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# Bioethics Outlook

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### Autonomy and Ethical Treatment in Depression

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Antidepressant medication and evidence-based psychotherapy have largely equivalent efficacy in the management of the common, less severe grades of depression. As a result, several national guidelines recommend that either can be used in the treatment of this disorder. Psychotherapy, however, differs in that it assists insight into how the depressed person appraises and manages the stressors that frequently trigger depressive episodes. I argue that the self-knowledge achieved through psychotherapy has moral value in that it promotes the autonomy of stressor-related decisions. I further argue that such an effect comprises a compelling moral reason for doctors to see evidence-based psychotherapy not as merely optional, but as a necessary treatment for their patients with depression.

#### In this Issue

Dr Paul Biegler, an emergency physician and philosopher, is the winner of this year's Australian Catholic University Eureka Prize for Research in Ethics. Applications for this award are judged on following criteria: Scholarly Excellence, Originality, Relevance and Impact, Communication, and Consistency with the ethos of Australian Catholic University. In this issue, we republish a short version of the research for which he won this award. A longer version is to be found in his recently-published book *The Ethical Treatment of Depression* (MIT Press, 2011).

We also include a reminder about the renewal of annual subscriptions!

Finally, may we wish our readers well in this season of advent, the season which the great Australian priest and poet Peter Steele SJ calls the 'festival of warranted yearning'.

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## Introduction

On January 16th 2006, Geoff Gallop, then Premier of Western Australia, made the following statement:

*It is my difficult duty to inform you today that I am currently being treated for depression. Living with depression is a very debilitating experience, which affects different people in different ways . . . My doctors advised me that with treatment, time and rest this illness is very curable. However, I cannot be sure how long I will need. So, in the interests of my health and my family I have decided to rethink my career. My commitment to politics has always been 100 percent plus. I now need the time to restore my health and well-being. Therefore, I am announcing today my intention to resign as Premier of Western Australia.*<sup>1</sup>

Although a high profile example, Premier Gallop's predicament demonstrates two elements that are applicable to many people diagnosed with depression. Firstly, his depression occurred in the setting of a stressful life situation – the rigours of high public office are legion – which, in all probability, contributed to its manifestation. Second, a pressing judgment was called for, either to make efforts to deal with the stressful contingency, or to reduce exposure to it.

In what follows, I will argue that the mode of treatment in depression has a profound impact on how such decisions are made and that, as a result, a moral dimension emerges in the management of this disorder which, up to this point, has gone largely unrecognized. The argument turns on a precise construal of the way autonomy is undermined in depression, and so a significant proportion of the paper is devoted to this task. I go on to

show that the self-knowledge acquired through psychotherapy assists the person with depression to make more autonomous decisions in relation to the object, or trigger, of the depressed response. Further, the degree to which autonomy is promoted with psychotherapy exceeds that seen with its major treatment alternative, antidepressant medication. Finally, I argue that doctors have compelling moral reasons to promote the autonomy of depressed patients, and hence to accord additional weight to the option of psychotherapy when making treatment recommendations in depression.

## Depression and its current treatment

Depression carries an enormous social cost, measured both in monetary terms and in the anguish it causes its sufferers. One in five people will experience depression over a lifetime<sup>2</sup> and, at 4.4%, it was the fourth greatest contributor to the global burden of disease in the year 2000, the most recent study available.<sup>3</sup> It is not surprising, then, that considerable resources have been directed at the development and evaluation of effective treatments.

There are two principal management strategies. Antidepressant medication (ADM) has been increasingly widely prescribed since the introduction of the relatively safe Selective Serotonin Reuptake Inhibitors (SSRI) in the early 1990s. However the evidence-based psychotherapies, including Cognitive Behaviour Therapy (CBT) and Interpersonal Therapy (IPT), have also been shown to be efficacious in depression. Assessments of efficacy are

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gauged through instruments such as the Hamilton Rating Scale for Depression.<sup>4</sup> This yardstick measures the presence and severity of depression's diagnostic features, including lowered mood, suicidal ideation, significant weight change, insomnia, anxiety, poor concentration, loss of energy, agitation or psychomotor retardation, and diminished interest or pleasure in usual activities such as work or hobbies.<sup>5</sup> Major Depression of mild to moderate severity – the subject of this paper – encompasses five or more of these symptoms, experienced over at least a two-week period. Impaired social or occupational functioning is also required to make the diagnosis.<sup>6</sup> Efficacious treatments are those that reduce these classic symptoms of depression.

