Working With Depression

by Les Simmonds

Depression affects many New Zealanders and this condition, according to a NZ Mental Health Survey (2006), impacts 5.7% of people in Aotearoa on an annual basis.

Depression is state of low mood which permeates throughout a person's life and results in thoughts of despair, hopelessness and foreboding. While hopelessness is a key feature of depression, evidence shows sufferers have cause to HOPE because effective treatments are available.

Life A Plenty Services have reviewed the history of how depression has been treated in the past and have considered effective approaches used to ensure positive outcomes for people seeking help. These approaches, noted in the following article, have been adopted by Life A Plenty for use in the Life After Depression Retreat.

5.7% of New Zealanders will experience a major depression over a 12-month period (NZ Mental Health Survey, 2006)

A vast number of theories of depression have been promulgated over hundreds of years. Hippocrates considered depression to be the result of an imbalance in the four basic humours (bodily fluids).

A person's dominant humour determined their personality type, for example, Melancholic. Melancholia (synonymous with depression) was described as a disease with symptoms "of fears and despondencies". The term melancholia was used well into the twentieth century, before it was replaced with depression.

Moral and spiritual theories prevailed in the Christian environment of medieval Europe and the term aecidia, a persistent malaise noting low spirits and lethargy, was used to describe depressive symptoms.

In the 18th century, the Hippocratic beliefs were challenged and the electrical and mechanical explanations were put forward as causes for depression. Along with this thinking, some theorists looked towards melancholia as being caused by a moral conflict within patients.

By the mid-1800s, medical dictionaries were referring to melancholia as a physiological and metaphorical lowering of emotional functioning.

During the early 20th century, Emil Kraeplin coined the term endogenous depression (internally caused depression) and exogenous (externally caused depression).

Kraeplin assumed depression was caused by underlying brain pathology while Freud theorised that intra-psychic conflicts generated depression. The internal conflicts had their genesis in early life experiences that, when not dealt with, created psychological pathology. This psychodynamic theory held sway for decades and in one form or another, exists today (Nemade et al, 2014).

Existential and humanistic theories emerged in the mid-20th century and Victor Frankl noted the link between an existential vacuum and depression. The existential vacuum is created by a life without meaning (Frankl, 1969).

Humanistic theorists believe that people have innate drives to achieve their potential (self-actualisation) and being unable to self-actualise, leads to psychological difficulties such as depression (Maslow, 1971).

The 1950s saw the rise of the behaviourists who disregarded concepts such as self-actualisation and the need to find meaning. This school of thought focused on the theory that mental health difficulties where caused by how a person's behaviour was reinforced. For example, if a husband gave care, love and attention to his wife when she felt depressed, this would increase the likelihood that she would continue with this depression.

Other researchers saw depression as a chemical imbalance involving the neurotransmitters in the brain and in a sense, this continued with Kraeplin's thinking of a biological cause for endogenous depression (Nemade et al, 2014).

While not completely discounting behavioural and biological theories, Aaron Beck developed a theory that depression was caused by the thoughts and beliefs people held in response to life events. Depression, in particular, was created by a set of triadic cognitions involving how a person conceptualised themselves, the future and their environment (Beck, 1978).

From this history of understanding and treating depression, a vast number of psychological therapies are used to treat this debilitating mental health disorder (Pilgrim, 2002).

Many treatments have their roots in the theories noted above, for example, a biological perspective was held by Kraeplin, and the use of antidepressant medication to alleviate depression is common practice today.

This paper will categorise psychological treatments for depression into five broad theoretical schools and review them as a basis for the treatment direction provided in this manual. The reviewed categories are:

1. Psychodynamic
2. Behavioural
3. Humanistic
4. Cognitive Behavioural
5. Existential

Psychodynamic Psychotherapy

Psychodynamic theory was prevalent during much of the twentieth century and dominated psychotherapy until it was challenged by the behaviourists, starting in the 1950s and 60s. A number of psychodynamic formulations exist and Freud's original interpretation looked to the mind having different parts: the Id (the seat of primal urges and desires which threaten to act out) and the Superego (the part that represents society's norms and values which can be seen as an internal law enforcement officer). Meditating between these polarised parts is the rational Ego which works to create a psychic balance.

If the psychic balance is threatened, from this perspective, the mind employs a number of defense mechanisms to protect itself from being overwhelmed by anxiety. These defence mechanisms include repression (burying events, thoughts and feelings) which is seen as the basis for other mechanisms. Other mechanisms involved in this formulation, while not extensive, include, regression (reverting back to more infantile behaviours), projection (displacing thoughts, feelings and actions onto other people) and reaction formation (acting in the opposite manner to the instructions of the unconscious).

