in which the patient's communication is ineffective and fails to achieve its goals. To this purpose, a thorough examination of a specific dialogue or argument that occurred between the patient and another person is performed. The aim is to teach the patient to communicate more effectively by increasing his clarity, directness, and accuracy of the message. The patient comes to learn that, by changing one statement, the whole direction of the dialogue and the associated affective experience can be changed.

Also, the therapist teaches the patient specific strategies that can help him deal with his interpersonal difficulties. Interpersonal problem solving includes basic skills, such as negotiation, perspective taking, clarification of relationship expectations and of available options, and clear expression of feelings and opinions. Techniques typically used in this phase are decision analysis and role playing. Decision analysis involves helping the patient consider a range of alternative actions that can be taken and the possible consequences, either positive and negative, associated with each of those actions. The therapist and patient practice evaluating the various available options and then selecting which one to implement first. In role playing, the therapist and patient act out a new strategy or competence that the patient is learning in a nonthreatening way in the therapy session, in preparation for use in everyday life. The therapist can model many useful interpersonal skills, such as effective communication, expression of affects, and use of decision-making strategies. Throughout the role play, the therapist gives feedback on interpersonal style while congratulating and encouraging the patient to use these new competences in daily life.

Adjunctive techniques comprise work assignments to be done between the weekly sessions. They usually involve practicing specific skills that were targeted by the sessions, and are referred to with the patient as "interpersonal experiments" or "work at home". This kind of work helps the patient develop and consolidate the new skills, gain a sense of mastery and competence independent of the therapist, and increase the probability that the skills learned in therapy will generalize to daily life situations.

The final phase of treatment, which occurs during the last few sessions, involves less emphasis on termination than psychodynamic therapy. In IPT, termination is seen simply as a 'graduation' from successful treatment that reinforces the patient's sense of competence and independence. Explicit discussion of feelings regarding the end of treatment is encouraged, and if the patient expresses feelings of sadness or loss the therapist helps him or her see such feelings as a normal reaction to separation, distinct from depressive affect. The termination phase includes clarification of early symptoms that can serve as warning signs of future depressive episodes, review of the successful strategies and new interpersonal skills that were learned in therapy and of the aims that were achieved, generalization of skills to future situations, and discussion of the need for further treatment. As a means of possibly reducing the risk of relapse and recurrence, the therapist should encourage the patient to identify specific future situations that may be difficult or stressful and review the use of the new skills in these situations. Patients who responded to treatment but are at high risk for recurrence due to a history of multiple depressive episodes or significant residual symptoms may be offered maintenance therapy in a new treatment contract. If treatment did not lead to improvement, the therapist blames the therapy rather than the patient, gives the patient credit for making the efforts, and encourages the patient to consider the alternative available treatment options [33].

Psychodynamic Psychotherapy

In Freud's original work [34], depression was described as a psychic wound or hemorrhage ("*innere Verblutung*"), a

kind of “hole in the psyche” (“*ein Loch im psychischen*”) that drains all energy of the individual.

While psychodynamic conceptualisations of depression may vary in accordance with the various psychoanalytic theories and approaches, there are some common themes. A basic tenet of all psychodynamic approaches is that a person's behaviour is influenced by the unconscious mind and by past experiences. Depression is considered to be a basic affect that signals a discrepancy between ideals and ambitions, a wished-for state of the self and the actual state of the self. This confrontation resulting from the gap between ideals, aspirations and actual achievements is often very painful and may lead to feelings of helpless or hopelessness. Depression is, thus, not conceptualized in terms of a static end state, but as a basic emotional response of the individual, in particular to feelings of loss of a wished-for state.

Loss, in all its various forms, is indeed a basic element in psychodynamic theorizing about depression [35]. Anger toward others (e.g., because of perceived rejection or disappointment) or toward the self (e.g., because of guilt or self-criticism) is also seen as playing a prominent role in depression in some approaches, such as those based on the work of Klein and Bowlby. However, in the last decades anger has been emphasized less, and conceptualized more as reactive than primary, whereas there has been greater emphasis upon the narcissistic vulnerability (i.e., sensitivity towards perceived or actual losses or rejections) and the resulting lowering of self-esteem of depressed patients [36].

According to Blatt [37], in the phenomenological experience of depression two central issues can be identified: dependency, concerning loneliness and feelings of neglect and abandonment; and self-criticism, relating to self-worth, responsibility, and guilt. Individuals with high levels of dependency or self-criticism tend to behave in ways that elicit particular reactions from others, which in turn often confirm the individual's fear of rejection and abandonment or of disapproval, thus creating a vicious cycle. For example, high levels of dependency are associated with annoyance and resentment in others, which may indeed lead to rejection and abandonment, whereas high levels of self-criticism are associated with ambivalence toward others due to fear of being criticised and disapproved, which may lead others to perceive these individuals as cold, competitive, and distant.

Issues of dependency and self-criticism are also central in attachment theory, which provided substantial empirical support to psychoanalytic theorizing about depression and many other topics as well. Evidence from various lines of research supports the key role of attachment in depression. Early disruptive attachment experiences play a central role in the causation of depression [38, 39]. Also, vulnerability to depression in adulthood is associated with attachment insecurity [40], and insecure attachment was found to be prospectively related to recurrent depression [41].

Psychodynamic psychotherapy aims at helping patients explore putative long-term causes of depression, including mental conflicts that may originate from difficulties in relationships with early attachment figures and from attempts to reconcile, deny or repress painful emotions. As compared with most other psychotherapeutic approaches, psychody-

amic psychotherapy focuses more on the patient's internal world, that is, representations of self and significant others that influence perceptions, feelings, thoughts and actions. It also puts greater emphasis on the role of unconscious motivation and intentionality. For example, psychodynamic approaches to depression aim to uncover how motivational factors which are often unconscious lead the patient to perceive and interpret external reality and experiences in his or her peculiar way, and to unwillingly create problems that perpetuate depressive symptoms, especially in interpersonal relationships.

Psychoanalytic approaches to depression underscore the need to understand the subjective experience of the disorder, and typically give emphasis to the importance of a developmental perspective in conceptualizing and treating depression as they specifically underline the role of insight into the past in changing current attitudes and feelings. Even in brief psychodynamic approaches to depression that focus more on the present, developmental antecedents of behaviour, thoughts, feelings, and attitudes are characteristically taken into account [42].

As compared with other psychotherapeutic approaches, psychodynamic therapy tends to put a stronger emphasis on the past and its influence on the present, on interpersonal experiences, on affect and emotional expression, on the identification of recurring patterns in behaviour, feelings, experiences and relationships, on the exploration of wishes, dreams, and fantasies, on patients' tendencies to avoid topics as a result of defences, and on the therapeutic relationship [43]. While psychodynamic competencies overlap to some degree with those of other psychological treatments, such as the ability to engage the patient and build a positive therapeutic alliance, there are a few competencies that are specific to psychodynamic therapy, such as the ability to continuously monitor countertransference during sessions, and to work with transference phenomena directly as they arise in the therapeutic relationship rather than indirectly through the patient's accounts of his or her experiences with significant others [44].