Following exhaustive reviews of a large number of controlled trials, various national guidelines have concluded that ADM and the evidence-based psychotherapies, especially CBT, have comparable efficacy in the less severe grades of depression.<sup>7</sup> Accordingly, practitioners have considerable discretion in the treatment that they ultimately recommend patients. Up to this point, however, ADM has proved to be the most commonly instituted alternative. For example, in Australia, around 80% of those with depression who seek treatment attend their general practitioner,<sup>8</sup> and roughly 80% of those are treated with ADM,<sup>9</sup> with less than 25% receiving a validated psychotherapy.<sup>10</sup>

While the reasons for this disparity are not wholly clear, it might appear to be little cause for concern. It is understandable that doctors who prescribe ADM for depressed patients are seen to have discharged their duty of care, given the established efficacy of this

management option. However, standard efficacy criteria fail to measure an important treatment effect. Successful psychotherapy engenders insight in the recipient about the nature and significance of the depressed response. Such insight, I will now argue, serves to advance patient autonomy, and is central to a differentiation, on moral grounds, between the two principal treatments for depression.

### **Autonomy: the importance of understanding material facts**

To appreciate the relative effects on patient autonomy of the various treatments for depression one must be able to quantify, with some degree of reliability, autonomy itself. While the major contemporary theories – hierarchical,<sup>11</sup> historical,<sup>12</sup> reasons-responsive,<sup>13</sup> and life-plan accounts<sup>14</sup> – make valuable contributions to our understanding, individually they are, at best, unwieldy clinical measures of autonomy. However, they do share a common denominator that is useful in this regard. Consistent emphasis is placed, in each theory, on the importance of an understanding of material facts for the autonomy with which related decisions and actions are made.

Faden and Beauchamp – whose authoritative work on medical informed consent pre-empted much legal reform – define materiality in the following way: ‘A material description is or would be viewed by the actor as worthy of consideration in the processes of deliberation about whether to perform a proposed action’.<sup>15</sup> For example, the small functional improvement that might result from surgery for a broken finger is unlikely to

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carry material significance to a professional boxer. However, for a concert pianist, such information holds clear importance.

That an apprehension of material facts is widely held to be necessary for autonomy is attested to by its prominence in the informed consent process, a standing that has been reinforced through common law across a range of jurisdictions.<sup>16</sup> Doctors offering interventions to patients are now, mostly, at pains to specify risks and benefits that are pertinent to the patient's concerns. This practice reflects the generally accepted, and legally endorsed view that what is material is ultimately a matter for the individual, reflecting that person's important goals, values and interests.

Given its general requirement, a failure to grasp material facts should raise serious questions about the autonomy with which associated decisions are taken. Moreover, given that it is possible to elucidate and quantify material facts, it is reasonable to see the degree to which they are understood as providing some measure of autonomy.

I aim to show now that a failure to comprehend material facts forms a principal basis of the impaired autonomy that characterizes many with depression. I want to be specific about how personal autonomy is eroded in depression so as to make clear, in a later section, how ADM and psychotherapy differ in their effects to promote autonomy in this disorder. To that end, I will demonstrate that emotional responses – depression included – are markers of *salience* in the events that trigger them. As a consequence, I will argue, information pertaining to those events carries material significance to the individual. I will then

show the nature of depression to be such that the sufferer is, in most cases, poorly placed to appreciate that information.

### **How depression undermines autonomy**

It is uncontroversial that depression can, sometimes dramatically, impair the autonomy of those so affected. In severe cases, when psychological and motor processes are slowed almost to standstill, the presence of diminished autonomy is incontrovertible. Yet in the less severe categories – our present concern – autonomy lapses can be more subtle and difficult to characterize. A starting point in discerning how depression undermines autonomy is to recognize that, while a disorder of emotion, depression possesses vestiges of the functionality that is common to healthy emotional responses.

