Depression - Understanding and Therapeutic Intervention

by Krzysztof Kielkiewicz & Ivan Kennedy

Abstract

Depression is considered a mental disorder of increasing incidence throughout current civilised societies. Studies suggest that 25% of people are or will be touched by this problem. Recent literature extensively investigates various aspects of depression to ascertain models to understand, cope, and heal this dysfunction. Depression, as an ailment, is handled by various medical and therapeutic approaches (including psychiatry and psychotherapy) which appear as specialised and diverse. This review paper aims to examine existing knowledge in order to develop a comprehensive model of therapeutic intervening. For this purpose, it utilises recent studies and presents pros and cons of different therapeutic understandings and models of intervening with depression.

Introduction

Even though the term "depression" was not generated within the discipline of psychology, in recent decades it has become highly associated with it as a mental state and syndrome of psychological imbalance. The reason for this lays, perhaps, in the fact that depression appears increasingly as a problem within civilised societies. Statistics suggest that 10% of people living in economically developed and developing societies suffer from depression. According to the HSE, around 300,000 (7.7%) of the population of Ireland have depression (HSE, 2014). The highest cause of admissions to psychiatric hospitals in Ireland in 2009 was depressive disorders (CSO, 2012, Table 5.10). According to the HSE (2014), every fourth woman and every tenth man living in the Republic of Ireland has experienced or will experience depression at certain stage of life. Despite the fact that men are less likely to experience depression, they are more likely to die by suicide than women. Although 10,000 people are hospitalised in Ireland yearly, costing the Irish economy around 170 million euro, 66% of people who are clinically depressed do not undertake any treatment nor consult with their GP[1]. If all clinically depressed people did undertake treatment, the cost would rise to over half a billion euro yearly. Nevertheless, statistics suggest that the vast majority of people who undertake treatment against depression successfully recover (Keller & Boland, 1998; Kessler et al., 2003) and that the promotion of treatments would be a valuable pursuit.

Various disciplines have developed many understandings of this social problem and accordingly employ courses of treatment. The theme of depression is broadly investigated in current medical and psychological literature (Bose, 1995; Berger et al., 2008); whereas many aspects are well explored, knowledge about depression still expands. The aim

[1] HSE report published in *Independent.ie,* 2004.

of this research paper is to present a comprehensive understanding of the problem of depression based on the existing evidence within different disciplines.

Understanding of Depression

Ancient Greeks identified four personality types (or *humours*): choleric; melancholic; sanguine; and phlegmatic. These humours were understood as somatic fluids that ran through the human body and affected personality and attitudes. i.e., any deficiency or excess of any of them caused an imbalance and an unhealthy condition.

Hippocrates (460-370 BC) identified personality with dominant levels of melancholia as a disease. In his work *Aphorisms* (section 6.23), he stated, "fears and despondencies, if they last a long time" are symptoms of illness. Clearly, the depressive human condition was recognised many years ago. However, the term "depression" has seen many definitions contingent upon area of study, e.g., geography, a ground lying below the sea level (Barnhardt, 1995), economics, a severe recession sustained for two or more years with symptoms of unemployment, decline in gross domestic product, the bankruptcy of companies and other economic failures (MacFarquhar, 1997), and medicine/psychiatry a long-term state of low mood with aversion to any initiative or activity, affecting thoughts, feelings, behaviour and sense of wellbeing (Salmans, 1997).

From the psychological viewpoint, Newman (2007) identifies (i) depressive symptoms as disadvantageous and long-term states characterised by sad mood, tearfulness and feeling down, (ii) depression as more severe and extensive feelings of low mood, despair, self-depreciation, guilt, self-blame, hopelessness and helplessness, and (iii) clinical depression as associated with somatic disorders of eating, sleeping (extensive or reduced), with long-term lasting chronic pains; the aftermath of which could be a self-harming mentality and severe cases may be characterised by withdrawing from reality and experiencing delusions, hallucinations or becoming psychotic.