Psychodynamic therapy involves the exploration of patients' fantasy life and of the entire range of their emotions, including feelings they may not be aware of. With the help of the therapist, the patients find ways to talk about feelings that are difficult to express, such as contradictory, troubling, or threatening feelings. Patients are also helped to become aware of feelings they may not initially be able to recognise or acknowledge. Moreover, psychodynamic therapy puts special emphasis on recognizing and addressing behaviours that are interpreted as expression of putative 'defence mechanisms' used to avoid distressing thoughts and feelings. Examples include constantly changing topic when specific topics come up, attending to facts and events to the exclusion of affect, being late or even missing sessions when the topics have become distressing, or focusing on external details rather than on one's own role in an event.

As the therapy progresses, the therapist works to identify and explore repetitive themes and patterns in patients' thoughts, feelings, self concept, relationships and behaviour. Patients are guided to recognize the presence of these patterns and are helped to understand how they influence their

reactions and their mood. This work almost invariably involves an examination of past experiences and of their possible influence on the present. The focus is not on the past for its own sake; rather, the therapist is interested in how the past may affect patients' relation to and experience of the present, and how it may help understand their current difficulties [45, 46].

The relationship between the therapist and the depressed patient is considered to be of particular importance on the basis of the assumption that previous difficulties in close interpersonal relationships would tend to arise within the therapeutic relationship through a process known as 'transference'. The constant attention to the therapeutic relationship gives the therapist first-hand information about how the patient feels and behaves in other relationships. This information, coupled with that stemming from patients' descriptions of their interactions with significant others, is quite useful to identify any significant difficulties that patients may have in relating to others. The therapist then can gradually help patients to gain insight into how past relationships may be influencing their perception of present relationships, to understand how their dysfunctional interpersonal transactional styles may maintain depressive symptoms, and to find ways to solve or cope better with their interpersonal difficulties in order to have their emotional needs adequately met. The actual interventions used in psychodynamic psychotherapies can be conceptualized as lying on a continuum between supportiveness and expressiveness [47]. At the supportive end of the continuum, there are interventions such as advice, praise, empathic validation, encouragement to elaborate, and affirmation. At the expressive end of the continuum, there are the interventions most associated with exploratory and uncovering strategies, such as interpretation, confrontation, and clarification. In contemporary psychoanalytic approaches, increased respect and importance are given to supportiveness, in recognition that support is concerned with those interpersonal conditions that allow the patient to feel a sense of trust, safety, hope, and purpose, and thus allow him or her to open up to the therapist. While supportive techniques were previously used only when necessary, nowadays supportiveness and expressiveness are considered part of an indissoluble whole, whereby greater expressiveness follows from supportive conditions and allows to develop insight and to understand what was previously out of view of the patient's perspective [36].

Given its developmental and explanatory focus, psychodynamic therapy aims at helping patients gain insight into the origin of their depressive symptoms and the function that these symptoms may play in their life. Therefore, differently from other psychotherapeutic approaches, psychodynamic therapy does not only aim at achieving relief from depressive symptoms, but also at helping patients understand their meaning. Given that increased understanding does not necessarily imply symptom relief, gaining insight into previously unconscious factors and conflicts that contribute to depressive symptoms is not considered as an end in itself, but rather as a means to promote the development of internal resources and abilities needed to deal with and effectively manage the psychological issues and difficulties that have caused emotional suffering and depression. Therefore, although psychodynamic therapy does not teach specific skills,

it still aims at helping patients learn healthier, more functional ways to deal with the previously unconscious factors and conflicts that contributed to their depressive symptoms. Indeed, treatment success is judged not only by symptom remission, but also by the achievement of a more sophisticated understanding of self and others, and by the development of the capacities to have more fulfilling relationships, to make better use of one's talents and abilities, to tolerate a wider range of emotions, and to face the challenges of life with greater freedom and flexibility [48].

Psychotherapy for Chronic Depression

As compared with the large number of studies examining the effects of psychological treatments on depression, relatively few studies focused on chronic forms of depression such as chronic major depressive disorder and dysthymic disorder. It should be recognized that the empirical support for the efficacy of psychotherapy in the treatment for chronic forms of depression, especially dysthymic disorder, is lower as compared with major depressive disorder. Trials provided relatively little support for the efficacy of psychotherapy in the treatment of dysthymic disorder, although IPT reached the criteria for possible efficacy [20]. A recent meta-analysis revealed that psychotherapy for chronic depression and dysthymic disorder has a small but significant effect on depression when compared to control conditions (placebo, care-as-usual, non-specific control, or waiting list). Most of the included studies exploring this specific comparison examined the effect of CBT. The effect size was significantly associated with the number of sessions, with the results suggesting that at least 18 sessions are needed for psychotherapy to have an optimal effect. Combined treatments of psychotherapy (mostly CBT or IPT) and pharmacotherapy resulted in a higher effect size than either pharmacotherapy alone or psychotherapy alone [49].

While this meta-analysis corroborated the notion that psychotherapy might be less effective in chronic depression and especially in dysthymic disorder than it is in major depressive disorder, it nevertheless found that psychotherapy has a significant effect on chronic depression and dysthymic disorder, and although this effect is not large, it is relevant from a clinical perspective. In fact, although pharmacotherapy clearly has demonstrated efficacy as both an acute and a maintenance treatment for chronic depressive syndromes, medications do not help all patients, and do not eliminate residual symptoms and psychosocial dysfunction in some patients who do respond to them. Hence, there is an opportunity and a challenge for psychotherapy to treat medication non-responders and partial responders.

As attested by the smaller effect size of psychotherapy in chronic depression as compared with acute depression, in clinical practice chronic depression is usually more difficult to treat. There are several differences between patients with chronic and non-chronic depression, and these differences have important implications for psychotherapy with chronic patients. While we borrow mainly from the IPT and CBT literature to describe the problems that may be encountered in therapy and the steps needed to address them, most of these considerations have general value and can be applied to any psychotherapy model.

A first, important characteristic of patients suffering from chronic depression is that, differently from those with episodic depression, they emphasize trait over state and tend to see themselves as having depressive personality rather than a mood syndrome. As they have grown up with feelings of sadness, they see them as part of their personalities. Some individuals suffering from chronic depression have the sense that the depression is who they are [50]. These patients have been depressed for such a long time that their depression has merged with their identity, and they may be afraid to give up their depression for fear that they will lose part of themselves. Other patients view their being chronically depressed as a kind of proof of their depth of feeling and keen insight, so that they may take a sort of perverse pride in remaining hopeless and depressed. For other patients, a depressive role may have provided a non-threatening reason for failing to live up to the expectations of themselves and significant others.

