DEPRESSION AND PSYCHOTHERAPY

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Abstract – Depression has become highly treatable and this article explores some ways of treating it with the use of psychotherapy. The approach presented is a communication focused psychotherapy which has been developed and described by the author before. Psychotherapy alone may not be sufficient in more severe cases, where medication is usually added to bring faster relief to the symptoms of depression, which also facilitates the psychotherapeutic treatment.

Keywords: depression, psychotherapy

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Introduction

Depression usually means feeling low and lacking motivation and energy to do anything enjoyable. The initiative to do things is lower, concentration and focusing on tasks worsen. About one out of three people experience an episode of depression in their life-time. It can interfere significantly with a person's professional and private life.

Depression is a consequence of maladaptive internal and external communication patterns. (Haverkampf, 2010a, 2013, 2017a) However, communication is also the instrument to treat depression. Communication is the exchange of meaningful messages and this process can be disturbed at different stages in the sending and receiving of information within the brain and among individuals. Communication-Focused Therapy (CFT) was developed by the author for the treatment of depression and has been described elsewhere. (Haverkampf, 2017a) The following is intended to provide a brief overview of the treatment of depression.

Atypical Depression

Sometimes a depression predominantly shows in disturbed sleep, a lack of appetite or other diffuse bodily symptoms. The mood itself does not have to feel appreciably lower. This form of depression is called an atypical depression. There is some discussion about the overlap of atypical depression and attention deficit disorder (ADHD). However, this debate may be largely academic as psychotherapy and medication need to be geared to the specific case with the particular symptoms, while keeping in mind possible causes and pathogenic mechanisms. In clinical practice, atypical depression has shown to be as accessible to a communication-focused psychotherapeutic approach as the other forms of depression. On the medication side, one has to choose drugs that target the specific symptoms at the least amount of potential side effects.

Co-Morbidity

Frequently, depression is associated with anxiety, and in many cases also with some features of OCD. One biological explanation is that similar neurotransmitter-receptor systems are involved in

all three. However, some antidepressants target more one condition that another, which also shows that there must be biological differences.

Psychologically, depression, anxiety and OCD come with different internal and external communication patterns, although there is significant overlap. The focus on negative outcomes is common to all three and negative information is given a great emphasis. In the interactions with the environment, by which individuals get their needs, aspirations and values met, there are also disturbance in depression, anxiety and OCD.

The Untreated Health Condition

Often individuals remain undiagnosed or misdiagnosed for a long time before someone correctly identifies the underlying problem as a depression. This can lead to losses of relationships and jobs, prolonged suffering, and potentially a lower life expectancy. Since depression affects how individuals communicate with the environment, as well as with themselves, the condition could be visible to anyone who has a basic understanding of depression. More public awareness about mental health conditions, and particularly about the specific interaction patterns someone affected by it has with others and with himself or herself would be helpful. (Haverkampf, 2010b)

Major Depression, Dysthymia

Major depressive disorder (MDD), also known simply as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations.[1] It is often accompanied by low self-esteem, loss of interest in normally enjoyable activities, low energy, and pain without a clear cause.[1] People may also occasionally have false beliefs or see or hear things that others cannot.[1] Some people have periods of depression separated by years in which they feel ‘normal’ while others nearly always have symptoms present.[2] Major depressive disorder can negatively affect a person's personal, work, or school life, as well as sleeping, eating habits, and general health.[1][2] Between 2–7% of adults with major depression die by suicide,[3] and up to 60% of people who die by suicide had depression or another mood disorder.[4]

Causes

The cause is believed to be a combination of genetic, environmental, and psychological factors.[1] Risk factors include a family history of the condition, major life changes, certain medications, chronic health problems, and substance abuse.[1][2] About 40% of the risk appears to be related to genetics.[2] The diagnosis of major depressive disorder is based on the person's reported experiences and a mental status examination.[5] There is no laboratory test for major depression.[2] Testing, however, may be done to rule out physical conditions that can cause similar symptoms.[5] Major depression should be differentiated from sadness which is a normal part of life and is less severe.[2] The United States Preventive Services Task Force (USPSTF) recommends screening for depression among those over the age 12,[6][7] while a prior Cochrane review found that the routine use of screening questionnaires have little effect on detection or treatment.[8]

