Case study dealing with depression

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Depression is one of the most common and widespread psychiatric disorders in the UK. Of over 5000 British residents, approximately 5. 9% of males and 4. 2% of females suffer from depressive illnesses (Based on DSM-IV criteria) (Ohayon, 1999). Consequently there has been much emphasis on implementing techniques and psychotherapy to solve these issues and find effective treatments for depression. This essay will explore, psychodynamic and CBT therapy, in treating depression. There are clear disparities between these two forms of therapy in regards to their theoretical underpinnings as well as the arguments both for and against their effectiveness in treating depression. Throughout this review particular attention will be paid to the similar features which run through both approaches in order to gather a much more conclusive view regarding psychotherapy in the treatment of depression.

The essay will begin by briefly outlining depression and discussing the development of psychotherapy in treating it. After this, psychodynamic therapy which is one of the most traditional psychotherapeutic methods of dealing with depression will be explored, in order to gather an understanding of its views on solving the problem of depression. Before moving on to compare this too, the much more modern and focused intervention CBT, developed by Beck (1979). After each approach has been outlined the essay will go on to critically evaluate each approach, firstly in terms of its empirical grounding in research before moving on to gather an understanding of the arguments regarding their theoretical grounding. Before finally going on to conclude as to what is the best option for dealing with such a common and problematic condition.

Depression is a condition which is characterized by negative moods and unpleasant states of mind which can undermine our ability to function normally (Gilbert, 2007). In some cases people are born with a predisposition to depression through neurological disorders. However, for many others, depression is likely to occur as a consequence of changing life circumstances. (Hollon, Thase, & Markowitz, 2002) For many years clients were effectively treated with medicines such as anti-depressants. However, the stigma and the side effects that are associated with this medication, mean that many patients diagnosed with depression are reluctant to use them. A survey carried out by Priest, Vize, Roberts, Roberts and Tylee (1996) used questionnaires and interviews to discover the lay person's beliefs and attitudes to pharmaceuticals as treatment of depression. The study found that 78% of the 2003 participants from across the UK, regarded antidepressants as negative and addictive. This demonstrates that the general public are still very sceptical about using medication as a quick fix to their depression. (Priest et al, 1996)

Psychotherapists believe it is addressing the central psychological underpinnings of depression which is essential to long term recovery. (Gilbert, 2007) One of the first alternative forms of treatment was psychodynamic therapy. Psychodynamic therapy is based on the belief that that the majority of mental functioning occurs in our unconscious. Jacobs (2004) explains that, according to Freud the structure of the psyche is constructed from birth, and therefore the child's relationship with significant others in the early years of their life, notably their mother and father, are vital to the individual's future developments.

When gathering an understanding of depression Freud (1917) believed that the symptoms of depressed individuals were very similar to those reactions of loss and mourning. As such he proposed that depression originates from a loss in early childhood. Nelson-Jones (2009) explains that Freud believed this loss, could be real or imagined. Freud's (1917) definition of what constitutes a loss was broad, as it was clear that not all depressed individuals had lost a loved one, thus Freud (1917) incorporated the idea of a symbolic loss. This could involve the loss of social status, a job or even the loss of some believed affection they once held. Comer (1992) suggests that it was the reaction to losing the real or imagined object; that Freud believed leads the individuals to become depressed and thus develop feelings of self-hatred.

Although, at first sight, it would seem as though experiencing love and attention as a youngster is required in order to prevent depression from presenting itself in later life. Freud (1917) argued that in some instances, too many positive experiences are present during the first year of life. This consequently leaves the youngster vulnerable for developing depression later on in life, as he or she has never had the need to develop beyond the oral stage; of requiring constant attention and gratification. Thus when this begins to disappear as the child grows older; the feelings of loss and thus depression and unworthiness begin to develop. (Comer, 1992),

Gilbert (2007) explains that in treating depression, psychodynamic therapy aims to aid clients in exploring and understanding the long-term origins to the current function of their issues and problems. This can include various painful emotions, mental conflicts or problematic connections with key attachment figures. Hollon et al (2002) portray that when working with

depressed individuals psychodynamic therapists are concerned with exploring any indicators such as loss, fear etc as to the unconscious psychic activity of the client. By the way they talk about key events and situations both in their past and present and the associated feelings they hold with these events. (Hollon et al, 2002) The therapy aims to constantly correspond between past and present experiences in order to make any possible connections between these.