All people use defense mechanisms in order to maintain psychic balance and it is only when these mechanisms rigidly persist that pathology begins. The formulation of depression from this perspective is when these intra-psychic mechanisms fail to achieve balance. For example, when a person is unable to get their needs met via assertive action, the anger they experience is turned inwards rather than towards the source of their discomfort.

The literature points to a number of psychoanalytical approaches which are too extensive to note in this manual, however, the genesis of these approaches is noted above.

Behavioural Therapy

The behavioural view is that depression results from life events which lead to low levels of positive reinforcement. Williams & Chellingsworth (2010) note that depression is caused by a person experiencing a loss or perceived loss, of another person, an object in their lives or their status. For example, the death of a spouse may lead a person to withdraw from daily life and without gestures of appreciation from work-colleagues, stimulating social interaction with friends and joy from spending time with family, find themselves sinking into depression. Without reinforcement for pleasant activities, the depression is maintained by avoidance which leads to further restrictions, increased depressive symptoms and increased avoidance.

In the example noted above, the cycle of avoidance can be compounded by family and friends rallying around to support the person who is depressed as a result of their grief over the loss of a loved one. The person may subsequently have their depression reinforced because social contact becomes contingent on their sadness and withdrawal from the world.

Research shows that depressed clients engage less in activities that provide pleasure and when encouraged to participate in pleasurable events, improvements in mood are directly correlated to this increased activity (Antonuccio, 1998).

Similarly, depression can relate to a person who has a poor repertoire of social skills, and because of this, does not engage in rewarding social activities. Minor changes to such a person's life, for example, being re-housed in a different neighborhood, could lead to a depressive episode. The same formulation with this example can be employed to support the behavioural view on depression, as the aforementioned person may find themselves engaging in fewer social interactions and as a result, a subsequent loss in positive reinforcement (Reinecke, 2002).

In dealing with depression, the behavioural approach is to develop baseline behaviours, rank pleasurable activities and develop plans for clients to engage in them. Social skills training may be employed to support behavioural activity and monitoring and feedback sheets are implemented. In a nutshell, positive reinforcement supports non-depressive behaviour and the

pleasure derived from this behavioural activation leads to an amelioration of the client's symptoms.

Humanistic Therapies

Humanistic psychology was developed in response to psychodynamic and behavioural ides which dominated the field in the 1960s.

Humanistic thinking held a focus on the subjective-self, rather than holding to the objective clinical view of the scientific behaviorists. Taking this view of the importance of the subjective-self, psychologists such as Carl Rodgers and Abraham Maslow believed that people innately held the ability to make decisions which promoted health and wellbeing in their lives.

The drive towards wellbeing or self-actualisation (Maslow, 1971) was in this view, thwarted by parents, teachers and other authority figures who set out to impose their often unhealthy ideas or convictions on others.

From this perspective, depression, anxiety and a range of mental health difficulties were generated by the gap between a person's drive towards health and being made to conform to a parental/authority figure directive to conform to their directive. The directive, for example, may tell a person to become an accountant which is counter to their desire to become an artist.

Client-centered therapies were developed out of humanistic psychology because they used and promoted the notion of the subjective-self. Client-centered therapy seeks to create a safe therapeutic environment in which the client discusses their issues with a therapist as they move towards understanding and insight.

During this process, the client is freed to direct their own life, unconstrained by the unhealthy sanctions of negative authority figures. The therapist supports the client's movement towards health by providing unconditional positive regard, fostering a genuine client-therapist relationship, reflecting the client's thoughts and emotions back to them and holding to an empathic understanding of difficult and painful experiences (Rogers, 1977).

This approach is still current and is also included in therapies such as Motivational Interviewing (Sachse & Elliot, 2002), an approach very much in synch with Cognitive Behaviour Therapy (CBT).

Existential Psychotherapy

Existentialism is a broad field of psychotherapy and this manual holds a focus on the work of Victor Frankl (1969), who believed that the primary motivational force of an individual is to find meaning in life. Three basic principles were espoused by Frankl:

1. Life has meaning under all circumstances, even the most miserable ones
2. Our main motivation for living is our will to find meaning in life
3. We have the freedom to find meaning in what we do, and what we experience, or at least in the stand we take when faced with a situation of unchangeable suffering

Frankl conceptualised that depression occurred at psychological, physiological and spiritual levels. In viewing depression from a psychological level perspective, he believed that feelings of inadequacy stem from a person undertaking tasks that are beyond their ability. He recognised a vital low at the physiological level which, he defined as a diminishment of physical energy. At a spiritual level, Frankl believed that a person experiencing depression faces tension between who he actually is in relation to what he should be. This he refers to as the *gaping abyss.*

Finally, Frankl suggests that if a person's goals seem unreachable, the individual loses a sense of future which equates to meaning and resulting depression.