It is generally accepted that mammals evolved developing attachment as an environmentally advantageous adaptive feature helping to survive in harsh environmental conditions by ability of building social bonds. In order to prevent breaking relations and social bonds, mammals' brains developed a negative reaction to loss and breaking union by experiencing so called "separation distress". This sensation could be captured by such words as protest, panic or despair (see Solms, 2012). Many premises referring to this constant and pathological experience of separation distress are linked to depression. Somatically, separation distress is activated by releasing hormones and peptides to the body system. However, what causes this pathological experience of despair remains unclear. Perhaps, the answer does not necessarily lie in the hands of anthropologists and biologists.

Psychiatry

In psychiatry, depression is perceived as a neurological reaction to an imbalanced level of hormones or other neurochemicals. Neuropsychologists and psychiatrists believe that depression is largely caused by a low level of the neurotransmitter serotonin, which is responsible for feelings of wellbeing such as happiness (Young, 2007). According to Solms (2012), recent decades of neuropsychological research on depression vastly focused on the processes of serotonin depletion as a reason for depression (Schildkraut, 1965; Harro & Oreland, 2001; De Kloet et al., 2005; Zupancic & Guilleminault, 2006; Levinson, 2006; McEwen, 2007; Koziek et al., 2008). However, other findings demonstrate that serotonin depletion is not a direct cause of depression (Delgado et al., 1990), because this neurotransmitter plays the role of modulator while experiencing emotions and feelings either positive or negative (Berger et al., 2009). This suggests that while serotonin is important in experiencing or non-experiencing of depression, it does not cause nor prevent depression itself.

Leaving aside the complexities of neuropsychological reactions in the human nervous system and discussion of whether one neurotransmitter or another triggers depression, it can be said that beyond the biochemical processes, the grounds of the ailment lies somewhere else; perhaps somewhere deeper than within the sphere of somatic and neuropsychological reactions. Somatic and neuro-somatic actions in the body do not appear unreasonable, but are triggered by beyond-body stimulation, which are environmental, psychological, and/or spiritual.

Behavioural Approach

Within the growing psychological and psychotherapeutic family of sub-disciplines, behaviourism plays an important role. With CBT, and its pragmatic tools of intervention, behaviourism is commonly recognisable as a fast and effective manner of therapeutic help for

many issues, including depression (for more on the effectiveness of CBT in therapy see Elkin et al., 1989; Clarke et al., 1999).

Skinner, the father of behaviourism, defines humans as organised systems of responses (Skinner, 1953). According to behaviourists, human personality consists of acquired experiences, genetic conditions and learned behaviours. Personality is just a complex of contingencies which expresses itself through the repertoire of behaviours (Pérez-Álvarez & García-Montes, 2006). Different personalities have different contingencies according to their different repertoires. Depression, in this context, functions as a learned attitude, out of which the maladaptive thoughts and behaviours create a state of depression. Treatment of depression is based on the unlearning of these maladaptive thoughts and behaviours and the learning of adaptive repertoires of behaviour.

However, behavioural understanding of depression as well as the whole concept of behaviourism faces challenges, especially in recent decades. Psychoanalysis can perceive behaviourism as a superficial concept that neglects large spheres of the human condition (Moran, 2008), psychoanalysts can perceive behaviourism as limited as it neglects the unconscious sphere of a personality, which plays a crucial role in understanding and handling depression from a more comprehensive perspective (Milton, 2001).

Psychoanalysis

Simplifying the psychoanalysts' perspective, mental dysfunction is a reaction to unconscious and repressed feelings. Although feelings can be reactions to direct environmental stimuli, reactions to subconscious and/or repressed feelings may appear in a form of negative experiences, popularly called depression. Feelings associated with depression are very similar to those accompanying loss and grief. The difference, however, lies in the processing of both conditions. Whilst grief is typically a dynamic process from the experience of loss to recovery, depression is a constant and long-term experience of the aforementioned negative feelings. Therefore, the statement can be made that depression is a pathological form of grieving or a pathological reaction to loss (Freud, 1917, see pp. 239-258). This opinion is also shared by Bowlby (1969; 1980) who believes that first depressive symptoms are triggered by the experience of social loss. Further psychoanalytical explanations of depression link biology and evolution (Freud, 1917).

