# DEPRESSION

## characterisation, classification & diagnosis: clinical characteristics

- **clinical depression:** patient must display **persistent low mood** for over 2 weeks & 5 other symptoms
  - **emotional symptoms**
    - extreme feelings of sadness, hope & despair
    - loss of interest in previously enjoyed activities
  - **physiological symptoms**
    - weight loss or gain over several weeks
    - drastic changes in sleep pattern (hypersomnia, insomnia)
  - **cognitive symptoms**
    - recurrent suicidal thoughts
    - excessive guilt over real or imagined deeds
  - **behavioural symptoms**
    - observable agitation (e.g. restlessness, wringing of hands, pacing)

## characterisation, classification & diagnosis: diagnosis

### benefits

<table>
<thead>
<tr>
<th>treatment</th>
<th>support</th>
<th>understanding</th>
</tr>
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<tbody>
<tr>
<td>medication &amp; professional help to improve</td>
<td>others diagnosed with same condition &amp; friends/family</td>
<td>of selves &amp; from others</td>
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### issues

#### INDIVIDUAL AFTER DIAGNOSIS

- **labelling**
  - self identity/behaviour determined/influenced by terms used to classify them
  - become self fulfilling prophecy
  - attaches stigma to patient
  - treated differently - worsening condition
  - issues with employment

- **sick role**
  - patient adopts expected behaviour of someone who is ill
  - may change perception of self to a negative cycle
  - demotivating to improve condition
  - obsessive focus on illness

#### CO-MORBIDITY & DIAGNOSIS

- when an individual suffers more than 1 disorder
  - important to identify **primary disorder - root cause** of second
  - primary treated first, so secondary also cured

#### GENDER & DIAGNOSIS

- **women 2x more likely** to be diagnosed
  - more socially acceptable for women to express their emotions
  - more likely to seek help & be diagnosed
- different diagnosis rate for men & women not a genuine difference in incidence of depression
- **men** need to be aware asking for help is not a sign of emotional weakness
CULTURE & DIAGNOSIS

- **cultural relativism**: the belief that mental disorders need to be understood in context of culture of sufferer

**DAVIDSON & NEAL**
- Asian cultures praise no expression of emotional turmoil
- display physical symptoms of depression

**KUA**
- 72% people in China presented with chest/abdominal pain or headaches later found mental health issue
- mental health **classification systems** must be **relative** to common symptoms in that **culture**
  - can't use **westernised ICD/DSM** manuals across eastern cultures - less valid as diagnosis tool
  - western systems may not diagnose eastern patient

characterisation, classification & diagnosis: classification systems

- **DSM-IV**
  - diagnostic & statistical manual of mental disorders
  - published by American psychiatric association
  - list of mental health disorders
  - patients rated on multiple dimensions & diagnostic categories

- **ICD-10**
  - international statistical classification of diseases & related health problems
  - published by WHO
  - medical classification list

RELIABILITY - consistency

- how far the classification system produces the **same diagnosis** for a particular **set of symptoms**

- **inter-rater reliability**
  - the extent to which 2+ diagnosticians would arrive at same diagnosis with the same individual

- **BECK - inter-rater reliability**
  - looked at inter-rater reliability between 2 psychiatrists
  - 54% - 71/154 failed to diagnose in the same way
    - temporal validity - 1961 - manuals have evolved since then

- **reliability of DSM** when diagnosing depression in clinical interview

**EVALUATION OF RELIABILITY OF DSM**

<table>
<thead>
<tr>
<th>study</th>
<th>sample</th>
<th>type of reliability</th>
<th>correlation coefficient</th>
<th>evaluation</th>
</tr>
</thead>
</table>
| **ZANARINI** (2000) | 52     | **external reliability**         | +0.61 moderate correlation | 7 day test retest
  - good day/bad day |
| **ZANARINI** (2001) | 45     | **researcher reliability**       | +0.90 strong correlation  | difference in sample size could affect correlation
  - difference in observation could affect diagnosis |
| **LOBBESTAEL** (2010) | 151    | **researcher reliability**       | +0.66 moderate correlation | demand characteristics |
**external reliability** (Zanarini 2000)

+ consistency moderate
  - consistency to diagnose 1 patient 2x with same psychiatrist using DSM moderate (+0.61)
  - still low
    - would not accept correlation coefficient when diagnosing physical illness
> mental health more vague
  - can't expect high correlation coefficient as can't see/test mental health in same way