In finding meaning which, according to Frankl, is essential in alleviating depression, Bergner (1998) has proposed a therapeutic approach to problems of meaninglessness. Essential to this approach, is the therapist understanding the root cause of the state of meaninglessness presented by the client and locating it in one or more of the three bases in which, according to Bergner, meaning is found. In his analysis, individuals find value in (a) instrumental action, for example, a parent going out to work in order to provide for his/her family, (b) intrinsic actions such as creating art, caring for and loving a child and participating in athletic or outdoor pursuits or (c) via spiritual means, such as "living out God's Plan or, working to save the planet from humankind's environmental blunders.

In locating the source of meaningless, in one or more of the three bases, the therapist seeks to aid the client in overcoming or removing the barriers which prevent them from finding life-giving meaningfulness. This perspective identifies five barriers:

1. **Intellectualising and philosophising** about meaning without reaching a conclusion or taking action, provides a barrier to finding meaningfulness
2. **Self-preoccupation** which leads to excessive introspection and prevents meaningful action
3. **The inability to appreciate significance**, a person who fails to appreciate their actions and achievements. A person diminishing the work they do by saying I am only a pencil-pusher rather than appreciating their skill in, for example, being a legal secretary
4. **World views that precludes meaning** leaves people without goals, no sense of their intrinsic value and a blindness to spiritual awareness
5. **Critic disqualification problems** occur when people operate in the role of self-critic in which they disqualify their own actions by viewing them as deficient or worthless

In summary, Bergner (1998) believes that people derive meaning from living if they participate in lives that engage in instrumental, intrinsic and spiritual activities. Failing to achieve this creates meaninglessness and difficulties such as depression. The role of the therapist from this perspective is to identify the barriers and obstacles noted above and work towards removing them.

Cognitive Behavioural Therapy

The basic formulation underlying Cognitive Behaviour Therapy (CBT) is that situations and events which happen in everyday life trigger cognitive processes in the form of automatic thoughts and in turn, generate emotional, behavioural and physiological reactions.

These reactions are not caused by the event itself but moreso, the client's perception of the event. Perceptions are based on the beliefs people hold about themselves, others and the world they live in. For example, a person who is given constructive feedback about how they could improve on a task may consider themselves to be a miserable failure, while another may use the same information to improve their performance. The person who feels like a failure is likely to hold a core belief that they are worthless or unlovable and the person who uses the feedback to improve will, in contrast, see themselves as worthwhile. The person who

used the feedback positively, clearly perceived the event differently because of the different core beliefs they hold. These core beliefs manifest themselves as automatic thoughts which in general are more accessible to clients as they seek to understand their cognitive processes.

The way people deal with their automatic thoughts or painful core beliefs, such as “I’m unloveable” is to develop a set of rules, attitudes and assumptions which protect them from psychic distress. For example, a person might avoid intimate relationships in order not to find themselves in a position where someone might tell them that “they don’t love them” (Beck, 2010).

The aim of CBT is to change the way people process information and to modify the dysfunctional beliefs that lead them to experience distress. In changing the perceptions, beliefs and cognitive processing of the client in relation to events, the unpleasant reactions they experience will be modified to ones that cause less distress or even provide pleasure.

Beck (1967) developed a cognitive therapy for depression which was based on a paradigm that depressive thinking is maintained by negatively biased information processing and dysfunctional beliefs. This therapy taught clients to recognise their negative thinking and to discover the relationship between the beliefs they held and the reaction they had to this processing. Beck’s cognitive triad, the view a depressed person holds towards themselves, others and the future, stills holds today and forms the basis of The Becks Depression Inventory, a commonly used psychometric test (Beck, 1978)

In general, the standard approach used by CBT practitioners for depression is structured in a way that teaches them to:

- Write down their negative thoughts and to discover the relationship between them and reaction (depression)
- Question and evaluate the accuracy and usefulness of this thinking
- Modify this thinking and the beliefs that accompany it to accommodate a more adaptive viewpoint
- Use problem-solving techniques and coping strategies in order to support this increased and adaptive processing
- Use activity scheduling to increase the control they have over their given situations
- Engage in behavioural experiments to increase personal rewards and gain positive reinforcement

- Engage in tasks which have the potential to provide rewarding experiences

Central to this structure is the use of psychoeducation, guided discovery, socratic questioning, role playing and imagery.