As the process of transference is such a distinctive and key component of psychodynamic therapy, the relationship between the depressed individual and the therapy is viewed as essentially important (Jacobs, 2004). Freud (1912) believed that if a strong therapeutic relationship was produced, then the depressed individual would begin to express their true unconscious thoughts and beliefs, while they play out previously disturbing relationships with the therapist. Hollon et al (2002) explains that the depressed client is likely to make negative, erroneous judgements and beliefs about the therapist; as they portray previously difficult relationships onto the therapist. Freud (1912) believed that it is through the therapist's interpretation of this transference that the client can begin to gather a conscious understanding of their own underlying beliefs so these can be dealt with, and thus action taken to prevent them from reoccurring in future relationships.

Find all citations by this author (default). Or filter your current searBeck (1979) argued that this approach to dealing with psychological disorder such as depression is far too subjective and thus proposed that an effective alternative to this form of psychotherapy was a structured, practical and problem focused intervention which he named Cognitive Behavioural therapy

(CBT). Beck (1979) believed that by focusing instead on assessing and modifying how the client has constructed their faulty thoughts and thinking habits, along with encouraging the adoption of more functional behaviours, then CBT would give clients a much more active and effective alternative outlook in overcoming their depression.

In comparison to psychodynamic therapy, the focus of CBT is on the patient's present thoughts and behaviours. Beck (1979) postulates that although depression is likely to be related, at least to some degree, to previous life events and difficulties, it is the way that we view these difficulties and the coping strategies that we implement that plays a major role in the nature and degree of subsequent depression.

When applying the CBT technique to depression the main premises of the technique remains, it is a present orientated, collaborative and a very problem focused approach. Initially, the nature of depression and its maintaining factors (i. e., thought patterns and behavioural tendencies) are outlined (Mor and Haran, 2009). From the outset the client plays a very active role in identifying these factors and working collaboratively with the therapist to mitigate these in the future.

Beck (1979) demonstrated that the course for tackling depression using CBT consists of three phases; the first phase consists of behavioural change in which the client is asked to monitor their behaviours by keeping a log of their activities in order to identify the link between their behaviours and their subsequent mood. The therapist and client can then work together to identify those areas which seem to enhance their mood, and thus set

realistic short and long-term goals, which concentrate on eliminating and avoiding negative behavioural outcomes or replacing them with active coping strategies. (Moe and Haran, 2009) When these goals have been met successfully patients can receive rewards for achieving them. (Persons, Davidson & Tompkins, 2001)

Beck (1979) believed that once the client has become a much more active participant in their own environment, the focus of the therapy can focus its attention on cognitive restructuring. This is where the therapist works with the client using techniques such as Socratic questioning to identify their faulty core beliefs and thus to evaluate and refute these in order to mitigate and question their automatic negative thoughts and beliefs in the future. (Beck, 1979) Recording these thoughts allows the therapist to identify any cognitive distortions that are held by the individual and express these to the client as well as new positive outlooks. (Moe and Haran, 2009)

Finally it is important that the therapy concentrates on avoiding any relapse for the client. Therefore it is important that this stage aims to change dysfunctional assumptions and schemas. Fennell, (1989) suggests that this phase, in which, clients learn from current setbacks and plan how to deal with future ones is an essential element to prevent the reoccurrence of this disorder through future relapses.

Identifying an effective and long-term treatment of depression is crucial. Segal et al (2002) demonstrate that of those who experience major depression 85% of these will relapse into depression over their lifetime. Combining the reoccurrence of this disorder with its prevalence in today’s

society, demonstrates how imperative it is to identify effective approaches to helping those suffering with depression.