**researcher reliability** (Zanarini 2001, Lobbestael 2010)

+ consistency strong
  - consistency to diagnose 1 patient 2 times with different psychiatrist using DSM stronger (+0.66-91)
  - should be higher
    - patient may not get correct treatment

**overall**

- reliability diagnosing depression low anyway
  - patient statements not representative
    - differ from time to time/psychiatrist to psychiatrist
  - may give vague responses/may be misinterpreted
  - symptoms change daily

**VALIDITY - accuracy**

> whether the classification system is **measuring what it's supposed to** measure

- **concurrent validity**

  - the extent to which a diagnostic manual correlates with an already valid one

  - **WITTCHEN - depression screening - DSM vs ICD**
    - asked 20,421 patients aged 15-99 to fill out depression screening questionnaire
      - 4.2% fulfilled criteria for major depression - DSM
      - 11.3% fulfilled criteria for major depression - ICD
      - 2-3x more diagnosed using ICD
        - ICD takes minor depression into account//DSM higher threshold for diagnosis

- **concurrent validity**

  - low concurrent validity between classification systems
    - 2-3x diagnosis with ICD
biological explanations of depression: genes

- seems to be a link between biological closeness of the relationship & likelihood of developing depression

- **role of gene 5 HTT**
  - codes for serotonin transporter protein gene
  - transports serotonin from synapse to presynaptic neurone
  - long & short variants
  - **CASPI - short variants**
    - found shorter variants more likely to become depressed after environmental stress
    - objective, scientific measure
    - triggered by environmental stress
    - diathesis stress model - purely biological theory reductionist

WEISSMAN - family
  - 2x number of cases of depression in 1st degree relatives of sufferers than not
  - figure higher in females
  - suggests genetics possible cause of depression as more likely to develop if closely related

McGUFFIN - twins
  - studied 214 pairs of twins
  - 1 or both treated for depression
  - MZ = 46% // DZ = 20% concordance rate

ALLEN - twins
  - MZ = 40% // DZ = 11% concordance rate
  - suggests genetic link as concordance rate higher in MZ twins who share 100% genes

WENDLER - adoption
  - biological relatives of adopted sufferer 7x more likely to have depression than adoptive relatives
  - shows biological predisposition as genetic link determined depression over influence of environment (upbringing)
  - would be expected to have inherited shorter variant of gene
  - however, triggered by environmental stress - adoption

REDUCTIONIST
  - explanation reduces complex set of behaviours to a **oversimplified** explanation (gene 5 HTT)
  - explanation too simple to account for all aspects of depression
    - may limit understanding of all contributing factors (e.g. environment)
    - limits further research
  - stress diathesis model - interaction of factors better explanation
  - can help treatment
    - identifies main cause - biological treatments effective & appropriate in most cases
### Biological Explanations of Depression: Biochemical

- **Genetic factors influence** the amount of **catecholamines**
  - Group of neurotransmitters - noradrenaline, dopamine, serotonin

- **Depression caused by deficit** of neurotransmitters at brain synapses
  - Too much **MAO-A** activity
    - Enzyme that breaks down neurotransmitters not reuptaken by presynaptic neurone
    - Too much broken down = not enough taken up by receptors
  - **Reuptake** of neurotransmitters **too efficient**
    - Not enough reaches receptors
  - Too little neurotransmitters **produced**
    - Not enough to have effect
  - **Low sensitivity** of receiving neurone
    - Not enough receptors = not enough taken up

#### WENDLER & KLEIN - Drugged Rats

- Administered drugs to rats which lowered noradrenaline
  - Rats became sluggish & inactive
  - **Supports catecholamine hypothesis** as suppressing levels of neurotransmitter noradrenaline caused rats to show symptoms of depression

#### ANTIDEPRESSANTS - Reboxetine & Prozac

- Drugs have immediate effect on levels at synapse, but take 2-4 weeks to alleviate symptoms
  - Reboxetine increases noradrenaline levels by inhibiting reuptake
  - Prozac increases serotonin levels by inhibiting reuptake
  - **Supports theory** as increasing availability of neurotransmitters decreases depression