### **Emotions as markers of salience in the environment**

A prevalent view amongst psychologists and philosophers is that emotions enable rapid detection of, and response to, events that are relevant to the agent's primary interests.<sup>17</sup> Ronald DeSousa uses the term 'salience' to describe this property of an environmental occurrence.<sup>18</sup> Such a view derives, in large part, from an evolutionary approach, which sees emotions as 'indexing' occurrences of value or disvalue in the surroundings, and promoting adaptive responses to them.<sup>19</sup> According to this account, in an earlier evolutionary environment positive emotions such as happiness, joy, or love, signalled an advantageous situation, for example, the procurement of food, shelter or a mate. In addition, a positive emotional response

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reinforced 'approach' type behaviours that secured the important goals at stake in these scenarios. Conversely, negative emotions, such as fear, sadness, and shame indicated disadvantageous circumstances like a predator threat, loss of a possession, or defeat by an opponent. Negative emotions strengthened desires to avoid a recurrence of such stimuli and motivated 'avoid' type behaviour in response to them. The evolutionary account suggests that emotions have been retained because they confer a survival advantage on our species.

The Appraisal Theory of psychologist Richard Lazarus builds on an evolutionary view in proposing that emotions signify the agent's principal interests to be at issue in an emotion-provoking occurrence. As Lazarus has put it, '[T]he minimal cognitive prerequisite for an emotion, any emotion, is that one senses a goal-related stake in the encounter'.<sup>20</sup> On this view, emotions contain, or are precursors to, evaluative judgments about whether given contingencies are likely to benefit or hamper the individual's important concerns. Consider the example of a husband who becomes jealous after perceiving his wife to be seducing another man. The presence of jealousy is instructive in two ways. Firstly, it indicates the husband to have a strong investment in his marital relationship. If no emotion were generated, a serious question would be raised as to the strength of his feelings, or commitment, towards his wife. Second, the emergence of jealousy suggests an evaluation has been made that the observed behaviour poses a threat to the stability of the marriage. According to Appraisal theory, if no such 'interest-oriented' evaluation has occurred then the possibility for subsequent emotion is minimal, or absent.

## **Salience, materiality and autonomy**

The relevance of Appraisal Theory for autonomy is that, by noting the strong bearing an emotion-eliciting event has on interests, it suggests that factual information pertaining to such an event would be material to the agent. The information is material because it contributes to the evaluations that ultimately guide behaviour aimed at preserving the significant interests at stake. Following this, greater autonomy will likely ensue in cases where accurate emotional evaluations are viewed as such by the individual, but also in cases where dubious evaluations are treated with a requisite degree of suspicion. Whether the jealous husband decides to confront his wife, accost the other male, cast doubt on the future of the relationship, or none of these, hinges, in large part, on the credence he accords his jealous assumptions. How realistically the husband views his emotion-driven cognitions has relevance for the autonomy of whatever course he decides to take.

But when ought someone to take her emotional appraisals at face value, and when should she view them with scepticism and perhaps try to delay action until their veracity has been determined? One possibility is to take note of a particular emotion's track record in terms of action-guiding utility. If anger or jealousy has led one astray many times in the past, then later judgments made under the same influence might justifiably be held at arm's length until a fuller appreciation of the facts is reached. Another means is to identify when emotions have become disordered. In these cases, as I will now describe with reference to depression, emotions give

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rise to false appraisals with much greater frequency than normal.

### **Depression: disordered appraisals of salient events**

Depression lies at the dysfunctional end of a spectrum that includes normal emotions. In fact, Lewis Wolpert has eloquently described depression as 'malignant sadness'.<sup>21</sup> I want to argue that depression retains some aspects of the appraisal function of its healthier cousin, sadness. Showing depression to possess this characteristic supports the further claim that accurate information concerning its trigger will be material to the depressed person. However, I will also show that perceptual biases make it difficult for the person with depression to glean that information.

Depression has been shown, in nearly 70% of cases, to be triggered by stressful life events, which share themes of loss, social rejection, thwarted ambitions and disempowerment.<sup>22</sup> For example, in a study by Kenneth Kendler and colleagues,<sup>23</sup> common precipitating stressors included divorce or separation, assault, financial difficulties, housing problems, job loss or other serious work issues, illness, death of a family member and interpersonal conflict.

The robust nature of the stressor-depression relationship is supported by emerging research, which has identified a plausible underlying neurobiological mechanism. Elevations of the hormone cortisol, released as part of the stress response, appear to cause damage to the hippocampus, a structure in the brain's limbic system, the site where emotions are processed.<sup>24</sup> Hippocampal atrophy is a frequent finding in depression,<sup>25</sup> and may well be responsible for many of its

symptoms.<sup>26</sup> Cortisol has also been shown to reduce levels of the neurotransmitter serotonin, which plays a major role in the aetiology of depression.<sup>27</sup> Cortisol is, therefore, at least one of the likely mediators of a depressed response to stressors.