The effectiveness of the CBT approach in treating depression is demonstrated through its grounding in empirical research. Numerous meta-analysis are cited throughout the literature regarding psychotherapy, which support the value of CBT in treating depression. A wide scale meta-analysis carried out by Gaffan (1995) which analysed 65 studies, confirmed previous conclusions that the outcome of CBT in treating depression was superior to that of other forms of psychotherapy and to that of pharmacotherapy. Further support for the effectiveness of CBT comes from a smaller scale meta-analysis by DeRubeis, Gelfand, Tang and Simons (1999), which examined four individual studies to compare the outcome of medication and CBT therapy in treating depression. The analysis concluded that CBT is equally as effective as medication in treating depression. However by examining the procedure used by DeRubeis, et al (1999) in more detail, it is clear that the methodology is flawed. Of the four studies used in this meta-analysis three used the drug imipramine and one nortriptyline to represent anti-depressants. Nevertheless, these two drugs were generalised to represent all antidepressant medications. Such problems in methodology, question whether CBT is as effective as antidepressants in treating depression, or whether this finding is in fact limited to the anti depressant, imiparimine, alone.

Meta-analysis is a widely accepted method of synthesising independent studies in order to distinguish the efficacy of therapy. Nonetheless it is important to distinguish that they are not without their limitations. It is

imperative, to recognise that the assumptions and conclusions drawn from these wide scale meta-analysis are often incorrect and misinterpreted.

Lynch Laws and Mackena (2009) recognize that these meta-analysis ignore important variables such as gender differences, age, as well as methodological inconsistencies, which are hidden in the mix of numerous independent studies. Furthermore when investigating the, conclusions drawn from these studies they have been carried out against treatment as usual or a waiting list control group which are not randomised, this forfeits the external validity of such results. In addition they consistently fail to use clear diagnostic criteria to assess depression and consistently ignore the moderating effect of blindness altogether (Lynch Laws and Mackena, 2009) All these sources of bias, which are consistently overlooked in these studies evidently, question whether the majority of meta-analysis studies can actually be considered as rigorous in literature reviews and in the evaluation regarding the effectiveness of CBT in treating depression. Shapiro Barkham, Rees, Hardy, Reynolds and Startup (1994) suggest that the common theoretical background of CBT and the Becks Depression Inventory (BDI), which is commonly used to test depression outcomes, may to some degree introduce bias when using the BDI as a measure of comparisons between CBT and psychodynamic therapy.

Although these wide scale meta-analysis are highly criticised, the effectiveness of CBT in treating depression can not be ignored. There have been countless studies that demonstrate the effectiveness of this treatment of depression. Recent independent research by Schindler (2010) implemented a questionnaire to distinguish the prevalence of symptoms

before and after CBT. Results illustrated that 61% of all participating clients achieved better than 50% improvement of their symptoms during the course of CBT. Although it is easy to criticise empirical studies such as these as implementing restrictive quantitative analysis such as questionnaires, it is nonetheless important to recognise the empirical validity of this approach in alleviating client's symptoms of depression and psychological manifestations.

One key area where CBT stands out in demonstrating its effectiveness is through relapse prevention, especially as it focuses on modifying behaviours and maintaining these modifications after treatment has been terminated. Gloaguen, Cottraux , Cucherat & Blackburn (1998) carried out a meta-analysis that collated findings from eight independent studies. They found that 60% of patients treated with anti-depressants would go on to relapse after discontinuing medication compared to only a 29. 5% relapse rate for those treated through CBT. Nevertheless there are restrictions to how this study can be generalised as the studies included were small scale with only 241 patients in total from all eight studies. Furthermore the duration of CBT therapy and anti depressant treatment was not specified; meaning that further more comprehensive research would be needed to be able to conclude that CBT does in fact decrease the risk of relapse from depression

Spinelli (1994) offers an explanation for the vast amount of empirical support for CBT in treating depression. He suggests that it is the focus that is placed on the depressed individuals current thoughts and feelings which makes CBT an effective form of treatment. He explains that by avoiding, emphasise on hypothetical constructs such as the unconscious, which is a key component

in psychodynamic therapy, CBT allows clients to feel much more engaged both emotionally and intellectually in treating their own depression. As the approach is so participatory in nature, this consequently leads to positive feelings of empowerment for the client. This is supported by Sheldon (1995) who by gathering client's responses to CBT therapy aimed to discover the reason why this approach seems to be so effective in treating depression. He found that clients consistently described the approach as a useful and a user-friendly intervention.