#### MINTUN - Brain Scan of Serotonin Receptors

- Used a PET scan to compare brain activity of depressed/non-depressed
  - Marked serotonin receptors with chemical tracer (altanserin)
  - Depressed people fewer serotonin receptors throughout the brain
  - **Supports theory** as fewer receptors = less serotonin uptaken, leading to lower levels of neurotransmitter

#### Reductionist

- Explanation reduces complex set of behaviours to a **oversimplified** explanation (gene 5 HTT)
- Stress diathesis model - interaction of factors better explanation
  - Can help treatment
    - Identifies main cause - biological treatments effective & appropriate in most cases
## Biological Treatments for Depression: Drugs

### TCAs/Tricyclics
- Block reuptake of noradrenaline & serotonin

### SSRIs/Selective Serotonin Reuptake Inhibitors
- Block reuptake of serotonin

- Increases levels of neurotransmitters in body as less taken up by presynaptic neuron

## Effectiveness

### TCAs vs SSRIs

#### AROLL - Drugs vs Placebo
- Both TCAs & SSRIs both produced significant reduction in depressive symptoms compared to placebo

#### SSRIs Only Work in Severe Cases

- KIRSCH - SSRIs vs Placebo
  - SSRIs only more effective than placebo in severe cases
    - Could be because placebo offers less depressed people hope, lessening symptoms
    - Severely depressed patients - expectation of effective treatment gone, removing placebo

#### not a long term answer

- DERUBLIS - SSRIs vs Cognitive Treatment
  - 58% in both groups reduced symptoms

- HOLLON - Relapse Rates
  - Cognitive - 31% relapsed
  - Drugs throughout - 47% relapsed
  - Drugs discontinued - 76% relapsed
  - Long term effectiveness low - drugs reduced relapse, but combining with cognitive worked much better

#### Publication bias

- In favour of medication as treatment
  - Cheaper, quicker & easier than cognitive treatment
  - Favoured by doctors - waiting lists long & quick treatment often needed

## Appropriateness

### TCAs vs SSRIs

#### MONTGOMERY - Tolerance
- SSRIs better tolerated than TCAs
- Patients more likely to continue treatment & recover

#### Not Suitable for Children/Teens

- GELLER - Drugs vs Placebo in Children
  - Antidepressant medication consistently fails to show superiority over placebo in children/teens

#### Increased Risk of Suicide

- BARBUI - Risk of Suicide Teens/Adulthood
  - Increased risk in adolescence, decreased risk in adulthood

#### Initially More Appropriate

- Offer quick & easy treatment - works within 2-4 weeks

#### Not Suitable Long Term

- Lead to dependancy, wear off
biological treatments for depression: ECT

- **electroconvulsive therapy**
  - uses electrodes to pass an **electric current** through one (unilateral) or both (bilateral) sides of brain
  - creates a **small seizure** which hopes to shock the part of the brain malfunctioning
- unsure why it works
  - changes blood flow/metabolism in brain
  - helps new cells/nerve pathways to grow in certain areas
  - changes functioning/levels of neurotransmitters
- **treats resistant depression**
  - last resort treatment
  - side effects: memory loss, anxiety & panic attacks

### EFFECTIVENESS

ECT vs placebo
- **GREGORY**
  - significant difference favouring true ECT

ECT vs antidepressants
- **SCOTT**
  - reviewed 18 studies/1,144 patients comparing both
  - ECT more effective short term in resistant depression
- **FOLKERTS**
  - ECT effective in treating resistant depression
- **HUSSAIN**
  - ECT no improvement in resistant depression

### APPROPRIATENESS

**side effects**
- **ROSE**
  - found 1/3 patients complained of memory loss
- **DPT. OF HEALTH**
  - found 1/3 reported permanent fear/anxiety

**treats resistant depression**
- good last resort treatment
psychological explanations of depression: Beck’s cognitive model