It must be said that for a stressor to trigger depression, an appropriate 'diathesis', or degree of vulnerability, must be present. Other work by Kendler and colleagues<sup>28</sup> points to early life adversity, including abuse, parental loss, and a disruptive family environment, as a predictor of later depression risk. In addition, there is increasing evidence of a genetic element predisposing the individual to become depressed in the face of stressors.<sup>29</sup> However, it is apparent that depression is, frequently, not an isolated disorder of brain chemistry but is very much contextual and a response to circumstances. For this reason, it is possible to view depression as retaining something of an appraisal function, in common with healthier emotions. Depression signifies, in many cases, that an event or situation has been judged as onerous. Given the kinds of stressors implicated in the cited study by Kendler and colleagues,<sup>30</sup> such an evaluation will frequently be justified. However, and contrasting with normal sadness, events in depression are deemed taxing to the point where the individual's coping resources are overwhelmed. As a result, while a negative assessment is mostly appropriate, depression is a dysfunctional response that hinders the deployment of strategies to deal with the demands of the situation.

That depression commonly indicates the presence of a threat to interests suggests the argument put forward here – that facts concerning the object of an emotion



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carry material significance – applies to depression, despite its status as an emotional disorder. I want to suggest that three aspects of the stressful circumstances that often bring about depression might be material to the depressed person.

### **The materiality of stressors in depression**

Firstly, it will be pertinent to most with depression to understand *how* stress triggers depression. The action of ‘mood congruent’ information processing biases means those with depression tend to recall preferentially and engage more with negatively toned information.<sup>31</sup> For example, if there have been many pleasant encounters with an acquaintance, but one distressing contact, a depressed mood favours consideration of the unpleasant meeting. The negative encounter will typically be given disproportionate weight in deliberations about, for example, whether to contact that person. The undue significance attached to negative data in depression often leads to predictions that are unrealistically pessimistic.<sup>32</sup> In addition, depressed thinking is characterized by ‘negative attributional style’, which describes a propensity for self-blame in the face of negative outcomes.<sup>33</sup>

Negative biases impact on the way stressors are addressed in depression. The outcomes foreseen for stressful events are excessively poor. The individual also tends to overestimate her role in generating the adverse result, and underestimate her capacity to rectify it. Insight into the actions of mood congruent biases is possible – knowledge that can alter the decisions that are made

in relation to stressors. As a result, such information will, very likely, be material to the person with depression.

Second, it will have consequence for most with depression to know *that* stress can trigger the disorder. In general, those with an illness wish to know something of its aetiology, especially causal agents that can be addressed. For example, the ill effects of cigarette smoke are noteworthy for the asthmatic because that knowledge affords a means of improving the condition. Similarly, the causal role of stressors warrants consideration by those with depression who are, for example, contemplating demanding new roles, or considering how best to delegate exacting tasks.

Finally, people with depression will have an interest in *what* they can do to manage stressful life events. Recall that the individual has much at stake in the stressful circumstances that trigger depression. Depression is undesirable not just because it brings distressing feelings, but because it signifies an unproductive response to threatened goals. Those who deal with relationship problems, financial difficulties, or work issues in a way that heightens their risk of depression jeopardize the interests that are tied to each pursuit. Therefore, knowledge that an alternative and more adaptive response to these hurdles can be mastered will, in all likelihood, be material to them.

### **Failure to appreciate the role of stressors undermines autonomy in depression**

Depression diminishes autonomy in large part through the negative information-processing biases that skew judgments towards pessimism. False perceptions are

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antithetical to autonomy on most, if not all accounts. Yet I want to suggest that a failure to *understand* how negative biases act, and the influence of stressors, are also central to the erosion of autonomy in depression.

The presence of pessimistic biases is seldom transparent to the person with depression. Susan Andersen and colleagues describe how negative forecasts are held with increasing conviction as depression worsens until there is, '[D]epressive predictive certainty, the point at which dreaded future events are treated as certain to occur or that desired future events are treated as certain not to occur.'<sup>34</sup> That dire and false predictions are taken at face value in depression implies a lapse in 'metacognitive awareness'. This term describes a 'stepping back' from one's thoughts and feelings in order to monitor their correlation with reality.<sup>35</sup> Accepting the materiality of the biases that distort stressor appraisals in depression, a failure of insight here undermines the autonomy of stressor-related decisions.