This identification with their depressive illness may influence how chronically depressed patients experience the objectives of psychological treatment. In psychoanalytic psychotherapy, notions like recognition and care, rather than cure, may initially make more sense for such patients and facilitate the building of a working alliance [36]. In psychotherapies that aim more explicitly at cure, the issue of the 'depressive identity' should be directly addressed for therapy to have a chance of being effective.

In IPT, the therapist deals with this issue by presenting the patient with a formulation that shifts the patient's attention from Axis II to Axis I [51]. A typical formulation might be: 'I understand that you feel flawed. However, the problem is not with you as a person; you suffer from dysthymic disorder, a form of chronic depression that you have had since childhood. As you grew up with the illness, you understandably see it as who you are'. Rather than facing the gloomy prospect of an intractable character disturbance, the patient is confronted with the recognition of a chronic illness that may be treatable. This formulation retains several key elements of IPT, such as the medical model, hopeful outlook, and emphasis on the link between mood and interpersonal life situations. As guilt is displaced from patients to their illness, this formulation also helps to relieve the pervasive feelings of guilt that are typical of chronically depressed patients. For such patients who often have no recent life events on which to focus treatment, it provides what is called a 'iatrogenic role transition', as psychotherapy itself becomes a role transition from chronic illness to emerging health [52]. The therapist's task then becomes that of helping the patient mourn the old (chronically depressed) role and come to terms with and gaining mastery of the new (healthy) role. It is important to recognize change as difficult for the patient to tolerate even in situations like this one, where the direction of change is a positive one.

CBT therapists may address a depressive identity by teaching patients to objectify their illness so that it can be distinguished from their true self. Although patients may report that their depression had a steady, unremitting course, even chronically depressed patients experience some degree of fluctuation or reactivity in their mood. By suggesting them to look at old photographs and videos, and by using

imagery exercises or the moviola technique [15] to replay important events in their life, the therapist may guide these patients to recall and examine periods of their life when they were not depressed, or at least were less depressed, in order to counter their belief that they have always been in a chronically depressed state. Those patients who are concerned about giving up their depression may benefit from an analysis of the advantages and disadvantages of remaining depressed. Those patients who feel protected by their depressive role from fears of failing to meet expectations may be helped to articulate some of their objectives, along with how they may fear setting the bar too high and risking disappointment [53].

Behavioural experiments aimed at breaking and reversing the vicious cycles may also help patients who are trying to leave behind an identity as chronic depressives. First, ideas should be generated about how the patients would need to conduct their lives as if they were self-assured, hopeful, and sociable. Then, the patients should create a list of graded tasks that requires them to progressively enact these behaviours in their daily life and to put efforts to express the constructive attitudes related to these behaviours.

A related problem is that some patients with chronic depression succeed to maintain a good psychosocial functioning while continuously experiencing sad, miserable feelings. Although they perform well and are liked by other people, such patients disregard the positives and view their deeply ingrained self-critical beliefs as the only truth. This is sometimes described as the 'impostor syndrome' [54]. With patients such as these ones, who maintain that they are really not the kind of persons they seem to be, it is usually unproductive to get into an either-or argument with them about this issue. Rather, the therapist should encourage the patients to look at all the available data as true and relevant. The point is that the patients' internal life and external behaviour are both aspects of who they are and should both be viewed as worthy sources of information [53].

A second important difference between patients with chronic depression and those with episodic depression is that the former ones usually have more severe social skill deficits. Years of chronic depression and the related social withdrawal may hinder the development of social skills or undermine existing skills by inaction and extinction. Therefore, interpersonal functioning is typically impaired in patients with chronic depression. Chronically depressed patients are often passive, submissive, unassertive, find it uncomfortable to express emotions, tend to live marginalized lives and have fewer social contacts.

Psychotherapy needs to address these social skills deficits and the related interpersonal difficulties. The therapist should devote time to detoxifying and normalizing feelings. For example, the emotion of anger is validated as a normal response to being bothered by other people, and is defined as a useful interpersonal signal rather than something to be embarrassed of. Also, self-assertion is encouraged, by helping patients realize that if they do not pursue their own needs, these needs are unlikely to be fulfilled. As these patients often tend to put other people's needs ahead of their own, the therapist encourages them to put themselves first and to tolerate a certain level of 'healthy selfishness' [55].

As the social skill deficits of patients with chronic depression are usually long-lasting, they should be tackled gradually. Frequent practice, both in session and between sessions, is required, as well as graded task assignments. Social skill training would involve techniques that promote greater activity and involvement with others in everyday life between sessions. Role-playing can be used to help patients develop and expand their social communication repertoire. By adopting a respectful attitude, paying attention, and maintaining appropriate boundaries, the therapists themselves can function as role models for effective interpersonal relating. As patients become more proficient in social communication and practice in their daily life the new skills learned in therapy, they may begin to see more positive responses from the environment.

Chronically depressed patients also suffer from a persistent sense of hopelessness that permeates all aspects of life. After years of unremitting chronic depression, they often become hopeless about their future and feel unable to do anything about it. As these patients may hide the depth of their hopelessness behind a passive dependent or cynical exterior, the first step is recognizing and drawing out their hopelessness [36].

Hopelessness is a serious problem because it not only bolsters feelings of sadness, it also discourages patients from seeking and continuing activities that could help them, including psychotherapy itself. Working with chronically hopeless patients is more difficult because of their lack of motivation. For instance, in CBT they may be less interested in guided discovery, less willing to develop alternative explanations for automatic thoughts, and less motivated to set an agenda, stay focused on the problems, and complete homework tasks [56].

The therapist should not fall into the trap of responding to the patient's passivity and lack of motivation by reducing the level of structure of the sessions, as this would typically be an ineffective strategy. On the contrary, the therapist should remain focused on the problems and preserve the integrity of the session as much as possible, by setting a prioritized agenda, focussing on key behaviours and beliefs, and encouraging the completion of homework assignments. Clearly, the therapist should patiently and carefully explain the rationale for these procedures to the patient, and be ready to express empathy if the patient raises doubts about the prospect of working so methodically in therapy.

While hopelessness needs to be recognized and addressed in therapy, the therapist should be mindful of patients' negative beliefs concerning the notion of hope and deal with them with caution. Many patients with chronic depression are afraid of becoming hopeful, as they believe that hope is illusory and would make them vulnerable to further pain. For many of them, such beliefs are related to actual experiences of failure and loss across several life domains. Therefore, if the therapist tries to instil optimism too strongly he or she will be viewed as naive or excessively optimistic and may lose credibility.