- depression is the result of faulty or **maladaptive cognitive processes**
- emotional/physical symptoms = consequence of thinking patterns
- theory has 3 aspects:
  - **COGNITIVE TRIAD**
    - Cognitions > Affect (emotions) > Behavior
    - according to Beck, depressed people have **unrealistically negative ways of thinking** about themselves, their experiences & future
    - many secondary symptoms of depression can be explained by the core negative beliefs
      > lack of motivation = result of pessimism
      > might lose interest in previously enjoyed activities due to expectation it will not make them feel better
  - **SILENT ASSUMPTIONS**
    - assumptions that shape conscious cognitions & **dominate** thought processes of depressed people
    - assumptions derived from parents, teachers, other people
      > intentionally/unintentionally infer assumptions from behaviour & way they talk
    - negative silent assumptions make people vulnerable to depression
      > “I must get everyone’s approval”
      > “I must do things perfectly or not at all”
  - **INFORMATION PROCESSING**
    - depressed people are prone to **distorting** & misinterpreting information from the world
      > inclined to make **overly negative & self-defeating** interpretations
      > lead to low mood & passivity
    - **faulty thinking strategies**
      > catastrophising
      > exaggerating a minor setback until it becomes a complete disaster
      > personalising
      > taking responsibility & blame for all bad things that happen
      > overgeneralising
      > drawing sweeping conclusions based on a single incidence
      > selective thinking
      > focusing on negative details or events while ignoring positive ones

**LEWINSOHN - attitudes & life events**
- measured dysfunctional attitudes (e.g. “my life is wasted if I’m not successful”) in adolescents without depression at beginning of study
- assessed again a year later - examined negative life events/whether they developed depression
- those who experienced negative life events only developed depression if initially high in dysfunctional attitudes
- supports cognitive theory as shows reason for depression is not negative life events, but high level of dysfunctional attitudes
- demonstrates idea that dysfunctional attitudes increase vulnerability whilst considering environmental cause
+ longitudinal study
  - looks at long term effect of dysfunctional cognitions - increased validity of theory

**MEZULIS - parental criticism**
- examined origins of cognitive vulnerability, specifically Beck’s idea that parental criticisms can cause negative thinking & depression
- followed 289 children from infancy to 11yrs
- used questionnaires to look at cognitive style, life events & parenting style
- parental behaviour not associated with negative cognitive style in children
- challenges theory as refutes idea that negative parental influence (e.g. negative silent assumptions) can cause depression
+ longitudinal study
  - looks at long term effect of parental criticism - increases strength of opposition
EVANS - dysfunctional thinking in pregnancy

- assessed negative self beliefs in women in 18th week of pregnancy
  - women in highest scores of negative self beliefs 60% more likely to become depressed
  - negative self beliefs predicted onset of depression 3 years later
- supports the theory as shows negative though processes can predict likelihood of depression

**EVALUATION**

- inconclusive research
  - lowers reliability of theory as no solid conclusion reached
- cause/effect
  - not known if negative cognitions are cause or effect of depression

**NATURE/NURTURE**

- explains depression as learned cognition from environment rather than biologically predisposed disorder
- ignores influence of genes/biochemistry which obviously play large roll
  - stress diathesis approach better
- focuses on upbringing/learning silent assumptions
  - socially sensitive to parents - places blame on them for onset of depression in child

**DERMINIST**

- less determinist explanation of depression than biological/psychodynamic theories
- shows we have control over severity of disorder by altering the way we think
  - vulnerability to depression not determined, but develops over time

**ETHICAL ISSUES**

- experimenting with those suffering from depression:
  - potential psychological harm to recovery
  - issues with lack of motivation to take part in experiment
  - difficult to identify actual external factors due to self blame
- stimulating depressive symptoms used to protect depressed people
  - not as representative/valid
psychological treatments for depression: CBT

- **cognitive behavioural therapy**
  - encourages people to consider the beliefs/behaviours which are the **root cause** of their depression
  - aims to **replace irrational, negative thoughts** with more positive ones, **adaptive ones**
  - claims to change the way people think, therefore ending their depression

- therapy has **cognitive** (focusing on thoughts) & **behavioural** elements (focusing on actions)
  - therapist encourages client to become aware of beliefs leading to their depression
    - test beliefs in therapy or in everyday life
    - shows consequences of irrational thinking
      - become aware that their thoughts lead to depression
  - techniques used to encourage client to develop more rational, positive beliefs
    - once adopted, clients depression should end

- **REBT - Ellis' rational emotive-behavioural therapy**
  - therapy states that irrational thoughts result in dysfunctional behaviour & emotional distress
    - **irrational thoughts** = irrational **internal dialogue** = irrational **behaviour**
  - aim of therapy is to replace maladaptive thoughts using **ABC model**, ending depression
    - using different cognitive, emotive & behavioural activities, the client (with help from therapist) can gain more rational & constructive ways of thinking