There is also evidence that many depressed people do not appreciate the role of stressors in this disorder. Studies suggest that up to one-third of those with depression believe it to be a primary disorder of brain chemistry that is independent of the effects of external events.<sup>36</sup> Further data suggest that some physicians might reinforce such beliefs. In a qualitative survey of twenty physicians, one expressed the view that depression was 'no different to diabetes', an analogy endorsed by eight respondents.<sup>37</sup> In the same study, a physician described depression as a 'neurotransmitter deficiency' and another told patients that antidepressants would correct a 'chemical problem in [their] nervous systems'.<sup>38</sup>

Undoubtedly, there are brain chemistry changes in depression. However, that psychosocial stressors can effect these brain changes is germane to the autonomous decision-making of those with depression.

Finally, it is plausible that the depressed person could see the effective management of stressful circumstances as unachievable. Feelings of hopelessness can make, for example, financial disarray or marital disputes seem irremediable.

To summarize, aspects of the stressor-depression relationship are likely to be material to the depressed person, but there are good reasons to think they will be poorly understood. The autonomy of stressor-related decisions in depression is thus undermined. It is instructive to apply these findings to the case of Premier Gallop, described in the introduction. It is reasonable to suppose that knowledge of an aetiological role for stress in depression would have serious implications for his decision to step down. Identifying stress as a risk factor for a potentially severe and recurrent psychological disorder is crucial to a decision to remain in, or withdraw from, a stressful occupation. Similarly, understanding that strong negative affect can generate excessive pessimism might lead to the postponement of major decisions until depression has improved. Also, awareness of techniques for managing stressful contingencies would be central to deliberations on whether or not to remove oneself from a stressful environment. In the light of the materiality of this information, there are good reasons to see diminished autonomy in decisions taken without its full understanding.



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## The effects of psychotherapy and antidepressant medication on autonomy in depression

### Psychotherapy and autonomy

CBT is the evidence-based psychotherapy most frequently instituted in depression. The therapist explains the action of negative biases and teaches strategies to 'de-bias' the judgments that are coloured by them.<sup>39</sup> This approach uses 'collaborative empiricism', whereby therapist and patient explore the rational underpinnings for bleak predictions.<sup>40</sup> The patient is encouraged to disown those that do not bear scrutiny, and to employ a similar tactic when pessimism recurs. Through metacognitive awareness, scepticism about the validity of depressed thoughts can lead to more realistic evaluations. In addition, behavioural techniques stress adherence to a schedule of activities. Some enjoyment usually results, providing experiential reinforcement for the falsity of negative predictions. CBT also aims to identify stressors and uses problem-solving skills to manage them.<sup>41</sup> In short, evidence-based psychotherapy promotes autonomy by imparting information that, I have argued, is material to those with depression.

It is worth noting that the insights achieved through psychotherapy have not been definitively shown to mediate its therapeutic effect in depression. The few studies that have addressed this issue have found some, but not conclusive, evidence for a causal link between the cognitive changes experienced in therapy and the amelioration of depressive symptoms.<sup>42</sup> However, given the materiality of the information gleaned through evidence-based psychotherapy, the absence of a categorical link does not,

I contend, vitiate the autonomy claims made here.

### Antidepressant medication and autonomy

Without question, ADM can also promote autonomy in depression. In severe depression slowed psychomotor function can make direct targeting of neurochemistry a necessary intervention. There is also evidence that ADM might act to reverse negative biases. In one of the few investigations of the neuropsychological mode of action of ADM, Catherine Harmer and colleagues showed that, in healthy volunteers, ADM increases perception of events with a positive emotional valency and reduces processing of negatively toned material.<sup>43</sup> These data suggest that ADM might act to 'de-bias' negative attributions and pessimistic predictions to a similar extent as psychotherapy.