In order to deal with the low expectations for therapy and impoverished sense of self-efficacy that are typical of chronically hopeless patients, behavioural activation tech-

niques are often useful to achieve some degree of symptom reduction already in the early phases of therapy. Given that early symptom reduction is very important, starting with two sessions per week is advisable, whenever possible. Once an improvement in symptoms has been obtained, the frequency of sessions can be reduced to once per week.

It should be underscored that chronic, severe hopelessness can be kind of contagious. Therapists themselves can be discouraged and begin to harbour doubts about the treatability of such patients. Such a pessimistic attitude is quite counterproductive, as the patients may become aware of therapists' negative feelings and thoughts, which may activate internal working models of abandonment. Therapists should monitor and control their own sense of hopelessness and keep clear in their mind that chronic depression may show a slower response to treatment than acute depression. Making this adjustment may help therapists to retain enough confidence to put in the hard work that is needed with chronically depressed patients. Therapists should be models of tenacity and determination, convey a sense of optimism, and adopt the attitude of regarding patients' passivity and ambivalence toward therapy as further data to be examined [53].

Patients with chronic depression have often experienced early negative life events, as well as failures and losses across a range of domains. Therefore, the kind of structural problems variably defined across different literatures as insecure internal working models [27], negative models of the Self [15], or early maladaptive schemata [57], are likely to be particularly pronounced, rigid, and overly generalized in these patients. These models and schemas are characterized by themes of unlovability, inadequacy, incompetence, dependence, distrust, rejection, and abandonment. As a consequence of their activation, the patients are prone to experience and express intense emotions that other people may regard as disproportionate to the situation and as a sign of hypersensitivity.

Given the prominence of personal themes such as helplessness and mistrust, the therapist may find it more difficult to establish a working alliance with these patients. It is important to first address the patient's strong need for recognition and validation, and only then move to techniques aimed at change. For instance, given that such patients often are blamed for being hypersensitive, the therapist can convey acceptance and empathy for their seemingly excessive reactions, explain that such reactions suggest that something deep has been triggered, and emphasize that becoming aware of this presents an opportunity to gain a greater understanding of oneself and to change [53].

Finally, when working with chronically depressed patients, the therapist should keep in mind that treatment duration should usually be prolonged with these patients. Even if therapy provides rapid improvement, they need time to adapt to their new, happier circumstances. Therefore, continuation and maintenance therapy for several months, possibly delivered with lower frequency, is usually indicated if acute treatment is helpful in order to bolster patients' recovery [55]. Also, some patients are disoriented by the experience of feeling less depressed after years of depression, and need time to adjust to the new situation. These patients may also benefit from continuation therapy extending beyond symp-

tom remission and focussing on adjustment to a life without depression. The therapist should also be alert to the fact that patients who have improved may face an existential crisis as they realize that they may have cultivated a depressive identity for a long time, thus actually missing the opportunity for a happier life. Patients may be so upset by this realization that they may stop making progress and rather go back to claiming that they were right and that their depression would never go away. These patients should be helped to create meaning to their suffering and reframe the accumulation of difficulties in their life and the time spent in therapy in a purposeful way, as something that was needed to reach this point, when the patients' task is to make the most of the rest of their life. The ongoing availability of the therapist during the continuation phase is instrumental to consolidate treatment gains and to counteract the possible emergence of feelings of loneliness and abandonment in these patients who are facing what is in many respects a new existence [53].

Psychotherapy for Depression in Adolescents

IPT, and especially CBT, are the most studied non-pharmacologic interventions for the treatment of depression in youth. While initial meta-analyses conducted throughout the late 1990s may have overestimated the effect size of CBT, the effectiveness of IPT and CBT for the treatment of depression among adolescents is nevertheless supported by recent reviews, meta-analyses, and clinical trials [58-60].

McCarty and Weisz [61] reviewed the treatment programs that showed at least moderate effect size in clinically diagnosed samples, and identified several common therapeutic foci and techniques. One common thread was identified in all of the effective treatments: a focus on having the youths achieve measurable goals or increase their competence in a self-identified area of their life in which improvement is desired. In addition, most effective treatment programs provided psychoeducation about depression and its treatment to youths, included some form of self-monitoring of some target activity or state, addressed social relationship skills and communication skills, taught cognitive restructuring and general problem solving skills, and used behavioural activation in order to help youths engage in active behaviour that can elevate mood and see the relationship between their activity and mood.

It is important to recognize that psychotherapy with adolescents presents the therapist with specific challenges that are different from the challenges of psychotherapy with adults. As adolescents are not 'little adults', they require a developmental approach to psychotherapy and appropriate modification of the treatment. Therefore, when treating adolescents with IPT, CBT, or other psychotherapies, the therapist should factor in developmental considerations. For illustrative purposes, we describe here the adaptation needed for using IPT and CBT with adolescents.

A first important developmental consideration is that adolescents' ability to recognize and process emotions is still developing, along with their ability to think in an abstract way. The therapist should keep in mind that working with a 13-year-old can be quite different from working with a 17-year-old, and that cognitive ability must be determined individually for each patient, because chronological age is only a rough

proxy for it. Given these developmental limitations, the use of role-playing, stories, and metaphors may be helpful in demonstrating abstract concepts. If the adolescent has difficulties with conventional problem solving or decision analysis procedures involving generating alternative solutions and identifying positive consequences of potential solutions, the therapist may use a simpler version of problem solving, such as asking the adolescent to list the pros and cons of an action. Also, adolescents with limited cognitive ability will require greater emphasis on the behavioural components of therapy [62].

Adolescents tend to be focused on the present and may find it difficult to envision how working on current difficulties will improve their future. Therefore, the therapist should put greater efforts to engage patients in treatment and to enhance their motivation and commitment. There are some specific difficulties in creating an alliance with adolescents as compared with adults. First, adolescents are not usually the ones to initiate treatment, as in most cases parents or other outside influences are the initiators of treatment. Also, adolescents are at a stage in their development in which they are struggling with autonomy and individuation, which may make it difficult for them to connect with an adult therapist, who may be seen as another authority figure in their lives. To increase the probability of creating a successful therapeutic alliance, collaboration in therapy should be emphasized [63], in addition to highlighting confidentiality. A further factor that may make it difficult to build an alliance with depressed adolescents is the frequent presence of irritability as a symptom of depression. Indeed, establishing an alliance with an irritable, emotionally dysregulated adolescent is a challenging task that may require the therapist to be able to tolerate not only intense emotions during sessions, but often also hostility and devaluation. In times of distress, irritable depressed adolescents will often devalue both therapy and the therapist. The capacity of therapist to tolerate distress and to help the adolescent regulate disruptive emotions is instrumental to maintain and strengthen the alliance. A nonjudgmental stance is another key factor in developing a therapeutic alliance with adolescent patients, because depressed adolescents often experience their environment, and particularly adults, as judgmental. Adopting a nonjudgmental, empathic, genuine, and tolerant stance will enable the therapist to establish an alliance with a wide range of adolescents and their families [62].