In using standard CBT, clients are expected to show rapid improvement (8-12 sessions) and a full course of treatment is usually 14-16 sessions (Butler et al, 1995).

This basic formulation of CBT demonstrated the treatment's effectiveness and by 1989 over thirty clinical trials had been completed (Dobson, 1989).

A number of formulations derived from Ellis's work, continue to proliferate and the Five Areas Approach (Williams and Chellingsworth, 2010) demonstrates the model's adaptability in becoming part of the United Kingdom's Health Service. This approach uses a number of service delivery mediums: individual therapy, group work, self-help publications, telephone counselling and online services.

Cognitive Behaviour Therapy continues to evolve and the most current manifestation has been coined The Third Wave. The First Wave was made up of behaviourists, including Pavlov and Skinner and directly challenged Freudian psychology. The Second Wave saw the rise of cognitive therapists, starting with Beck and Ellis. These cognitive theorists connected events, feelings and behavior, which is described above in detail and incorporated behavioural ideas to formulate CBT (Leahy, 2004).

Third Wave therapies, unlike traditional CBT, focus on changing the function of psychological events experienced by people, rather than making changes to actual events. For example, Second Wave has a focus on changing a person's cognition and its relationship to a given event, while Third Wave approaches may work towards the person accepting their feelings and disentangling themselves from their thoughts instead of modifying them (Hayes, 2004).

Third Wave CBT doesn't seek to control thoughts and emotions in the traditional CBT sense and uses non-traditional methods to deal with unhelpful cognitions. Many of these Third Wave Therapies use Mindfulness, an eastern Buddhist tradition. Mindfulness-Based Cognitive Therapy (MBCT) and Acceptance and Commitment Therapy (ACT) provide well known examples of using this technique. Core conceptions of these approaches is that

psychological distress occurs when people become entangled with their thoughts, have rigid responses to distressing cognitions and use experiential avoidance as a coping mechanism.

These therapies use techniques such as cognitive diffusion (reducing the tendency to reify thoughts and emotions) in which Mindfulness plays a significant part. From this perspective, finding acceptance by allowing our thoughts to be thoughts and to cease struggling with them is an important premise. Having an awareness of the present moment is central to these perspectives, as is reducing rigid behavioural responses by experiencing life with openness and curiosity (Hayes, 2004).

However, some would argue that these Third Wave approaches are not vastly different and are consistent with traditional CBT, even though differences regarding procedure and theoretical formulations exist (Hofmann et al, 2011).

A Review of Cognitive Behavioural Therapy Compared With Other Approaches

The Cochrane Collaboration (Churchill et al, 2013) examined the Third Wave CBT approaches compared with treatment as usual (behavioural, humanistic, psychodynamic, cognitive and philosophical approaches) and the results demonstrated that Third Wave CBT were effective, on a short term basis, in treating depression. However, questions of researcher bias were raised and the study called for further studies in order to establish if this latest wave of CBT is effective in treating people with acute depression.

Standard CBT or traditional CBT for depression has a strong evidence-base and an extensive range of positive outcome studies have led it to be recommended as the treatment of choice by the British National Institute for Health and Clinical Excellence (NICE, 2009).

Mindfulness-Based interventions proved themselves effective in reducing symptoms of depression in groups presenting with mood disorders (Kabat-Zinn, 2003). Mindfulness is a common factor present in most, if not all, of Third Wave CBT modalities and should not be ignored as a key treatment variable.

Mindfulness-Based Therapy research shows that this technique is effective for depression across a range of severity and in circumstances where co-morbidity exists. It is suggested that mindfulness approaches reduce stress and encourage subjects to see their symptoms differently, which ameliorates the impact of their difficulties (Hofmann et al, 2010).

The strong evidence for CBT and the growing evidence for Third Wave approaches are based on a methodology that is manualised and documented. However, gathering evidence for other modalities is a different proposition, as humanistic and psychodynamic therapies are much more subjective because they rely on a vast variety of human experiences rather than being distilled into changing, accepting or processing cognitions differently.

Taylor (2008) argues that randomised controlled trials favour CBT applications and when different principles of evidence-gathering are used; the case for using psychodynamic therapy is equivalent to CBT. In short, his argument is that short-term psychodynamic therapies are as effective as CBT/medication. In addition, he states that the benefits from psychotherapy continue to increase after treatment.

