Autonomy, stress, and treatment of depression

Psychotherapy can help patients understand the triggers for depression and how to deal with them. **Paul Biegler** argues that these effects should be given moral weight when deciding on treatment

Most guidelines on the treatment of less severe forms of depression conclude that antidepressants and psychotherapy have similar efficacy and recommend that either can be used.[1 2] The evidence for these recommendations derives from studies that measure reduction of symptoms on instruments such as the Hamilton rating scale. However, these studies fail to take into account the role of self knowledge in the success of evidence based psychotherapy and the potential importance it has for depressed people. Psychotherapy affords people with depression greater autonomy in decisions and actions that relate to the object, or trigger, of the depressed response. Patient autonomy is rightly given considerable weight in medicine, and it should have greater influence on the discussions that guide treatment in depression.

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Depression as a response to stressors

Some years ago, the philosopher and physician Carl Elliot wondered what might be wrong with using antidepressants to treat a melancholy Sisyphus, sentenced in perpetuity to pushing a big rock up a steep hill, only to see it roll back down again. Elliot concluded that to modify the affective response of Sisyphus with a drug was to ignore "certain larger aspects of his predicament connected to boulders, mountains, and eternity."[3] Elliot's concerns—that the use of antidepressants fails to deal with the context in which the depression occurs—are given impetus by data showing that nearly 70% of depressive episodes are triggered by psychosocial stressors.[4] Moreover, it is increasingly likely that many of the changes in brain chemistry that feature in depression, and that are targeted by antidepressants, follow from increased production of cortisol in response to stress.[5]

It is acknowledged that genetic predisposition[6] and individual vulnerability stemming from adversity in early life[7] predict a depressed response to stressors. And there is some evidence for a kindling effect, whereby stressors provoke depression at ever lower thresholds as the number of episodes mounts.[8] Also, melancholic depression can occur independently of the effect of stressors, although it is uncommon.[9] However, it remains the case that stressful life events are a common causal antecedent to many depressive episodes, a fact that has strong bearing on personal autonomy.

Personal autonomy

Through autonomous decisions individuals are well placed to act in accordance with deeply held values and goals that form part of an overarching life plan.[10] The information that is important for, or material to, such decisions is that with relevance for the person's significant interests.[11] To use an example from the informed consent model, the small functional improvement that results from surgery for a minor fracture of the finger is likely to be material to a concert pianist but not to a professional boxer.

Information about the relation between stressors and depression is likely to be material to depressed people, hence understanding it promotes the autonomy with which the person decides, and acts, in relation to a stressful event. Appraisal theory, which holds that negative affect arises when important goals and interests are threatened, supports this.[12] Consider the despondency that often follows, for example, a broken engagement, the loss of a job, or failure in an examination. Depression, although a pathological sadness, can, in many cases, be thought of as an appraisal signifying loss, disappointment, and thwarted ambitions. If depression is viewed as a marker of a threat to interests, there is good reason to see information pertaining to its trigger as material to the depressed person.

Material facts in depression

Three facets of the stressor-depression relation are strong candidates to comprise material information for depressed people. Firstly, it is likely to be pertinent that stressors can bring on the disorder. If data from the general population can be used as a guide, around a third of people with depression may fail to recognise this fact.[13] Just as most would agree that people with asthma ought to be apprised of the deleterious effects of cigarette smoke, so too should people with depression know of the aetiological role of stressors. This information affords a further option for dealing with the illness.

Secondly, it is important for depressed people to appreciate how stressful events precipitate depression. Evidence supports a pivotal role for biases that favour the processing of negative information.[14] These biases lead to unrealistic pessimism about the outcome of stressful events as well as excessive self attribution of their cause. In depression, false negative thoughts are commonly taken at face value and guide the person's subsequent behaviour. Given that such behaviour is mostly self defeating, and that a more accurate way of dealing with negative thoughts can be learnt, insight into the action of negative biases is also likely to be material to the depressed person.

Of course, some circumstances are so grievous that a depressed response can seem warranted. The concept of "depressive realism" takes this observation further in proposing that the predictions of those with depression are in fact more accurate than those of their non-depressed counterparts.[15] However, although extreme sadness is sometimes appropriate, depressive realism

is contested,[16] and the evidence remains strong that depressed perceptions are mostly unreliable[14] and become even less reliable as depression worsens.[17]

Finally, people with depression will be concerned to know what can be done to help them deal better with stressful life events. Underpinning this contention is the recognition of depression as a maladaptive reaction to taxing circumstances.[18] People whose initial response to relationship, financial, or work difficulties is one that heightens the likelihood of subsequent depression, place in jeopardy the compelling interests that are tied to each pursuit. Thus, knowledge that a more adaptive response to these kinds of hurdles can be mastered is likely to be material.