Adolescents generally do not love homework. This poses a particular problem to CBT therapists, as homework is a key component of CBT. The challenge lies in designing homework assignments that will be seen as worthwhile. To increase the probability that homework is completed, it is vital to begin with easily achievable assignments that have successful outcomes. In addition, having a reward system that is meaningful to the adolescent is mandatory [64]. In case of noncompliance, the therapist should first determine the reason, which may range from forgetting and avoidance, to the assignment being too difficult. Next, the therapist should work on the homework together with the patient in session and look into ways to get the homework done. Although completing homework is essential, the adolescent should by no means be made to feel guilty or inadequate, as this would damage the alliance and greatly decrease the probability that homework would be completed [62].

The objectives of treatment should take into account adolescents' developmental tasks. For instance, in the adolescent version of IPT [65], objectives include individuation from parents, achievement of autonomy, development of dyadic romantic interpersonal relationships, coping with initial experiences of loss and death, and dealing with peer pressures.

In IPT, there is also a reconceptualization of the sick role to have a more limited focus. The patient and his or her parents are informed that the adolescent has a medical illness that may affect normal activities and performance. The patient is encouraged to participate in as many normal activities as possible, and the parents are advised to encourage participation and completion of responsibilities and to be less critical of the adolescent's performance and more supportive of participation. Both the patient and parents are informed that the motivation to do these activities and the performance will improve as the depression improves. Allowing a patient to assume temporarily a limited sick role removes the blame for poor performance from the adolescent and places it on the depression, gets the patient to engage in more activities, allows for a temporary revision of expectations, instils hope that the situation can change, and reduces the negativity between parents and adolescent [66].

Given their influential role in the lives of most adolescents, the involvement of parents in therapy is of particular importance, and ideally is extended throughout the therapy process. In IPT, during the initial phase of treatment parents are educated about depression, the limited sick role, treatment procedures and goals, and the importance of family support. In the middle phase, family members are asked to participate as needed to facilitate work on communication between the adolescent and the family. In the final phase, a family member is included in a session to discuss progress in treatment, changes in the family as a result of treatment, and interpersonal issues that may arise in the future, as well as to assess the need for further treatment and relapse prevention. In CBT, parents may help with the learning of coping skills, may act as 'coaches' in exposure exercises, and may help develop a behavioural rewards system to motivate the adolescent to work. Also, parents may be valuable co-therapists who continue facilitating treatment gains when therapy is terminated [62].

Combined Treatment

Recently, there has been increased interest in the combination of psychotherapy and medication in the treatment of depression. Both psychotherapy and medication, considered separately, have advantages and disadvantages, and differ in their strengths and weaknesses. Medication may provide rapid relief from symptoms; however, it may cause side effects, and recurrence may occur once it is discontinued. Psychotherapy may be slower in providing symptom relief and requires more clinician time; however, it can help reduce persistent symptoms and the risk of relapse or recurrence; also, it provides an opportunity to address co-occurring personality disorders or disturbances as well as trauma sequelae that may increase suffering and vulnerability to depression. Moreover, the combination of psychotherapy and medication may aid in adherence to both treatments. Medication may allow for more effective use of psychotherapy by providing

initial relief from depressive symptoms and increasing concentration and motivation [67]. It may even be the key to engaging in therapy some patients who would not otherwise be engaged, as those patients who are highly depressed, anxious, or treatment-reluctant might not start psychotherapy without receiving concurrent drug treatment, at least initially [68]. In turn, psychotherapy may aid in adherence to drug treatment, as it may allow for reduced doses and lower side effect burden of medications.

These considerations suggest that a proper combination might be more effective than either treatment alone. Indeed, three recent meta-analyses [69-71] demonstrated small but significant advantages of combined treatment compared with each treatment modality alone. Recent practice guidelines (APA) and literature reviews [67] suggest that combined treatment should be considered for patients with moderate to severe major depressive disorder, chronic forms of depression, history of childhood trauma, psychosocial issues, interpersonal problems, a comorbid personality disorder, and poor medication adherence.

Psychotherapy and medication may not have to be started at the same time. The literature suggests that sequencing treatments may allow to identify those patients who need only a single treatment [67], and that the sequential administration of psychotherapy (alone or in combination with antidepressant medication) after response to acute-phase pharmacotherapy may have a protective effect against relapse or recurrence in major depressive disorder [72]. Likely, psychotherapy helps patients develop interpersonal and emotion regulation skills that they can continue to use after treatment ends, which may reduce vulnerability to relapse or recurrence.

Some patients treated with psychotherapy and medication receive discordant messages regarding the nature of their disorder and the putative mechanism of action of treatment. As such, psychological therapy and pharmacotherapy might not only fail to act synergically, but even compete one against the other. Care should be applied not to simply add psychotherapy to medication, but to introduce it to the patients as a treatment that would work in synergy with pharmacotherapy, in accordance with a psychobiological model overcoming the traditional brain-mind dichotomy [73]. Such a model underscores that psychoactive drugs affect mental phenomena, while psychotherapy influences brain function; as such, it is particularly useful in conceptualizing the value of combining medication and psychotherapy.

No study has compared the relative efficacy of a single clinician providing combined treatment and a split treatment. On one hand, the potential for conflicts between two treating clinicians is avoided when a psychiatrist provides both psychotherapy and pharmacotherapy. Also, the greater frequency of visits allows for more regular monitoring for residual or recurrent depressive symptoms. There are also some potential problems with this approach, however, such as the risk of the psychiatrist losing sight of the more systematic assessment of symptoms and medication that are performed almost automatically during pharmacological visits. On the other hand, when two clinicians are involved in combined treatment there are some potential areas of conflict between the mental health professionals and in patients' ex-

perience and perception of them. For instance, the clinicians may experience competitive and professional tensions, and they may have different theoretical background and use different clinical models. Also, patients may idealize and devalue one or the other of the clinicians. A triadic therapeutic alliance and open communication between clinicians are useful to identify and address potential problems [67]. Also, treatment is greatly facilitated if both clinicians share a biopsychosocial perspective [74].

BIPOLAR DISORDER

Until recently, patients with bipolar disorder were rarely offered psychological therapies. Three main reasons accounted for this limited interest in psychotherapy for bipolar disorder. First, models underscoring the etiologic role of genetic and biological factors dominated research in the field. Second, it was erroneously believed that most patients made a full inter-episode recovery and returned to their pre-morbid level of functioning. Third, psychoanalysts historically expressed doubt about the suitability for psychotherapy of patients with bipolar disorder.