When the basic social bond between mother and offspring is lost, the offspring automatically and subconsciously feels "bad" rather than consciously acknowledging that the loss of the mother decreases chance of survival. Similar happens to the mother (Solms, 2012): the "feel bad" is just an emotional shortcut to and/or a simplification of a long conscious thought process (Bowlby, 1980).

Carey (2005) calculates that since our bipedal ancestors left the trees, they spent 99.6% of their evolution time living in the pre-agricultural stages; modern humans' lifestyle changed drastically within only 0.4% of the entire evolution time. Additionally, our ancestors lived for millions of years in hunter/gatherer groups of 20-150 individuals. Usually, they were preoccupied with survival challenges including the need to eliminate a useless individual from the original herd, e.g., an old male who is unable to hunt and an old female who cannot breed nor feed. As such, depressive symptoms like shame, rejection, uselessness, and guilt developed within a time when one's survival was more precarious (Carey, 2005).

Intervening with Depression

Psychiatry

Since psychiatry categorised clinical depression as a mental illness, comprehended as an excess or shortage of certain neurochemicals in the body, the goal of treatment is to bring the body system back to balance by use of drugs or other medical means. Treatment, therefore, intends to stimulate some neurological processes which influence a sensation or perception of self towards increasing the client's wellbeing. Contrarily, the process may break some neurological process causing negative feelings in order to achieve the same purpose.

Antidepressants are the most popular ways for treating depression; however, placebo pills are also effective. Another method is electroconvulsive therapy which stimulates the brain to facilitate relief in the illness (Rudorfer et al., 2003). Similar to electroshock is a developing method of deep brain stimulation (Marangell et al., 2007). This technique implants an electronic device into the brain which constantly stimulates a specific part of the brain in order to release the tension. Similarly, magnetic stimulation utilises magnetic streams instead of the electric one.

Among less popular ways of treating depression in the psychiatric field are giving up

smoking, music therapy, light therapy, exercises, meditations, which would belong to niche and experimental methods.

Numerous scholars see the weakness of the psychiatric approach to the problem of depression in overrating effectiveness of antipsychotics and other medications. DePaulo (2010) says that "some psychiatrists refer to themselves as psychopharmacologists, a term meant to indicate their expertise in the use of psychotropic medicine" (DePaulo, in Hartelius, 2010, (p. 170). A similar sentiment is shared by many psychiatrists, e.g., William Glasser.

Glasser (2003) states that the psychiatric approach could worsen the patient's condition as some depressed people are not sick in psychiatry terms but are simply extremely unhappy. As said by Hartelius (2011, p. 124), "science and medicine do not tell the whole story" [of depression], it can also be said that psychiatry is unable to give extremely sufficient tools to handle depression to its core; then, in the search for solutions the same task needs to be directed to other bodies.

CBT Approach

The cognitive-behavioural approach to depression focuses on coaching and elimination of maladaptive thoughts, behaviours and emotions that stimulate and/or exacerbate depression. The first step in therapy would be to identify the irrational beliefs feeding depression such as, "I am useless", "I must do...", etc. A further aim would be a transformation of these thoughts into more rational ones such as "sometimes I fail, but I am not bad", "I do not have to do...", etc. The aim of CBT is to challenge the client's way of thinking from 3 perspectives – logical (if what the client thinks makes sense), empirical (if what the client thinks appears in reality) and pragmatic (is the client's way of thinking helpful in everyday life?) (Dryden, 1999; James, 2012).

The behavioural therapeutic approach is largely based on simple mind training. From session to session, interspersed with homework, the client practices new ways of thinking and behaving – adaptive ways. The tasks would be formed depending on the character of depression and the specific issues faced by the client (Dryden, 1999; James, 2012). CBT is a goal oriented therapy with strategies to teach the client to control the thoughts and behaviours in order to eliminate depression as a dysfunctional condition and to learn how to maintain balance in life. The role of the therapist is to coach and educate on the path to therapeutic solutions. However, as mentioned above, a limitation of this approach is that CBT intervention works on the conscious level only (Solms, 2012) whilst excluding and not even referring to the deep layers of human personality. In some cases, such exclusion of (crucial) subconscious processes may detract from the therapy and hinder healing depression.