Psychotherapy and autonomy

Psychotherapies that have been shown to be effective in depression promote understanding of all three facets of the stressor-depression relation. For example, cognitive behavioural therapy and interpersonal therapy, while containing more generic elements, seek to locate a depressive episode within the context of an onerous situation. Cognitive behavioural therapy also uses "debiasing" strategies that challenge negative thinking. In addition, the therapies contain problem-focused elements that seek to elucidate depressive triggers and to assist coping responses to them. Indeed, problem solving therapy alone has shown promise as a treatment for depression.[19]

The effects of psychosocial stressors are critical for the depressed individual's interests. It follows that an understanding of those effects through psychotherapy promotes the autonomy with which the depressed person decides, and acts, in relation to stressful events.

Antidepressants and autonomy

There is little question that antidepressants can also promote autonomy in depression. Sometimes the paralysing torpor of depression can be lifted only with drugs. Antidepressants are life saving in many cases and are the treatment of choice in most categories of severe depression. Moreover, recent work suggests that selective serotonin and noradrenaline reuptake inhibitors have a neuropsychological mode of action that shares much with that of the evidence based psychotherapies.[20] These drugs seem to increase attention to positive information and, through that, may counter the negative biases that mediate depressed thinking.

However, medication alone does not afford the kinds of insight that, I argue, are material to people with depression. Depression recurs in up to 80% of sufferers[21] so, as a recent commentator has highlighted,[22] in most cases ought to be managed as a chronic illness. Successful psychotherapy enables depressed people to make more accurate appraisals during future stressful events, providing a credible autonomy advantage.

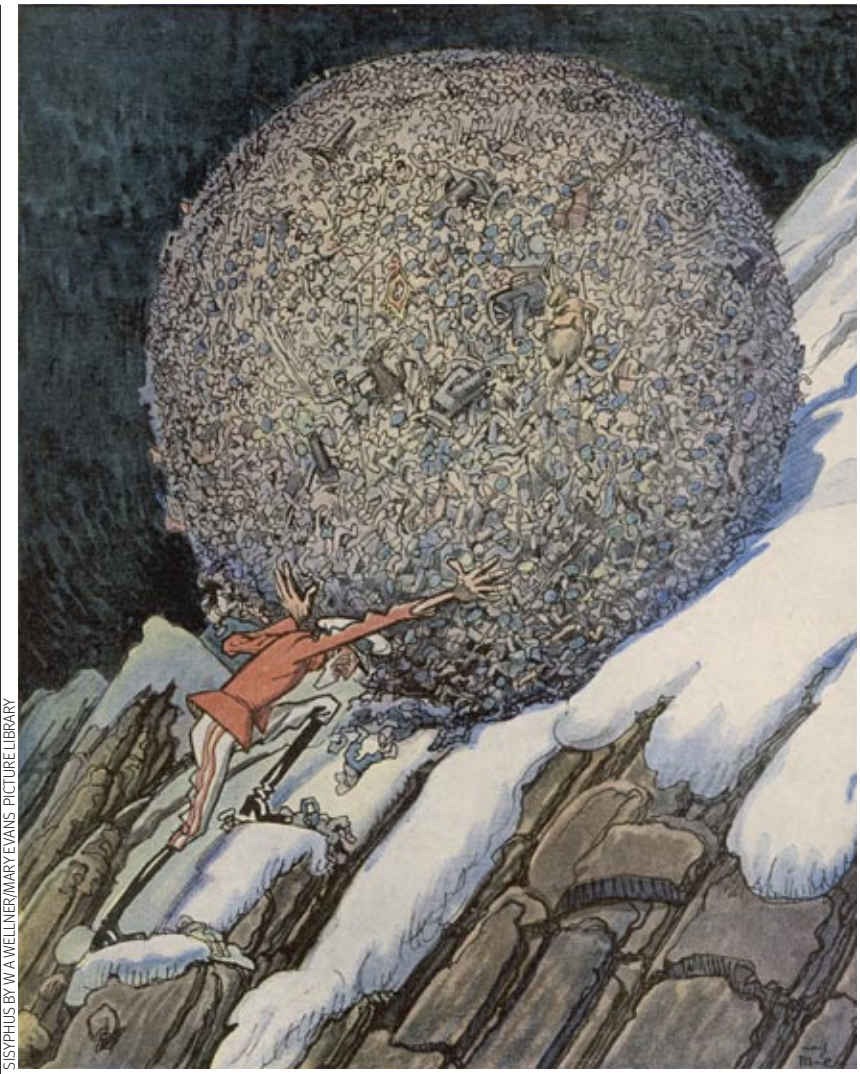
Beneficence and autonomy

If psychotherapy affords greater personal autonomy then it might be argued that it is the better treatment for depression and doctors should be required to provide it under their duty of beneficence. But this is valid only if autonomy is viewed as primarily of instrumental value in furthering the individual's interests. The importance for wellbeing of acting from informed and rational preferences is widely acknowledged, and the autonomous individual is well placed to express such preferences.[23]