In considering the evidence for CBT, the picture is not as clear as it is made out to be by proponents of the model. In an extensive meta-analysis, Butler et al (2006) made the point that CBT is one of the most extensively researched forms of psychotherapy and that there are, at the time of the cited publication, over 325 published outcome studies on the effectiveness of CBT. However, in the results section of this meta-analysis, it was concluded that CBT is not as effective as its proponents suggest. In reviewing the results and taking researcher allegiance into account, the findings still show that CBT was superior to waiting lists, untreated controls, placebo effects and other psychotherapies. The difference between CBT and behavior therapy was not statistically different.

In considering the evidence for person-centered-counselling and existential approaches where people have to confront the realities around them, Cooper et al (2010) consider they are effective because, in part, the common factors in therapy are addressed.

These common factors (Hubble et al, 1999) include the:

1. Extratherapeutic Factors (finding employment or winning lotto are examples) account towards 40% of change
2. Relationship between the therapist and client (warmth, safety, genuineness, empathy) accounts for 30% of change
3. Expectancy the client has of the therapeutic approach
4. Techniques or modality used by the therapist

Pilgrim (2002) is cited in the Cochrane Collaboration as providing evidence for the effectiveness of interpersonal and client-centered counselling, provides strengths to these

claims. However, the Collaboration and the NICE Guidelines have come out in favour of CBT as the preferred modality.

One cannot ignore the importance of therapeutic factors in psychotherapy and Hubble et al (1999) point towards these factors in regard to achieving positive outcomes, rather than the use of a specific modality.

Williams and Chellingsworth (2010) cite the importance of addressing these common factors in their CBT, Clinician's Guide to using the Five Areas Approach. This approach uses traditional CBT, based on Beck's work and formulates it in a manner that is accessible, using a range of mediums for service delivery and takes note of the Hubble et al research.

Summary

In summary, evidence exists for all the approaches (psychodynamic, behavioural, humanistic, cognitive behavioural and existential) considered for this paper. The strongest evidence exists for CBT, closely followed by Third Wave CBT which incorporates Mindfulness practices. However, it is important to note that in addressing depression, the statistical differences between CBT and behavioural therapy are minimal. Surprisingly, some researchers say psychodynamic therapy is said to be as effective as CBT if the outcomes are measured differently. The least amount of evidence exists for humanistic and existential approaches. However, these approaches, according to some sources are useful modalities in treating depression and it should be noted that they address common factors which are essential in achieving positive therapeutic outcomes. These common factors are more important than the actual modality, in terms of achieving positive outcomes for clients.

The Cochrane Collaboration Review supports the findings for these approaches being useful in the treatment of depression. However, the report clearly finds CBT superior to other approaches in terms of delivering outcomes and supports Third Wave CBT as a variation which produces positive results, although carrying a rider that further research is required. Nevertheless, Mindfulness, a key component of Third Wave Therapies, has produced a range of positive outcomes.

Therapeutic Approach Adopted by Life A Plenty Retreats for Mild to Moderate Depression

Based on the evidence above, the development of a therapeutic retreat and follow-up manual for depression includes traditional CBT as a base. However, the effectiveness of Mindfulness

and its place in Third Wave approaches cannot be overlooked and will be incorporated into this manual for depression.

The evidence for Third Wave CBT is not strong enough for the author to adopt in its entirety. However, the stated vision of *Life A Plenty Therapeutic Retreats* seeks to address the emotional, psychological and spiritual needs of the clients, and traditional CBT in itself would not achieve all these aims.

The adoption of some aspects of the Five Areas Approach would generate the ability to address the common factors important for clients to achieve successful outcomes, and the need for the facilitators/therapists involved in the collaboration to place genuineness, empathy and warmth ahead of a specific modality.

The importance of meeting the spiritual needs of clients could be partially addressed by including existential approaches into the overall programme. The evidence-base for existential therapy does not match up with that provided by CBT however, using such an approach could act as an enhancement. In a broad sense, a case could be made that, at its heart, existential therapy is no different from CBT, as finding meaning and purpose is about developing new beliefs and perspectives.

In a conceptual sense, the step-by-step programme will include ten sessions of traditional CBT which fits with Beck's approach and ensures that an evidence-base is adhered to. The inclusion of Mindfulness is considered most appropriate within the programme and in itself is supported by evidence. With the addition of existential approaches, the overall Life A Plenty approach for The Life After Depression Retreats is seen as enhanced CBT, rather than Third Wave CBT.

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