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**ABC MODEL of REBT**

<table>
<thead>
<tr>
<th>Activating event</th>
<th>Beliefs about activating event</th>
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<tbody>
<tr>
<td><strong>(e.g. job loss)</strong></td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
<th>rational thoughts</th>
<th>irrational thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(&quot;I will get another job&quot;)</td>
<td></td>
<td>(&quot;I will never work again&quot;)</td>
</tr>
<tr>
<td>neutral emotion</td>
<td></td>
<td>depressive/unmotivated emotions</td>
</tr>
<tr>
<td>desirable behaviour</td>
<td></td>
<td>undesirable behaviour</td>
</tr>
<tr>
<td>(&quot;I will start looking for a job&quot;)</td>
<td></td>
<td>(&quot;there's no point in looking for another job&quot;)</td>
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### EFFECTIVENESS

<table>
<thead>
<tr>
<th>STUDY</th>
<th>FINDINGS</th>
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<tbody>
<tr>
<td>RUSH</td>
<td>CBT at least as effective as drugs</td>
</tr>
<tr>
<td>BLACKBURN</td>
<td>CBT significantly superior, especially over periods of 1 year</td>
</tr>
<tr>
<td>NICE</td>
<td>Most effective psychological treatment for moderate &amp; severe depression</td>
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**BUTLER - meta-analysis CBT**
- Reviewed 16 meta-analysis of CBT & depression
- Concluded CBT very effective for treating depression

**HOLMES - CBT research limitations**
- Trials are of highly selected patients with only depression & no additional symptoms
- Far less evidence for real patient problems with complex problems

### APPROPRIATENESS

**not an overnight cure**
- Patient has to do a cost benefit analysis at beginning of treatment
- CBT takes time & motivation
  - Lack of motivation is symptom of depression
    - CBT may not be appropriate in people who need immediate intervention (e.g. suicidal)

**costly**
- CBT not as effective as other treatments
- Not always available on NHS
  - Long waiting lists not appropriate in people who need urgent treatment
  - Private healthcare expensive

**no side effects**
- Non-invasive - No adverse impact on physical health (e.g. withdrawal)

**treats cause, not symptoms**
- Long term effects of treatment - No dependancy on drugs
- Can make a real change in a person's outlook & behaviour
  - Helps to face everyday situations & adapt to stressful situations in a way that drugs/ECT can’t
psychological explanations of depression: psychodynamic theory

- behaviour is the product of complex interactions between conscious & unconscious processes
- depressed behaviours arise from:
  - unresolved unconscious conflicts in childhood and/or fixation at one of the psychosexual stages
  - real or imagined loss in childhood
- process:
  - development of depression begins during the oral stage of psychosexual development
    - child seeks to satisfy needs via oral gratification
      - overly gratified = oral fixation
    - becomes excessively dependent on others to maintain self esteem
      - due to over-gratification
    - separated from caregiver (e.g. death)
      - attempts to get affection & attention back from caregiver they were dependent on
        - introjects (takes on personality) of caregiver
    - Freud suggested that we harbour negative feelings towards people we love in our deep unconscious
      - sufferer begins to hate themselves
      - cycle of self abuse/blame
        - due to taking on personality of caregiver they unconsciously feel negative about
        - depression occurs

EVALUATION

DETERMINIST/REDUCTIONIST
- argues only people who have suffered loss of a caregiver & experienced oral fixation will develop depression
  - not everyone who’s lost a caregiver in childhood becomes depressed
  - not everyone who suffers from depression has lost a caregiver

<table>
<thead>
<tr>
<th>BIFULCO</th>
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<tbody>
<tr>
<td>some who experience loss become depressed</td>
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<tr>
<td>partially supports psychodynamic theory as some who experience loss develop depression</td>
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<tr>
<td>however, small very small number indicates other factors</td>
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<tr>
<td>determinist nature of the theory lowers external validity</td>
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<tr>
<th>BONANNO</th>
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<td>&gt;10% who suffer loss of parent become depressed</td>
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IMAGINED LOSS
- although little evidence supports psychodynamic theory, Freud added the concept of imagined loss
  - realised loss did not have to be so specific
  - concept in which a person unconsciously interprets life events with a severe loss
    - simple failure may be equated to severe loss - e.g. loss of a friend
  - slightly less reductionist/determinist
  - further research including concept of imagined loss may find more research in support
+ aims to identify root cause
  * more effective, long term treatment rather than covering symptoms
+ practical applications
  * counselling children who experience loss of a parent
  * target development of depression early & prevent occurrence in adulthood
+ takes blame away from patient
  * self blame = aspect of depression
  * empowers them to take treatment & motivates to get better

