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UM professor seeks best treatments for depression

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UM PROFESSOR SEEKS BEST TREATMENTS FOR DEPRESSION

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UM News and Publications Office

Everyone has bad days. But some people have bad months, even bad years, when coping with the demands of daily life is nearly impossible. Every year, at least 22 million Americans suffer from depression, says University of Montana psychology Professor Janet Wollersheim. The figure may even be as high as 44 million if the milder forms of depression are counted.

People with severe, or "clinical," depression are haunted by sadness and often by a lack of interest in normally pleasurable activities. They develop a negative self-image and may experience a change in activity level, usually a slowing down. They also may have withdrawal and escapist tendencies, sleep problems, weight loss and a lack of interest in sex.

Although most people with this mood disorder think about suicide, "the vast majority of them won't kill themselves, even without treatment," says Wollersheim, who's studied depression since 1968. "The pull for life is very strong."

Without treatment, 80-95 percent of all depressed people and 90-95 percent of depressed people under age 30 will completely recover, she says. Only about 20 percent of depressed people seek help, whether from a clergyman, doctor or psychologist, she

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adds. The ones who seek help tend to be women, who are more prone to depression than men are.

If the odds of recovering without help are so good, why has Wollersheim spent 20 years developing ways to treat depression? "With competent treatment, people can usually get over depression more rapidly, can get to a higher level of adjustment, and there's less danger that it will reoccur," she explains, emphasizing that untreated depression tends to recur.

What she's come up with is coping therapy, a short-term method for treating depression. Short term means about 10-40 weekly sessions lasting one to 1 1/2 hours each. The method is a type of psychotherapy, which Wollersheim says "involves the detailed, systematic and sophisticated use of psychological principles to bring about changes in how people think, feel and behave."

Coping therapy identifies seven major problems areas of depression and offers ways of dealing with them:

o **Getting started.** The patient must begin helping himself, including accepting his condition. One technique is using "self-talk" -- telling himself things like "I'm depressed right now. I hate it. But I'm not going to get down on myself because I'm depressed. This is temporary."

The therapist also urges the patient to act contrary to his negative feelings. For example, if he used to enjoy movies, he should force himself to go see one now. "Depressed people have

got to keep active," Wollersheim says. "It will help them to be less preoccupied, self-absorbed and worried. Research shows depressed people greatly underestimate their abilities."

The people closest to the patient can help by using "kind firmness," she says. While showing compassion, they can insist that the person act contrary to his feelings, or they can disagree with his unreasonable ideas.

o **Coping with negative feelings.** The therapist encourages the patient not to believe the messages his negative feelings are sending. "We say, 'When you get better -- and you will -- you can evaluate these pessimistic messages, and you will see that many of them are really not accurate,'" Wollersheim says.

Often the therapist will limit or increase the amount of time the patient dwells on his sadness, depending upon the nature of his problem.

o **Energy and motivation.** The patient uses exercises in pleasant imagery to get relief from depression and increase his energy. He might create a fantasy or recall a happy time. The therapist also advocates postponing major decisions whenever possible until the depression is gone.

o **Feeling better by acting better.** Coping therapy teaches problem solving, emphasizing trying rather than succeeding. The patient learns to recognize problems, evaluate ways to solve them, try an approach, get feedback, and modify his approach or try a new one.

The patient also learns to use self-instruction with self-talk. To get through a situation, he tells himself what he needs to do. Then, as he follows his own instructions, he tells himself what a good job he's doing.

o **Challenging negative thinking.** Coping therapy helps the patient challenge his unreasonable ideas and replace them with more reasonable and adaptive ones.

o **Self-worth.** The patient must learn to value himself, not think he has to prove anything to anybody. He also must understand that doing something bad doesn't make him a bad person.

o **The self-defeaters: guilt, anger, anxiety.** Coping therapy holds that these emotions aren't necessarily bad but should be kept within appropriate bounds.

Over the years, Wollersheim and her doctoral-student researchers have conducted many depression studies, some including Missoula-area residents and inmates of the Montana State Prison. One project studied the types of treatment people prefer for depression; another focused on what happens when a person tells someone he's depressed.

Three UM studies have specifically tested coping therapy, an approach also being tested at the University of South Dakota and Washington State University. Wollersheim's major project on coping therapy, whose complex data she expects to finish analyzing this year, intensively studied 32 moderately to

severely depressed patients for nine months.

That project sought answers to a number of questions, among them: Is coping therapy better than having a patient read a self-help manual? Is having a psychologist and a self-help manual preferable to having either one alone? Is coping therapy, which is instructional, more effective than supportive therapy? How long must a person be treated before improving significantly?

So far, Wollersheim has learned that all the treatments in the study were effective -- including one in which patients were assessed and then had to wait 11 weeks for treatment. "Knowing they'll get treatment raises people's hopes and proves very therapeutic," she says.

She's also discovered ways to improve coping therapy, including decreasing the number of techniques presented in a session to avoid information overload. Another finding is that, for full recovery, a moderately to severely depressed person needs more than 10 therapy sessions, the number in the study.

Wollersheim's work with depression has carried her around the states and all the way to New Zealand, where in 1986-87 she spent six months at the University of Auckland and Massey University.

At Auckland, she demonstrated coping therapy and suicide-risk assessment to medical students, graduate psychology students, psychologists and psychiatrists. She also made

presentations at hospitals affiliated with Auckland's medical school. At Massey, she gave university-wide talks and addressed the psychology department and psychologists in the area.

Wollersheim's trip gave her insight into differences in the way New Zealanders and Americans treat depression. One is that "In New Zealand, there's more of a reliance upon medications and less on psychotherapy," she says. By contrast, Americans "Within the past decade ... have demonstrated that depressed people show a marvelous response to psychotherapy."

It's just that positive response to treatment that keeps Wollersheim so upbeat about something as miserable as depression. "I know of few other psychological conditions that rival depression in responsiveness to treatment," she says. "Although depressed people feel they'll never get well, their prognosis is excellent. It is a real joy to see these extremely distressed people recover."

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