Since humans spend their entire lives in interactions with themselves and others, communication web in which they live, work, love and play shapes their own communication patterns and styles as they shape those of other. The communication patterns then determine how one feels, whether one experiences the symptoms, anxiety or even psychosis. While there are biological predispositions for how information flows are organized in the brain and about the different communication channels one has available for interacting with the outside world, due to the high plasticity and adaptability of the human brain significant modification, or in some cases even radical changes are possible. Internal and external communication patterns that lead to the symptoms of depression are no exception. While medication alters intercellular and intracellular information flows in relatively predictable ways, which leads to system-wide changes and responses to these changes, psychotherapy affects the more system-wide changes in intracranial communication through a voluntary connection with external sources of new, meaningful and hopefully beneficial information.

Dysthymia

Dysthymia, also called neurotic depression, dysthymic disorder, or chronic depression, is a mood disorder consisting of the same cognitive and physical problems as in depression, with less severe but longer-lasting symptoms. [9] The concept was coined by Robert Spitzer as a replacement for the term "depressive personality" in the late 1970s. [10]

From a communication perspective, the degree of the depressive symptoms does not matter that much. The basic patterns and how to treat them is largely independent of the intensity. (Haverkampf, 2013, 2017a)

Communication

Individuals on the outside withdraw from social life, while on the inside they often develop a sense of alienation from their sense of who they are as a person. Stable values and interests become covered up by various negative thoughts and doubts. This leads to a sense of disconnect with oneself and, in more pronounced cases, an absence of feelings and emotions. Other than the feeling of void in personality disorder, it is a gradual reduction to ‘non-feeling’. In some cases of agitated depression this can be accompanied by tensions or inner pressure, which, however, cannot be identified in terms of specific emotions.

Progression

It is a condition that can last over a long time, even an entire life, and it often reduces the affected individual’s quality of life significantly. It can occur once or reoccur in several episodes, with or without an apparent triggering event. As people become older, a depression may become chronic, go into partial remission or lead over seamlessly into a personal disorder with symptoms of depression.

The change in symptoms over time can offer helpful clues in respect to diagnosis and treatment. On one end, we have the reactive depression triggered by an external event, which usually has a very good prognosis and may only need psychotherapy, on the other end the symptoms of depression which are held up by a personality disorder, which often has a more uncertain prognosis. Medication should often be added in the more severe cases of depression, especially when a patient's ability to lead an autonomous and fulfilling life is greatly reduced.

Treatment

Depression has become treatable in most cases, but probably only a minority of those afflicted seek help. Severe depression can also lead to suicidal thoughts, which requires immediate professional help. A communication-focused approach has been described by the author elsewhere. (Haverkampf, 2017a) It works with internal and external communication patterns through awareness, reflection and experimentation. The internal communication helps the patient identify basic parameters, such as own needs, values and aspirations, which can then with improvements in external communication lead to a more actualized, satisfying and content life. An important pillar of this approach is that internal and external communication represent two sides of the same coin. The basic rules of communication are essentially the same, whether between individual cells, whole organisms or people, on the outside and on the inside.

Psychotherapy

A central problem of depression is that it leads to social withdrawal, which tends to worsen the depression. It cuts a person off from interactions with other people. These, however, are effective in countering the underlying problem in depression, the felt sense of a loss of meaningful communication with the world and oneself. It seems paradoxical that depression leads to a withdrawal something that could help counter the depression, but the reason is that the mind focuses inwards in an attempt to cope with the cognitive deficits and the emotional pain of the condition. Also, depression makes the world appear as a less friendly place, leading to a withdrawal in the sense of a self-defence mechanism. The result is a greater focus on the internal

communication, the thoughts circulating in one's head. But the internal communication is also disturbed because the connectedness with one's values and interests is reduced. Neurobiologically this can have to do with difficulties in retrieving information and associations from memory. To circumvent this, a strategy is to look with patients at things they enjoyed doing in the past and get them to become more active again. Activity also helps to increase communication between the patient and the environment.