However, autonomy also has intrinsic value, independent of the benefits or burdens that might flow from the exercise of autonomous choice. For example, respect for the autonomous wishes of someone who continues to smoke, despite an appreciation that such a choice is detrimental to health, stems from the value accorded a basic right to decide on issues of subjective importance. Accordingly, the depressed person who deals more autonomously with stressors may be better off, but is not necessarily so. For this reason a therapy that better promotes autonomy cannot simply be relabelled as one that is more beneficent.

Implications for clinical practice

What do the above arguments mean for doctors treating patients with depression? All else being equal, and mindful of the importance already accorded patient autonomy in medicine, they provide strong



SISYPHUS BY W A WELLNER/MARY EVANS PICTURE LIBRARY

Uphill task: does the use of antidepressants fail to deal with the context in which the depression occurs?

additional reason to recommend psychotherapy for depressed patients. In fact, doctors who profess to take autonomy seriously are perhaps obliged to support this course of action.

But all else is often not equal when it comes to managing depression. For a start, the patient might show traits that make it likely that one or other treatment, or a combination, will be more effective. Alternatively, the patient might make a considered decision in favour of antidepressants and so a case could be made, on beneficence grounds, that antidepressants are the treatment of choice. Psychotherapy might be untenable because it is unavailable, too expensive, or cannot be delivered in a timely fashion. Or the doctor might be sceptical of the benefits of psychotherapy, believing its effects derive largely from the therapeutic alliance that it forges,[24] or that its efficacy in controlled trials translates poorly to effectiveness in the clinical setting.[25] Conversely, emerging evidence of better prevention of relapse with cognitive behavioural therapy could lead to it being considered more favourably on the grounds of efficacy alone.[26]

Although these concerns will drive treatment choice in some situations, for many patients both antidepressants and psychotherapy are available and effective options. In these instances, the argument presented suggests doctors should place considerable weight on the autonomy promoting effects of evidence based psychotherapy when discussing treatment with depressed patients. It also points to an ethical dimension that is worthy of greater attention in the ongoing debate on how best to tackle the formidable challenges posed by depression.

Contributors and sources: PB is an Australian bioethicist and emergency physician. He has a strong interest in psychological medicine, recently completing a PhD at Monash University's School of Philosophy and Bioethics, which examined ethical issues in the treatment of depression. This article derives from work completed as part of his doctoral dissertation.

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SUMMARY POINTS

Studies show antidepressants and psychotherapy have comparable efficacy in less severe grades of depression

Standard efficacy criteria do not measure the self knowledge that comes from successful psychotherapy

Self knowledge promotes autonomy in dealing with stressful life events

Personal autonomy provides strong additional reason to recommend psychotherapy in depression

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That was obstetrics that was

As a young child, I lived in a small town in southern Ireland where my late father was the local doctor and medical superintendent of a large institution. He qualified first as a pharmacist and later, in 1926, as a doctor. He then went on to get his DPH and MRCP. He was a dedicated doctor and was interested in medicine and academia. He was well read, and money meant very little to him.

At 1 am one morning at the start of the second world war he was called to a poor woman in a cottage three miles up the hills. The woman was expecting her sixth child and was bleeding from the vagina. The nearest telephone was three miles away and the nearest general hospital was 13 miles away, so getting the woman there meant a dead baby and mother for sure.

My father put two fingers through the cervix and pulled down a leg and kept gentle pressure until the child was born, unfortunately dead. There was blood all over the place, but the mother survived. My father remained in attendance for another three hours as he did not wish the mother to die and leave five orphans.

At 5 am there was a ring at our front door. My mother was frightened to open it, so she woke her four eldest children, and we assured her that if anyone touched her we would clobber him with our hurley sticks. She opened the door to be greeted by the husband of the patient. He doffed his cap in deference, begged pardon for disturbance, and then asked if the doctor could have a clean pair of socks.

Four of us went on to be doctors.

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