However, ADM acts without any requirement for insight into the role of stressors or negative biases, underpinning what I contend to be the autonomy-promoting advantage of psychotherapy. To put this claim in perspective, consider the course that depression tends to run. Up to 80% of those diagnosed with depression can expect a recurrence,<sup>44</sup> leading some to advocate that it be managed as a chronic disease.<sup>45</sup> The majority of people with depression can, when recovered, expect each future stressful event to pose a threat to their depression-free status. It is plausible that psychotherapy helps people to identify those situations presenting a depression risk, to be circumspect about taking dire predictions at face value, and to invoke problem-focused strategies to manage the stressor. A more realistic appraisal of the stressor is achieved, and thus greater

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autonomy in the ensuing deliberations to deal with it.

There is, however, a further issue that requires clarification. It is known that ADM can stimulate growth of neurons in the hippocampus, the brain structure whose atrophy has been implicated in depression.<sup>46</sup> If ADM can reverse neuronal damage that co-occurs with depression, does that imply a therapeutic advantage? If so, has the autonomy promotion associated with ADM use in depression been understated here?

There are several reasons to be cautious in accepting such a claim. Firstly, it is known that altered environment can also stimulate hippocampal neuron growth. Rats reared in isolation have a smaller hippocampus than those reared in group situations, an effect that is reversed when the isolated rats are moved into groups.<sup>47</sup> Moreover, this type of environmental enrichment can benefit rats with depression-like behaviour that has been experimentally induced.<sup>48</sup> In addition, exercise, which can improve depression in humans, also causes hippocampal growth and reduces depressive behaviour in animal models.<sup>49</sup> It is known, too, that Cognitive Behavioural Stress Management, a form of psychotherapy related to CBT, improves depression and reduces levels of cortisol, the hormone suspected to cause hippocampal damage in depression.<sup>50</sup> Such an effect might well indicate a degree of hippocampal protection conferred by psychotherapy. Finally, there is early evidence that CBT might be superior to ADM in preventing depressive relapse.<sup>51</sup> Taken together, these findings suggest that hippocampal effects in treated depression might not be exclusive to ADM action and do not necessarily justify seeing ADM as holding

an advantage in therapeutic effect, or in ability to promote autonomy.

## **Implications for clinical practice**

The argument put forward holds evidence-based psychotherapy to be superior to ADM in promoting the autonomy with which the depressed person makes important life decisions. This property of psychotherapy, I will now argue, provides reason to see it not as merely optional, but as a necessary treatment in depression. A starting point is to explain why autonomy is valued in the healthcare setting.

## **The value of autonomy**

Autonomy is generally accorded value on two counts. On a utilitarian view, autonomy has instrumental value in that it leaves the agent well placed to advance her prudential concerns. This account is predicated on a subjective conception of the good, where the agent's rational and informed preferences are deemed the best indication of her important interests.<sup>52</sup> The substantially autonomous individual is well placed to form, and act on, such preferences.

An alternative approach describes the intrinsic value of autonomy. On this view, autonomy is a valuable trait independent of the benefits or burdens that might flow from its exercise. Jonathon Glover provides an illustration in the following passage.

Suppose people's marriage partners and jobs were chosen by experts, and that studies showed a far higher level of satisfaction among those whose marriages and jobs were so chosen than among people who make their own arrangements. Even so, many of us would

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prefer to forgo a great deal of happiness, or risk a fair amount of disaster, to losing control of our lives in this way.<sup>53</sup>

The value of autonomy grounds a contention that it ought to be promoted in those with depression. However, a corollary of understanding autonomy to have intrinsic value is the recognition that autonomy promotion can assist, but does not equate to, advancement of patient interests. As a result, showing psychotherapy to promote autonomy more ably does not, at the same time, give rise to a duty from beneficence for physicians to recommend it. However, there are other reasons to think such an obligation exists.

### **Consistency**

Autonomy is already accorded great importance in healthcare. Respect for personal autonomy is now a cornerstone of ethics and the law in medicine. It is the principle grounding informed consent as well as the right of competent patients to refuse proffered medical treatment, even when the treating physician believes it to be in the patient's best interests. Doctors who take autonomy seriously when adhering to these practices would be inconsistent, I contend, if they failed to value the autonomy conferred by psychotherapy in depression.