The internal communication in depression can reinforce the negative feelings, leading to a vicious cycle and a worsening depression. It is important to remember that mental conditions are in some ways not that different from somatic conditions. Self-regulatory mechanisms break down. But it has also been argued that there can be an evolutionary benefit of such conditions as depression, schizophrenia and mania. The reasoning is that the focus inside in depression, the different association making in schizophrenia and the invincible feeling in mania can in small doses foster creativity, sensibility and new insights. To me it seems that the healthy version still requires that the individual is connected to the information in the self that makes goal-directed and coherent activities possible. Fundamental values and a sense of one's interests provide such information and being disconnected from it can lead into the endless ruminations and loops that make the individual even less active and more separated from the world around and inside.

A biological predisposition makes some people more susceptible in times of stress or heightened psychological pressures. A higher serotonin receptor density, for example, which leads to down regulation of the level of serotonin between the nerve cell endings (synapses) has been implicated in a higher probability to develop depression. It may be one reason why antidepressants which decrease the reuptake of serotonin between the synapses (SSRIs), and thereby increase the level of serotonin between the synapses, are effective in reducing the clinical symptoms of a depression.

The communication between client and therapist is both an indicator for the depression and a tool to treat it. Through the interaction with the client the therapist gets a sense for the depth of the depression. Since the depression impacts a number of functions, which not always have to decrease (as, for example, in the case of an agitated depression), the diagnosis can in some cases be more

straightforward than in others. It helps to remember that a depression can have biological, psychological and social factors, that often interact and amplify each other synergistically.

There may be an obvious trigger for the current episode of depression or even the onset of the depression as a whole, but in the more severe clinical depression often there is not. In the latter case, the onset of an episode of depression is often describes as a 'fog coming out of thin air and settling everywhere' that makes everything subjectively 'slow down'. The subjective element is important and underlines that in depression the perception of one's psychological functions and abilities in the world may be worse than they really are. A depressed state often colors the perceptions of oneself darker. Notwithstanding, concentration and other mental capabilities are often in psychological tests also objectively affected.

Communicating more effectively one's thoughts and emotions is an important way to make a depression bearable and deal with it effectively. This can lead to greater insights and skills to move forward in overcoming the depression and preventing relapses, but it may not be possible in severe cases and early stages of treatment. Analyzing what is underneath the depressed thoughts and feelings, the hopelessness and helplessness, the anger and sadness, or sense of void, often provides a feeling of getting in control again and can be very effective in dealing with the depression in a constructive way.

The depressed thought may give a clue about the things the client values and reflecting on it can facilitate a bridge between the inner world and one's sense of effectiveness in the outer world. Once a depressed thought is verbalized, it can be understood by another. This makes it less painful and can lead to actual change the client notices. This leads to greater faith in one's effectiveness and a greater sense of self-confidence.

Sometimes there may be no feeling at all, which, however, normally masks a whole panoply of feelings underneath. One might feel anger about an important person in one's life, find below that sadness, and further down a helplessness about being 'dumped' for no apparent reason, etc. This means restarting one's interactive capabilities may need a detour into the past, but with a clear sense of the future. Especially under a feeling of void and emptiness there can be a tremendous amount of issues that have never been adequately dealt with. They just cannot yet be

communicated to one's consciousness because they are associated with negative feelings, such as fear or anger.

The present has a special place because it is the only time frame in which actual change takes place. Depression can be a call for change, a property that often leads to fears and therapy avoidance in clients. However, once change looks beneficial, meaningful and relatively safe, the fear often disappears. The early change should be predominantly an internal change. I believe that if change feels good and is done gradually this is already a sign of leaving the depression behind and often a good sign. When clients get their social environment to support change, they already show an ability to interact with the environment that shows greater mental health.

Reintegration with society is important, particularly for those who also suffer from social anxieties, as long as there is a genuine interest in people. Humans need both, the communication with the outside world and the inside world, and the experiences from the interactions in one are used to reflect on the interactions in the other. Since our brains can process information in parallel and in different centers, 'self-communication' is possible and happens all the time. Depression is a state of reduced communication on the outside and the inside and facilitating more of it effectively reduces the depression. Communication is meaningful, and thus beneficial, if one sees a relevance to fulfilling one's values, needs and aspiration. If I am interested in a particular subject and find a challenging course at a local college, this can have an antidepressant effect. A relationship with someone who shares my values can also have an antidepressant effect. It is very much about the feeling to plug into humanity again.