Over the last decade, there has been increasing acceptance of stress-vulnerability models that highlight the interplay between psychological, social, and biological factors. The most commonly mentioned psychosocial factors are stressful events, family conflict, social and circadian rhythm disruption, and medication non-adherence. Also, evidence has accumulated regarding the effectiveness of psychological therapies as an adjunct to medication, and there has been greater recognition of the notion that, although genetically and neurobiologically based, the course of bipolar disorder can be modified by interventions targeted at the social and environmental context [75, 76]. While there has been particular interest in effective psychotherapeutic approaches for the treatment of bipolar depressive episodes, as antidepressant use is controversial due to the increased risk of mood switch, psychological interventions were found to be useful in all phases of the disorder.

The treatment of bipolar disorder is challenging as it does not only aim at resolving acute episodes, but also at preventing recurrences and assuring complete inter-episode recovery in terms of symptom remission and restoration of functioning. There is evidence from randomized, controlled trials that psychotherapy is an effective adjunct to medication in relapse prevention and episode stabilization among bipolar patients. A recent systematic review concluded that as adjuncts to medication cognitive-behavioural therapy (CBT) and family-focused therapy (FFT) are efficacious with respect to the reduction of depressive symptoms, with interpersonal and social rhythm therapy (IPSRT) possibly efficacious; FFT is efficacious with respect to the prevention of subsequent relapse and perhaps recurrence, with IPSRT and CBT possibly efficacious; psychoeducation is efficacious in the prevention of mania/hypomania and possibly depression [7]. According to a recent meta-analysis [77], there is a significant reduction in relapse rate with adjunctive psychotherapy compared to standard treatment alone. These therapies share several common elements and there is considerable overlap in their actual targets, as they all aim at promoting change in at least one of the following areas: patients'

awareness and understanding of bipolar disorder, medication adherence, social rhythm stability, misuse of drugs and alcohol, and patients' ability to recognize and manage early signs of recurrence and the stressors that may increase their vulnerability to future episodes.

Research suggests that, even with optimal psychological and pharmacological treatment, a substantial proportion of patients still experience recurrences. To achieve optimal outcomes, psychosocial interventions need to be tailored to the individual patient. For instance, patients with a large number of episodes in a short period of time may require more intensive and longer treatment [78]. As well, management protocols may differ depending on the stage of the disorder [79]. Also, chronic care models, in which patients move in and out of intensive psychosocial treatments as indicated by their clinical state, may be more effective over the long term than a single course of psychotherapy [74].

The following subsections provide an overview of therapies such as IPSRT, FFT, and psychoeducation, which were not covered in previous sections. Before dealing with these approaches, we briefly describe the adaptations of CBT that may be useful for patients with bipolar disorder. In fact, although CBT for patients with bipolar disorder shares many features with CBT for unipolar depression, to be most effective it should take into account the distinctive characteristics of this patient population.

On one hand, the extant research evidence supports the notion that during a depressive episode patients with bipolar disorder experience cognitions as negative as those experienced by people with unipolar depression, such as low self-esteem, negative self-beliefs, and self-blaming attributions about negative events [80]. The negativity of cognitions seems to diminish as depressive symptoms remit. On the other hand, there is some evidence for positive cognitive biases in bipolar disorder. Patients are likely to set very ambitious goals for their life, to express higher expectations of meeting those goals, and to become overly confident when they achieve even small success. One way of reconciling this apparently conflicting evidence is that patients with bipolar disorder have an excessive drive toward extrinsic success and admiration, and are overly influenced by environmental feedback [81].

Given the salience of negative cognitions, especially during depressive episodes, one would expect that challenging negative self-beliefs would be helpful; indeed, many of the cognitive techniques developed for the treatment of unipolar depression apply well to the treatment of depressive episodes in bipolar disorder. There are, nevertheless, some subtle but relevant clinical differences between unipolar and bipolar depression. The most widely replicated studies suggest that patients with Bipolar I Disorder have more psychomotor retardation, mood lability, and psychotic features, while patients with Bipolar II Disorder have more atypical depressive symptoms, such as hypersomnia, leaden paralysis, increased appetite, and interpersonal rejection sensitivity [82]. Given the prominence of behavioural symptoms such as retardation and lethargy in bipolar depression, behavioural techniques may be particularly useful in these patients [83].

Therapy should also address overly positive cognitive styles, if present. However, this is not an easy endeavour,

because the common strategies used to challenge negative cognitions, when adjusted to address positive cognitions, are likely to damage the therapeutic relationship. A more promising strategy is to help patients review the pros and cons of positive beliefs held in the past. Often, patients find it easier to gain perspective on their flights of confidence when looked at in retrospect than in the present moment. Another strategy is to help patients understand that their self-relevant cognitions can be heavily dependent on mood. To this purpose, patients may be asked to monitor their mood and confidence over the first weeks of treatment. In this way, they can be led to realize that their confidence may be less a reflection of their true abilities and more a reflection of their mood state. As patients begin to appreciate how much their confidence can vary over time, it becomes easier for the therapist to help them evaluate the validity of their beliefs about themselves. Once patients realize the basic fragility of self-evaluations, they can more easily accept suggestions such as asking close others for input about ideas. In any case, it should be kept in mind that addressing positive cognitive styles in bipolar disorder usually requires a strong therapeutic relationship [81].

Interpersonal and Social Rhythm Therapy

Interpersonal and social rhythm therapy (IPSRT) [84] has its theoretical roots in the instability model of bipolar disorder [85] and the Social Zeitgeber theory of mood disorders [86]. In these models, life events are hypothesized to precipitate or exacerbate bipolar episodes through their ability to disrupt social and sleep routines. Indeed, even apparently harmless or positive life events may imply considerable changes in daily routines, which, in turn, can place substantial stress on the body's capacity to maintain the synchronized sleep-wake, appetite, energy, and alertness rhythms that characterize the euthymic state. IPSRT incorporates these models into the framework of interpersonal psychotherapy; as such, it aims at stabilizing patients' social and sleep routines and at improving the quality of their interpersonal relationships and their performance of key social roles. By addressing the interpersonal problem areas in the patient's life, the therapy attempts to reduce the number, severity, and negative impact of the interpersonal stressors experienced by the patient.

IPSRT can be offered both as an acute and as a prophylactic maintenance treatment, and is implemented in a series of four phases. The first phase usually lasts from three to five sessions and begins with a focused history-taking that emphasizes the extent to which disruptions in social routines and interpersonal issues have been associated with affective episodes. The therapist also provides the patient and family members who may be involved in treatment with education about the nature of bipolar disorder, and with guidance on how to maintain a consistent medication schedule. Then, the therapist gathers the Interpersonal Inventory and assesses the regularity of the patient's social routines by asking him or her to complete an instrument called the Social Rhythm Metric (SRM) [87]. This self-report form requires the patient to record 17 daily activities (e.g., time out of bed, first contact with another person, mealtimes, bedtime) that act to set the circadian system. Finally, the therapist and patient collabora-

tively select an interpersonal focus, from among the four IPT problem areas.