Reality Therapy/Choice Theory (RT/CT) Approach

RT/CT is a therapeutic approach developed by William Glasser (1925-2013), an American psychiatrist who moved into psychotherapy[2]. According to Osatuke et al., (2005) RT/CT was a transitional approach between CBT and Person Centred Therapy (PCT).

The RT/CT approach to the problem of depression perhaps starts with the understanding of the client's dysfunctional "Quality World" that refers to things, people and meanings present and driving the individual's life. The client's general outlook on one's own self, personal values, other people, material things, relationships etc., does not operate as it "should" or as the client wants it. This causes a complexity of negative dynamics in forms of thoughts, emotionality, physiology, and/or actions (Total Behaviour) causing depression. In other words, the person acts and thinks in a destructive or inaccurate way so she/he feels bad emotionally and/or physically. The goal of RT/CT would be an identification of the dysfunctional thoughts and behaviours and changing them, what consequently would positively influence the client's interaction with reality through feelings, emotions and somatic responses (Glasser, 2010).

The role of a therapist is to assist and to help to identify the dysfunctional thoughts and behaviours and then to help the client to undertake constructive decisions to change life. Limitation of RT/CT is that this approach generally is focused on solution than causes. Additionally, it does not pay much attention to the client's individual sensitivity and needs that could be satisfied in the way of therapist's being.

Rogerian (PCT) Approach

Carl Rogers (1951) was an American psychologist who introduced a new and innovative approach to therapy. The PCT approach changed the focus from the psychological dilemma of the client into a genuine relationship with the client and counsellor. The problem of depression in PCT could be generally understood

2 William Glasser graduated (MA) in 1947 in clinical psychology and in 1949 (MD) in psychiatry.

as a consequence of sacrificing one's own self for the benefit of positive regard from others. This theoretical frame could be applied to any specific condition where depression develops and damages the well-being of a person who loses touch with one's deep self. Consequentially, the developed ailment would manifest itself by incongruence, a discrepancy between one's being and acting. PCT emphasises a client's role in the process of recovery and the role of the therapist is to assist with the client's journey. The counsellor offers a genuine relationship to the client and the goal of the therapist is also to look at the problem from the client's frame of reference by employing an emphatic understanding.

With depression, PCT, as a humanistic approach, utilises various theoretical backgrounds without restrictions, as long as they may be helpful. The healing notably occurs through the accepting relationship with the therapist which leads to self-acceptance within the client. On the path of healing, PCT works from the reference of client's self-actualising tendency. This means that it is a natural desire for every human being to be healthy, strong, mature, wise, free, etc., and every person has a capacity to follow this path. Limitation of the PCT is a perspective of lengthiness in the therapeutic process and perhaps only psychoanalysis proceeds slower. Perhaps, this is the reason why PCT has poor prospects to be incorporated as a part of health care. Insurance companies are unlikely to invest in long-term treatment which does not diagnose a problem.

Conclusion

The discipline of counselling and psychotherapy develops as a humanistic approach to the problem of human mental health. It expands within its own theoretical and practical framework; however, it is also a largely interdisciplinary utilisation of achievements from the fields of humanities, social science and medicine. References to the above enrich perspectives on various current psychotherapeutic concerns. Development of psychotherapy as an occupational paradigm, but also as an academic discipline, requires interdisciplinary confrontation with different practical and theoretical forums. Current disciplines of social sciences or humanity also do not grow within isolated frames, but utilise achievements of other disciplines for their own purposes.

Due to the fact that theories included in this study represent very developed concepts, this paper had to refer to the core of their comprehensions. Therapeutic disciplines and traditions which were presented herein aimed at capturing the deepest core of depression and to embrace the most meaningful knowledge reflecting the ailment. The above presented content cannot be considered as a complete approach; this goal would be very difficult to achieve in the context of such developed evidence. Whilst there is an increase of the depressive disorders emerging in civilised communities nowadays, raising knowledge about the problem within society is important.

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