The final step is to solidify the success by reflecting on the path travelled and identifying what helped and what did not. Since we all are different and carry entire worlds of experience and thought inside us it is often only possible to begin with some more general tools that work for most people, and then find what works in the individual case in the therapy sessions.

Medication

Medication in the form of antidepressants can be of significant help, especially in the early stages of a psychotherapy to facilitate the therapeutic process. (Haverkampf, 2017b) Physical exercise

has been shown to have a positive effect, as do activities that are enjoyable and take one's mind off negative thoughts and endless ruminations. Psychotherapy can identify causes of depression, reintegrate the client into the world and help build better patterns of communication with oneself and one's environment. This potentially lowers the likelihood of a future relapse. Studies have shown that a combination of medication and psychotherapy have the best long-term outcome, while psychotherapy is especially directed at the long-term.

There are several types of depression medications (antidepressants) used to treat depression and conditions that have depression as a component of the disease, such as bipolar disorder. These drugs improve symptoms of depression by increasing the availability of certain brain chemicals called neurotransmitters. It is believed that these brain chemicals can help regulate brain circuits that affect emotions.

Tricyclic antidepressants (TCAs)

Tricyclic antidepressants (TCAs) are some of the first antidepressants used to treat depression. They primarily affect the levels of two chemical messengers (neurotransmitters), norepinephrine and serotonin, in the brain. Although these drugs are effective in treating depression, they have more side effects, so they usually aren't the first drugs used.

Examples: amitriptyline (Elavil®, Endep®), clomipramine (Anafranil®), desipramine (Norpramin®, Pertofrane®), doxepin (Adapin®, Sinequan®, Zonalon®), imipramine (Tofranil®), nortriptyline (Aventyl®, Pamelor®), protriptyline (Vivactil®), trimipramine (Surmontil®)

Selective serotonin reuptake inhibitors (SSRIs)

Selective serotonin reuptake inhibitors (SSRIs) are a newer form of antidepressant. These drugs work by altering the amount or functioning of a chemical in the brain called serotonin.

Example: citalopram (Celexa®), escitalopram (Lexapro®), fluoxetine (Prozac®, Sarafem®), fluvoxamine (Luvox®), paroxetine (Paxil®, Pexeva®), sertraline (Zoloft®)

Serotonin and norepinephrine reuptake inhibitors (SNRIs)

Serotonin and norepinephrine reuptake inhibitors (SNRIs) are another newer form of antidepressant medicine. They treat depression by increasing availability of the brain chemicals serotonin and norepinephrine.

Examples: desvenlafaxine (Khedezla®, Pristiq®), duloxetine (Cymbalta®), levomilnacipran (Fetzima®), venlafaxine (Effexor®)

Serotonin antagonist and reuptake inhibitors (SARIs)

Serotonin antagonist and reuptake inhibitors (SARIs) are drugs that block neurotransmitter chemicals in the brain, such as serotonin or dopamine, thereby increasing serotonin levels.

Example: trazodone (Desyrel®, Oleptro®)

Monoamine oxidase inhibitors (MAOIs)

Monoamine oxidase inhibitors (MAOIs) are another early form of antidepressant. These drugs are most effective in people with depression who do not respond to other treatments. Substances in certain foods, like cheese, beverages like tap beer or certain wines, and some cough syrups and other medications can interact with an MAOI, so patients taking an MAOI must adhere to strict dietary restrictions and also avoid certain medications that can raise blood pressure. For these reasons, these antidepressants are not first-line antidepressants.

Psychotherapy and Medication

In mild cases of depression, especially the reactive kind, which is due to stressors in the environment, medication is often not necessary. All the work is done in psychotherapy. Working on what the patient values, is interested in and aspires to, as well as looking at strategies and patterns from the past which are no longer helpful, often ends the depression effectively.

In the more severe cases of depression medication is usually indicated. It not only brings substantial relief after a couple of weeks, but it also helps to make psychotherapy possible in patients with more severe depression. Psychotherapy requires communication, and if a patient is in a condition which does not allow this, psychotherapy is impossible. It is thus important to see the enormous benefit and mutual synergies a combination of psychotherapy and medication can have.

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