**SOCIAILY SENSITIVE**
- blames parent for causing oral fixation & psychological trouble in adulthood
- due to determinist nature
  * theory implies individual who has suffered loss will begin a cycle of self hate/blame, having taken on negative feelings towards that person, resulting in depression
    ‣ may result in a self fulfilling prophecy if aware of this theory
    ‣ implies no-one is resilient enough to withstand loss of a loved one without developing depression
- people who are depressed but haven’t suffered loss of a parent
  * not truly depressed as there is no trigger
  * may lead to discrimination from treatment as they do not fit into diagnosis categories
psychological treatments for depression: psychodynamic treatments

- aims to enable individual to **cope** better with **inner emotional conflicts** that are causing depression
- **unconscious** must be investigated to uncover the **root cause** of depression from childhood
  - **psychoanalysis**
    - intense, can last for years
    - includes several sessions a week
    - client traditionally lies on couch
  - **psychoanalytic psychotherapy**
    - less intense, may not last for years
    - fewer sessions per week
    - client & therapist in face to face scenario

- psychodynamic approach states root of depression is in childhood
- therapy explores patient’s past & links this to current emotional state
- experiences of **childhood loss & rejection** are concentrated on - key to beginning of depression
- therapy may involve making **unconscious memories accessible** in the conscious
  - encouraged to relive these experiences
    - patient may become **angry & upset**
    - emotions safely discharged in a process called **catharsis**
  - **gains insight** into childhood & therefore cause of depression
    - better able to cope with inner emotional state
    - enables them to:
      - deal with loss more effectively
      - become less dependent on others
      - make appropriate changes to everyday life
      - this should end client’s depression
- **techniques** used to gain access to unconscious
  - **free association**
    - client encouraged to say whatever comes to their head without censorship
    - reveals underlying conflicts/root of depression
    - analyst pieces together patterns of association & offers interpretation
  - **transference**
    - client transfers characteristics that are unconsciously associated with caregiver person
    - repressed feelings directed to analyst
    - reveals unconscious negative feelings/root of depression
- techniques lead to catharsis = removal of pathological effect

**EFFECTIVENESS**

not clear whether it works
- **EYSENCK - psychotherapy vs waiting list**
  - reviewed 2 studies of psychotherapy, incorporating waiting list controls
  - 66% of the control group improved spontaneously compared to only 44% of the psychoanalysis patients
  - concluded psychoanalysis does not work
- **BERGIN - waiting list treatment**
  - reviewed original data
  - control groups were receiving some form of treatment: 1 was hospitalised//others were treated by GP
  - selected different outcome criteria
  - improvement in psychoanalysis group rose to 83%/ control dropped to 30%

shows psychodynamic treatments are not effective as inconsistent findings as can’t make firm conclusions of beneficial effect

however, some do improve so there is some effect
**BURNAND - psychotherapy combined with drugs**
- investigated 74 patients to compare treatment by psychotherapy alone/antidepressant combination
  - both groups improved
  - combined associated with less treatment failure, better work adjustment & better global functioning

**why does it work?**
- placebo - getting therapy = getting better
- gives people attention (anti mental health view)
- treatments may be successful even if theory is incorrect
- support - talking about problems

**APPROPRIATENESS**

**why is it still used?**
- even when there are other working treatments, psychotherapy works well for some people

**engaging with therapy**
- symptoms of depression include lack motivation/energy
  - may become disheartened at amount effort needed to benefit
- rapid improvement needed in suicidal cases

**emotional harm**
- bringing up emotional trauma distressing - may worsen condition
- however, sometimes necessary to face root cause to get better
- therapists careful of ethics & consequences

**time/cost**
- treatment takes many years
- however, newer/shorter therapies developed - more affordable & quicker improvement seen