The second or intermediate phase of therapy typically requires 10 to 12 sessions and focuses on helping the patient establish more regular daily social routines and resolve the interpersonal problem area. Interventions aimed at regularizing social and sleep routines centre around the SRM, which enables to evaluate the degree to which the timing of a patient's routines varies throughout any given week. Working with the SRM, the patient begins to see the dynamic interplay among mood fluctuations and irregularities in daily routines, patterns of social stimulation, and sleep-wake times. After reviewing the SRM with the patient, the therapist strives to help him or her make the timing of these routines more regular, ideally varying by no more than an hour. This often has to be done quite gradually and is particularly difficult with adolescent patients. In such patients, the intervention usually focuses on minimizing changes in the patient's sleep schedule on the weekends. The therapist may suggest one night (ideally Friday) of later bedtime of 1 to 2 hours, and recommend that the patient sleep in the next morning no later than 1 to 2 hours past the usual wake time. Often, the parents have to increase routine in their own lives to help their son or daughter regularize his or her social rhythms. Once reasonably regular routines are established, the therapist reviews with the patient possible future events or situations that may trigger rhythm disruption and work on strategies for maintaining the greatest degree of regularity despite the presence of these possible disruptions [88].

This behavioural approach to rhythm regularity is then interwoven with work on the four main problem areas targeted by interpersonal psychotherapy. Often, the work focuses on grief, not only over actual losses, but also over the "lost healthy self." Many patients, in fact, split their lives into two: before their diagnosis and after their diagnosis. The IPSRT therapist's task is to help the patient grieve for the healthy self that would be in better control of his or her mood, more successful in career or other responsibilities, and would have more stable and meaningful relationships. To this purpose, the therapist encourages the patients to explore their feelings about having a serious disorder, to express their grief and possibly their anger for the loss of their formerly healthy self, and to come to terms with the often negative effect the disorder has had on their lives. As a result, IPSRT may reduce denial, increase acceptance of the lifelong nature of the disorder, and facilitate medication adherence.

In other patients, the work focuses on the role transition necessitated by the various lifestyle changes that have to be made to manage the symptoms of bipolar disorder. Some patients may need to rethink their choices of social and work roles, and make substantial changes to their life in order to decrease stress and overstimulation. When the work focuses on interpersonal deficits, it should be noted that, unlike patients with chronic unipolar depression who tend to be socially isolated, patients with bipolar disorder tend to be "chronically dissatisfied" with other people. The irritability that is often present in these patients during affective episodes can lead to pervasive interpersonal conflict and to a tendency to either disparage or idealize others. This interper-

sonal pattern often results in conflictual relationships or, ultimately, in social isolation.

Sometimes, the interpersonal problem area most closely linked to the onset of the last affective episode is a very delicate one, such as a serious marital role dispute. If this area is too threatening for the patient, it is best to select an alternate problem area that is acceptable to the patient as the initial focus of therapy. The therapist will usually be able to address the more salient problem area when the patient is improved and the working alliance is stronger [89].

The third or continuation/maintenance phase of therapy focuses on building up patients' confidence in their ability to use the skills learned earlier in treatment. A first important objective is for the patient to be able to maintain regular social rhythms despite the probable occurrence of challenges such as vacations, job changes, and unexpected life disruptions. The other key objective is maintaining and further improving interpersonal relationships. The patient is encouraged to continue to improve the quality of his or her relationships and to keep the level of interpersonal distress as low as possible. Techniques such as communication analysis, role-play, and decision analysis are commonly used to help the patient accomplish his or her interpersonal goals [88].

As the therapy moves from the intermediate to the continuation or maintenance phase, the frequency of sessions is typically reduced from weekly to bimonthly, and eventually to monthly. When termination of therapy is deemed appropriate, the clinician and patient will begin work on the final phase of treatment, which usually can be accomplished within three to five monthly sessions. During this phase, the therapist focuses on termination of psychotherapy, reviews treatment successes as well as patient's characteristic vulnerabilities, and helps the patient to identify strategies for management of interpersonal problems and symptom exacerbations that may arise in the future. If it is not considered clinically appropriate to discontinue therapy altogether, this final phase can be utilized to further decrease treatment frequency to little more than occasional booster sessions when necessary. For instance, if new interpersonal or social role problems arise, the therapist can work on the role transition by scheduling a few more closely spaced visits at the time of the role change; if the patient experiences a new episode of the opposite polarity to the one that brought him or her to treatment, this may provide the opportunity for additional psychoeducation. Indeed, IPSRT allows for considerable flexibility to use those treatment components that seem most appropriate to the patient's clinical state and interpersonal circumstances at various times throughout the course of therapy [89].

Family-Focused Treatment

Family-Focused Treatment (FFT) is a family intervention that is grounded in family systems theory, research on expressed emotion, developmental psychopathology, and psychoeducation [90]. FFT targets patients with bipolar disorder who are in the midst of an acute episode or started to recover from such an episode. Unlike some multifamily group psychoeducation models, FFT works with one family at a time and actively engages the patient in treatment. It allows flexibility regarding whom to involve in treatment, which may

include parents, children, spouses, siblings, and other significant relatives or caregivers in the patient's life. Typically, FFT is administered in 21 sessions over a period of 9 months; as the therapy progresses, the frequency of sessions is typically reduced from weekly to bimonthly, and eventually to monthly.

The first phase of treatment usually lasts 7-8 sessions and focuses on the need for information to assist patients and relatives in understanding the disorder and coping with it. In this phase, families are educated about the nature, symptoms, course, and treatment of bipolar disorder; they are presented with the notion that episodes result from the interaction between genetic, biological, familial, and environmental risk or protective factors; they are taught about the importance of sustained adherence to medications; and they learn that stress management may decrease the likelihood of future episodes [90]. If the patient is an adolescent, families are provided with education and skills training relevant to the distinctive characteristics and developmental problems of adolescents, such as rapid onset and offset of irritable or depressed mood, oppositionality, disturbances in sleep-wake cycles, and high levels of family conflict. Also, the therapist clarifies the boundaries between symptoms of bipolar disorder and the normal turbulence of adolescence and helps the family distinguish adolescent developmental struggles from the impairments associated with clinically significant mood swings [91].

During this phase, the therapist should make every effort to build a strong working alliance with the patient and his or her family. To this purpose, it is important to have an attitude of respect and acceptance towards the patient's and family's efforts to cope with their situation, even if dysfunctional. The therapist should also give the patient and family members the sense that their opinions are valued and are essential to the treatment plan. Differently from some family systems perspectives that tend to pathologize family relationships and caregivers' attempts to manage the disorder, FFT embraces a collaborative care approach and attempts to avoid blame and strengthen the protective influences of family relationships. The core assumption of FFT is not that the family was "dysfunctional" before the onset of the disorder, but rather that when the family gets to understand the disorder and its precipitating factors, learns skills to reduce family conflict, and implements illness management strategies, the outcome of the disorder will be improved [92].