A different perspective on this was offered by Newell & Dryden (1991) who argue that although the objective and structured nature of CBT in treating depression can be viewed as an attribute of its therapeutic model, in some instances, it can also be detrimental to it. Gilbert (2007) postulates that the CBT approach is a far to formulaic and ritualised approach to treat such an individualised disorder as depression, which is unique both in terms of nature and causes for each depressed individual. Dryden & Mytton (1999) elucidate that treating these patients in such a formalised way can make them feel inadequate and therefore resist the treatment, if therapists do not listen to their own feelings. Thus it is clear to see that in order for CBT to be an effective and worthwhile option, the therapist needs to a strike a balance between these two features; by carefully assessing the client's motivations and how to best approach him or her as an individual, while remaining structured in its approach, so the client can have a powerful voice in treating their own depression.

In addition, Spinelli (1992) questions the degree to which the therapist can be entirely objective in distinguishing faulty cognitions. (Alloy et al, 1990 cit

ted in Beech 1990) provides evidence that the perception and appraisal of the world and the self can actually be more accurate in depressed individuals than non-depressed individuals. Thus Spinelli (1994) questions the degree of objectivity that the therapist actually holds in making their own judgements when identifying faulty/dysfunctional beliefs or thoughts of the depressed.

It is inevitable that the strong empirical evidence that supports CBT means that the approach has emerged, in both research literature and the media, as one of the most effective forms of psychotherapy to treat depression. Beech (2000) criticised this research as being very fitting and self serving in pitching psychotherapeutic techniques against those of pharmaceutical, postulating that CBT must be used autonomously as the best form of therapy, and thus ignoring the presence of deliberating physical and biological symptoms such as sleep disturbance, aches and pains, in depressed individuals. Considerable evidence such as that posed by (Calarco and Krone, 1991 as cited by Beech, 2000) demonstrates that depression is clearly a psychological and biological disorder and thus incorporating the use of drugs and psychological interventions such as CBT is vital to effectively treating and overcoming such a deliberating illness as depression as there certainly is not one quick fix option for all.

Throughout the literature CBT is positioned as the most empirically valid way to treat disorders such as depression. Despite the significant lack of empirical support for psychodynamic therapy compared to CBT, numerous studies such as Hersen, Bellack, Himmelhoch, and Thase (1984) position psychodynamic therapy as equal to CBT and other psychotherapeutic interventions in treating depression. By analysing 120 women diagnosed

with major depression they aimed to investigate the difference between those patients treated via psychodynamic therapy, social skills training and the anti depressant amitriplyine. Analysis showed that there was no difference between these therapies in overcoming depression. Thus questioning whether the lack of empirical support for psychodynamic therapy does in fact mean it is not as useful as CBT in treating depression, or whether it is just the case that CBT is easier for researchers to test empirically and thus more research is readily available to be published.

This premise was supported further by Shapiro et al (1994) who used 117 clients in a comparison study, to investigate the efficacy of CBT and psychodynamic therapy in treating depression. Analysis proposed that both therapies were equally effective and equally efficient in improving client's mood, social adjustment and self-esteem in both eight & 16-week therapies in treating depression. However a key problem with such research is the subjective nature of psychodynamic therapy means that each individual case may have implemented different strategies and techniques to treat their patient and thus without a consistent theoretical grounding it is difficult to test and compare this therapy.

Furthermore, the key premise that loss predisposes an individual to depression in later life has been supported by Maier and Lachman (2000), who implemented questionnaires and telephone interviews to survey 2998 adults. They found that symptoms of depression were more common in those who had lost a parent in childhood through divorce or death. Evidently the methodology used can be scrutinised, as social desirability as well as accurate diagnoses was not reliable and therefore biases are very likely.