Moreover, physicians already recommend treatments that aim largely at promoting patient autonomy. Take the example of insulin-requiring diabetes. Most cases can be managed by monitoring blood glucose and adjusting insulin doses in consultation with a health professional. However, there has been a recent move to 'Diabetes Self-Management Education' (DSME).<sup>54</sup> The patient learns the effects of various food types on blood glucose, how exercise

reduces glucose levels, that weight loss can diminish insulin requirements, as well as general nutritional principles. Instead of merely keeping blood glucose steady with insulin, patients are informed of a range of options for dealing with the illness. Although DSME aims to improve patient well-being, that beneficent motivation is paired with the goal of enhancing autonomous choice. DSME can be seen as a precedent for the management of depression. It suggests that physicians ought to place additional value on a depression treatment that, of the available effective alternatives, better promotes patient autonomy.

### **Proportionality**

It is well accepted, too, that medical therapy ought to be proportionate to the severity, and the chronicity, of the illness it is intended to treat. For example, a minor respiratory infection is adequately treated, in most cases, with oral antibiotics. Once the individual has recovered, no further treatment is usually necessary. However, in more serious respiratory illness, such as emphysema, the affected person will be provided with a range of therapies including medication, chest physiotherapy and, sometimes, home oxygen. There is a clear distinction drawn between the management of minor, self-limiting illness, and that of more severe conditions affecting the individual over the long term.

The neuropsychological processes that colour judgment and engender pessimism in depression undermine autonomy to a significant degree. Moreover, the chronicity of depression – exemplified by its high recurrence rate – means that the threat to autonomy is, for most sufferers, ongoing. These observations suggest that in depression a therapy that promotes

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autonomy to a greater degree, and which the individual can deploy over the longer term, is a proportionate and warranted response.

## Competing principles

In making treatment recommendations to patients, doctors are guided by a number of principles. Reason to place less emphasis on autonomy as a goal of treatment is the presence of another principle that carries equal or greater weight in the relevant circumstance. Some potential competing principles in the management of depression warrant consideration.

### (i) Beneficence

There are cases where the doctor's duty of beneficence will trump autonomy promotion as a treatment determinant in depression. For example, the patient might prefer to take ADM, perhaps viewing it as easier or less time-consuming than psychotherapy. If such a preference is considered and rational, good reason exists to see ADM as the alternative of choice on beneficence grounds.

Beneficence might also favour the use of ADM if psychotherapy is unavailable or cannot be accessed within an appropriate time frame. Also, for some individuals ADM alone, or in combination with psychotherapy, might have a greater chance of being effective. In such cases a principle of beneficence would again appear to be the best guide to treatment. Conversely, if CBT turns out to be superior in reducing relapse,<sup>55</sup> it could claim the

status of first line treatment for efficacy reasons alone.

However, although individual cases may vary, the best current evidence suggests that ADM and psychotherapy are equally effective for most people with less severe grades of depression. Appeals to beneficence can, in these cases, be made to justify *either* treatment. As a result, considerations of beneficence do not, in general, limit the obligations that flow from the autonomy-promoting properties of psychotherapy.

It is important to acknowledge that other forms of psychotherapy may be effective in depression, despite less prolific evidence for them. Should questions of effectiveness be resolved in relation to these therapies, and if they are shown to engender the kind of self-knowledge that I hold to carry material significance for those with depression, the autonomy-based argument made here would, all else being equal, apply to those therapies.

### (ii) The proper goals of medicine

It has been suggested that autonomy promotion as a goal of treatment goes beyond what might be considered the legitimate aims of healthcare. For example, a multinational task force examining the goals of medicine had this to say:

*While it is true that health does enhance the possibility of freedom, it is a mistake to think of such freedom as a goal of medicine. Health is a necessary, but not sufficient condition for autonomy, and medicine cannot supply that sufficiency.*<sup>56</sup>

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The statement suggests that autonomy promotion is a by-product of the delivery of healthcare. It sees autonomy as proximate, but subordinate to the more traditional goals of symptom amelioration and the correction of pathology. Yet, it is increasingly evident that the promotion of autonomy is often necessary to understand *what health is* for the particular individual. The practice of diabetes self-management – alluded to earlier – is pertinent here. While one person diagnosed with diabetes might be content to continue with insulin, another might opt for exercise, weight loss, and dietary measures, with less need for medication. In such cases, it is reasonable to view autonomous choice as defining the properties of a healthy outcome for each individual. Accepting that the goals of medicine and autonomy are, in many cases, closely aligned, provides reason to view autonomy promotion as an appropriate goal of depression treatment.