A key component of the initial phase is the relapse prevention drill. The patient and the family are asked to identify situations linked to increased risk for relapse, and are taught to recognize prodromal signs of an affective episode, such as changes in mood, self-confidence, energy, activity, motivation, sociability, sexual drive, sleep, or appetite. Then, the therapist teaches the family how to create a relapse plan outlining the concrete steps that the patient and family can take if the patient begins to show affective symptoms. Such steps may include identifying who will call the treating psychiatrist, how relatives should communicate with the patient, and ways to keep the environment as structured and low in stress as possible.

The second phase of treatment generally continues for 7 to 10 sessions; it focuses on communication and problem

solving skills training, with the aim of changing unproductive cycles of family interaction. The objectives of communication training are to increase family members' skills in expressing their thoughts and feelings, listening to others' messages, and sending constructive messages. The therapist uses behavioural modeling and rehearsal to teach the family verbal and nonverbal skills used in active listening (e.g., nodding one's head, paraphrasing), how to communicate positive and negative feelings clearly and directly (e.g., praise, constructive criticism), and how to make requests for change in the behaviour of another family member (e.g., gently asking another family member to talk less loudly). The family is encouraged to practice these skills between sessions. Then, the focus of treatment shifts to building problem solving skills. Session frequency has been reduced to biweekly or monthly at this point. Families are taught to first agree on the definition of a problem, come up with several possible solutions that should be met with neither criticism nor approval, consider the potential consequences and evaluate the advantages and disadvantages of each proposed solution, select one solution to be tried out, develop a detailed implementation plan specifying who will do what and when they will do it, and subsequently review the status of the original problem, revisit the solution, and consider adjustments that may improve it.

The final two or three sessions are devoted to discussing termination of treatment, reviewing the course of treatment and the goals achieved, identifying strategies for maintaining gains, pinpointing areas in need of future work, and helping the patient and family to plan for future treatment needs [90]. If the family is still experiencing significant difficulties, or the patient is still unstable or non-compliant with medication, additional booster sessions are scheduled.

Psychoeducation

Basically, psychoeducation consists in providing the patient with information about his or her illness. It is based on the assumption that when patients gain knowledge of bipolar disorder, make a relapse prevention plan, learn to stay adherent to medications, and apply illness management strategies, they would have a better outcome. Psychoeducation aims at providing patients with a theoretical and practical approach to understanding their disorder and coping with its consequences, in the context of a medical model, and it facilitates them to actively collaborate with the psychiatrist in some aspects of the treatment. The main objectives of psychoeducation are increasing adherence, improving illness management skills, reducing suicide risk, and improving social and occupational function and quality of life [83].

Ideally, psychoeducation is delivered when the patient is euthymic [93] to facilitate assimilation of the information conveyed. Patients suffering from a mild depressive episode can usually benefit from psychoeducation as well, whereas the presence of elevated mood symptoms limits its impact. Psychoeducation should be carried out in a collaborative context in order to promote the therapeutic alliance and engage the patient as an active collaborator in treatment [94]. Patients' participation provides them with more opportunities to stay in contact with their therapy team and may result in increased satisfaction with therapy and alliance with their therapists [95].

Adherence enhancement is commonly regarded as a key mechanism of action of psychoeducation. Indeed, medication non-adherence in bipolar disorder has a stunning prevalence of up to 60% [96], and attitudes and beliefs about the disorder and its treatment account for a greater proportion of the variance in adherence than medication side effects or practical problems with the treatment regime [97]. Interventions aimed at increasing adherence include enhancing motivation for medication use, imaginal and role-play rehearsal of times and cues for pill storage and intake, as well as the use of simple reminders. Besides adherence enhancement, there may be other additional mechanisms of action, such as recognition of early signs of recurrence and induction of regularity of habits. Patients are informed about the importance of keeping regular sleep-wake cycles, and are taught strategies for effective coping with symptoms, such as the "Two-Person Feedback Rule" (testing out any new plan or idea with at least two trusted advisors) and the "48 Hours Before Acting Rule" (waiting two full days and getting two full nights of sleep before acting on any new plan or idea) [98]. Indeed, psychoeducational elements concerning compliance enhancement, the importance of lifestyle stability, and the identification of early warning signs of an impending episode are part of all effective psychosocial treatments for bipolar disorder [83].

Besides adherence enhancement, in most psychoeducation programs there are other important components, such as illness awareness, detection of early warning signs, substance misuse avoidance, and lifestyle regularity [83]. As these components are incorporated in more complex interventions such as CBT, IPT, IPSRT, or FFT, they have already been described in previous sections.

In conclusion, psychoeducation is an effective treatment that goes far beyond a mere transmission of information. Although some patients may have unwanted behavioural reactions, such as excessive preoccupation with the detection of early signs of relapse in patients with obsessive-compulsive personality traits [93], psychoeducation has limited adverse effects and is a useful adjunct to medication in patients with bipolar disorder.

CONCLUSION

Currently, psychotherapy is established as a major treatment option for the whole spectrum of mood disorders. The treatment of major depression is the area that has received the most research attention, while a growing body of studies deals with chronic depression and bipolar disorder. A variety of psychotherapeutic approaches are backed by robust empirical support, and other approaches are receiving increasing research interest. For instance, there is preliminary evidence that eye movement desensitization and reprocessing therapy and mindfulness-based cognitive therapy are beneficial in bipolar patients with a history of traumatic events [99] and unipolar patients with three or more prior depressive episodes [100, 101], respectively.

Psychotherapy has many attractive features; it may provide lasting gains, and adverse effects are rare, though not completely absent [102]. However, it has also some limitations. Acute symptoms of mood elevation are poorly responsive, if at all, to psychological treatment alone. The effects of

psychotherapy on depressive symptoms, while often long-lasting, usually require at least a few weeks to develop, which may increase the risk of premature termination of treatment, especially in patients who are highly symptomatic or looking for rapid improvement. With such patients, a careful explanation of the rationale and expected time course of therapeutic effects is of paramount importance. Also, the judicious short-term use of psychotropic medication to relieve acute symptoms may help engage severely depressed or anxious patients in therapy, and may allow them to benefit from a psychological treatment that would not have been possible otherwise [68]. Another limitation is that the patients who have low psychological mindedness, fear the development of psychological dependence, are poorly motivated, or show a marked preference for medication over psychotherapy might be difficult to engage and retain in treatment. With such challenging patients, the careful building of a strong therapeutic alliance is even more important than usual and may help deliver effective psychological treatment to the largest possible number of patients.

CONFLICT OF INTEREST

The authors confirm that this article content has no conflict of interest.

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