Although there is research to suggest that a psychodynamic approach to depression is as effective as CBT in overcoming depression. The key criticism of psychodynamic therapy, that too much emphasise is given to unconscious processes and subjective past experiences remains. (Gilbert, 2007) Nurture in childhood is seen as key to the development of depression in later in life, this consequently leads psychologists to ask fundamental questions such as how nurture can be accurately measured and tested in order too prevent depression in later in life. Such hypothetical constructs predispose psychodynamic therapy too criticism from Newell & Dryden (1991) who declare that the efficacy of psychodynamic therapies can not be scientifically proven and thus testing the effectiveness of psychodynamic therapy in treating depression, is difficult and inconsequential (Newell & Dryden, 1991).

The nature of depression lends itself to a psychodynamic viewpoint, in that providing a empathetic therapeutic relationship in which the client feels safe in revealing their thoughts and feelings is seen as central to psychodynamic therapy, and this is fundamental if depressed individuals are not to relapse again in the future. (Dryden & Mytton, 1999). As the presence of such a strong therapeutic relationship in itself can leave depressed individuals feeling less burdened, even without any interpretations from the therapist themselves. This idea is supported by (Blatt et al, 1995 as cited in Beech, 2000) who shows that it is the empathetic and caring therapeutic relationship which is most effective in overcoming depression. If this is the case then psychodynamic therapy holds as a very effective way of treating depression.

On the other hand it has been suggested that this approach puts too much emphasis on the therapist's skills, which can lead to individuals becoming overly reliant on the therapist and not an active participant in improving their current feelings. (Nelson-Jones, 2009) For depressed individuals who are characterised by feelings of worthlessness this may not improve their mind set in order to achieve long-term beneficial change. Because of this, psychodynamic therapy has been characterised as a therapy which is limited to those individuals with mild psychological problems who are motivated to spend a substantial amount of time attempting to uncover their unconscious feelings (Dryden & Mytton, 1999).

Fonagy (2010) adds that the very nature of psychodynamic therapy makes it a notoriously slow moving and long term approach to solving disorders such as depression which can last as long as months or years. This causes problems as depressed individuals often become frustrated as they do not feel that their condition is improving for some length of time, ultimately this leads many to give up on this or any form of psychotherapy, altogether especially in the cases of the suicidal depressed patients where a symptom-focused orientation may be much more beneficial. (Fonagy, 2010).

While it is clear that the psychodynamic and CBT traditions represent diametrically contrasting models of overcoming depression. The research postulating that there is no significant difference between such distinctive therapeutic interventions suggests that emphasis should instead be placed on the therapeutic relationship. (Shapiro et al, 1994) In both CBT and psychodynamic therapy, the therapist and client are seen as working in alliance with each other to treat the client's depression. Blatt et al (1996 as

cited in Beech, 2000) demonstrated that it is the bond between therapist and client that yielded the most effective developments in the clients regardless of which therapeutic intervention was implemented. If this is the case, introducing a much more eclectic approach, may be beneficial to treating disorders such as depression in the future.

In conclusion, it is clear to see that the way in which depression is treated through psychotherapy will proceed along very different paths depending on the client's choice of therapy. CBT will involve a much more interactive, action based therapy in which beliefs thoughts and actions can be assessed. Whereas psychodynamic will aim to identify problematic childhood experiences with significant others while examining how these are causing the feelings of depression. The Evidence indicates that CBT is the most effective psychotherapy to overcome depression however, for many, overcoming depression in the long term requires a exploration of the true reasoning behind their behaviours, for these people psychodynamic therapy will be helpful in promoting their inner resources and thus allowing them to lead more fulfilling lives. Overall it is clear that each therapeutic option has it own advantages and disadvantages and none are universally effective. Thus the most effective therapeutic intervention will depend on the individuals own values and beliefs. Despite the disparity between these two forms of therapy in regard to their theoretical background and the form in which therapy follows, the presence of a collaborative, therapeutic relationship seems to remain as a universally essential component of both psychotherapeutic interventions in order to treat depression successfully.

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