It might be objected here that in some situations the degree of autonomy that I advocate constitutes an unrealistic ideal. Not everyone is capable of achieving the kind of critical self-insights that have been described. The point is conceded, but care must be taken not to use assumptions concerning individual capacities as a justification for paternalism. It seems reasonable that, unless a person clearly lacks cognitive capacity, conclusions of an inability to master the skills of psychotherapy ought to come after empirical assessment. This, and the importance of the self-understanding at stake, suggests that a trial of psychotherapy should at least be offered, and preferably undertaken, by the person with depression.

A further point to consider is whether respect for autonomy compels doctors to

accede to competent requests for ADM by depressed patients. If this claim is legitimate, and my general argument is accepted, it leads to the somewhat uncomfortable conclusion that respect for autonomy mandates autonomy *not* being promoted in such cases.

I do find this objection compelling in that reason suggests autonomous individuals ought to be arbiters of the value they attach to the facility of autonomy itself. Admittedly, strong liberal utilitarian arguments have been made against the moral permissibility of agents *undervaluing* personal autonomy through, for example, selling themselves into slavery. But the same arguments do not obviously hold for agents who resist *promoting* what might be deemed their already adequate degree of autonomy. However, while respect for autonomous patient wishes might limit delivery of psychotherapy in individual cases it does not necessarily overturn a normative case for the value of autonomy promotion more generally in those with depression.

### **(iii) Cost-benefit considerations**

A further concern is that autonomy promotion through psychotherapy might run counter to cost benefit considerations. It is true that the cost of a course of CBT – in Australia, \$750 with a psychologist in the public healthcare system – outweighs that of a standard course of SSRI ADM at \$250–\$500.<sup>57</sup> Prima facie, if both treatments are of equal efficacy, then ADM appears to be more cost effective. However, when treatment effects are gauged in terms of Disability Adjusted Life Years (DALY), a measure of the number of healthy years an individual loses to a particular disease,

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psychotherapy compares favourably to ADM. For example, in a recent Australian study treatment with an SSRI ADM cost \$14000 per DALY saved compared with \$10000/DALY for CBT with a public or private psychiatrist, \$8500/DALY for CBT with a private psychologist, and \$3500 for CBT with a public psychologist.<sup>58</sup> These figures suggest that cost concerns do not represent a serious challenge to the autonomy-based argument presented here.

However, the figures do give cause to wonder why, if the cost-benefit profile of CBT compares so favourably with that of ADM, the latter remains the prevalent treatment in depression. It may be that its simplicity and ease of administration make ADM attractive for pressured doctors with full waiting rooms and for patients with busy lifestyles. A shortage of therapists trained in evidence-based psychotherapy is a further possible explanation.<sup>59</sup> Whatever the cause, if the ethical argument for CBT is found to be persuasive, this state of affairs is not just economically puzzling but morally problematic, and its origins promise a fruitful avenue for further research.

## Conclusion

Doctors who treat depression are undoubtedly dealing with people who have disordered brain chemistry. *Prima facie*, it might seem that the required treatment ought to be a drug that directly targets neurotransmitters, such as ADM. However, it is critical to remember that many brain chemicals involved in the regulation of emotion are exquisitely sensitive to environmental change, and in

particular, to stressors. Brain chemistry and emotion are context-dependent. While acknowledging that many depressed people benefit from ADM, these observations emphasize the value an alternative, or additional approach, one that addresses the context in which the disordered emotion has arisen.

I have argued that an important ethical difference exists between the pharmacological and psychotherapeutic approaches to treating depression. I argue that the difference is grounded in the understanding that is engendered in the depressed person through therapy, and that is largely ignored in purely drug-based management. That understanding has ethical weight in that it augments the autonomy of the depressed person's important decisions and actions. It does so by apprising her of material facts about the contextual basis of depression. In particular, therapy furthers an understanding that stressors can trigger depression, how that effect is mediated by negative biases, and what the individual can do to better manage stressful life events. The resulting autonomy gains, I argue, are greater than those achieved through treatment with ADM alone.

Given the importance already accorded patient autonomy in medicine, and the gravity of the threat to personal autonomy posed by depression, this property of psychotherapy provides a strong moral reason to see it as a necessary treatment in this disorder. As a consequence, the current rates of psychotherapy delivery in depression ought to be viewed as inadequate and, therefore, cause for serious concern.





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