Part 4. Maturity coaching

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Imagine one of your chronic depressives—*dysthymics* in current parlance. Reflect upon the many efforts you've made over the years to try to help.

Perhaps you've lost track of the number of extra-long appointments. Perhaps you've entertained more drug reps than you'd care to admit. Perhaps you've connected your patient with your local psychopharmacologist—more than once. And perhaps you've made more than one special visit to the emergency department.

What have all your efforts accomplished? A *good* outcome from treatment-as-usual for dysthymics is that they haven't gotten any worse. But over those many years, how consistently did that patient follow your advice? In most cases, the answer is very poorly.

New paradigm

One of the most important studies in the history of psychiatry was published in 2000.[1] In the 681-subject, 12-site randomized trial, researchers found that a combination of CBT and medication helped 85% of dysthymics who completed treatment improve by 50% or more. And these were "real-life" dysthymics: they'd been depressed more days than not for 23 years, with an average duration of "double depression" of 8 years. Further, 59% had at least 1 personality disorder, and 33% had a history of substance abuse. This study opened our eyes to a promising new paradigm: chronic depressives suffer from both a neurochemical problem and a *developmental delay*.

Most dysthymics aren't developmentally delayed in the traditional sense. But they might be delayed in the extent to which they take responsibility for creating their own moods. Many dysthymics suffer from what I call *mood entitlement*—the sense that they should be happy "by default." Their focus is often more on others than on their personal efforts to improve their emotions.

It's crucial that the term *developmental delay* not be construed as pejorative. Delayed does not imply bad. The boy who starts walking at 18 months is not bad, nor is the girl whose menarche isn't until age 17. The developmental delay of dysthymia has no moral connotations. Further, in saying *delayed* we are not implying that anything is *faked.* The suffering of the dysthymic is absolutely real.

Practical tips

Treatment is considerably more nuanced than counseling the patient to "grow up." Here are some practical tips:

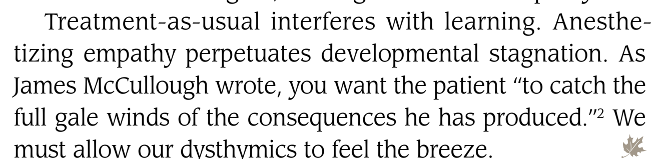
- Attend very carefully to the doctor-patient relationship. Your maturity message is not an entirely pleasing one. Your alliance must be strong enough to allow you to deliver that message time and again.
- Increase your empathy, but more to your patient's future self than to the poorly adherent current version. Care more that you're helpful in the long term than if you're "nice."
- *Primum non nocere.* Excessive activity can be iatrogenic. Avoid introducing yet another program for increasing exercise, yet another idea for improving socializing, and yet another sleep hygiene checklist. If you've worked with them for years, they know what they need to do. Beware implying that you will "fix" them with a shiny new program. They need to work the long-established plan to earn the rewards they desire.
- Your primary function is to expose correlations. Alfred Adler used the term *natural consequences.* The natural consequence of not taking medication is not getting the benefits of that medication. The natural consequence of failing to socialize is feeling lonely. Your job is to lay bare such causal associations.
- Outcome is optimized with a combination of medication and maturity coaching. Make sure you're prescribing medications at adequate doses.
- Expect slow progress. In my experience, a time horizon of several years is most appropriate.

Feel the breeze

The most common error we make is in overemphasizing empathy. Empathy is essential to a solid alliance, but when it excludes other interventions, it can be iatrogenic.

The routine with dysthymics commonly goes as follows: patient complains (again) ⇨ doctor draws up large volume of empathy ⇨ doctor administers empathy ⇨ patient feels great and returns to his world, changing nothing ⇨ patient returns in distress again, looking for another empathy fix.

Treatment-as-usual interferes with learning. Anesthetizing empathy perpetuates developmental stagnation. As James McCullough wrote, you want the patient "to catch the full gale winds of the consequences he has produced."[2] We must allow our dysthymics to feel the breeze.



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Acknowledgment
I thank the following CBT Toronto 2010 participants for their helpful critique of this paper: **Drs David Cook, Peter Duffy, Raul Vasquez, Colleen Ip,** and **Eshrat Sayani**.

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Next month: **The mood pie**