1 Introduction

If you are not already sure that depression is a major global health issue, consider the following statistics. One in six people will experience depression over the course of a lifetime.[1] The incidence of depression is estimated to have increased from 50 cases per million people in the 1950s to 100,000 cases per million in the late 1990s.[2] In 2004, depression was the third highest contributor to the global burden of disease, at 4.3 percent.[3] In the same year, however, depression was the *leading* cause of disease burden in high- and middle-income countries, at 8.2 percent and 5.1 percent, respectively.[4] Greenberg estimates that depression cost the U.S. economy U.S. $83 billion in 2000, of which U.S. $26 billion comprised treatment costs and U.S. $52 billion represented workplace costs, including absenteeism and performance impairment.[5] To say these figures are disturbing risks serious understatement. However, statistics, even of this enormity, are still only a dispassionate measure of melancholy's reach. William Styron, a writer who experienced depression at first hand, gives a more intimate account:

> [D]epression takes on the quality of physical pain. But it is not an immediately identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this cauldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion.[6]

Styron's description makes plain why so many with depression are driven to seek relief through the health care system. In my own nation, Australia, about three-quarters of depression sufferers attend their general practitioner[7]and nearly 80 percent of those are treated with antidepressant medication (ADM).[8,9] In 2004–2005, Australian primary care physicians wrote over 11 million prescriptions for ADM, up from nearly 7.5 million

in 1999–2000.[10] These are impressive numbers for a country whose population is a mere 22 million. The total cost of ADM prescriptions in general practice in 2004–2005 was just under half a billion Australian dollars, nearly double the amount of 1999–2000.[11] In the United States, the proportion of adults using ADM jumped from 2.5 percent in 1994 to 8 percent in 2002.[12] In that country, with a population of around 307 million, the number of ADM prescriptions rose from 154 million in 2002 to nearly 170 million in 2005.[13] Between 2000 and 2001 ADM sales in the United States increased from U.S. $10.4 billion to U.S. $12.5 billion, a rise of nearly 12 percent, cementing it as the highest selling drug category after cholesterol-lowering agents.[14]

It almost comes as a surprise, on viewing these figures, to learn that another, equally effective treatment for depression is available. Psychotherapy, in particular cognitive behavior therapy (CBT), has been subject to extensive trials that show its outcomes to be as good as those achieved with ADM. Ellis and Smith, funded by Australia's national depression initiative beyondblue, conducted a meta-analysis of 107 randomized controlled trials of depression treatment. In a summary that echoes national guidelines in the United States and the United Kingdom, they reached the following conclusion:

> For the initial treatment, our meta-analysis shows there is little difference [in relative effectiveness] between the major pharmacological and psychological treatment options for mild to moderate depression.[15]

There is also emerging evidence that depressed people treated with CBT may have lower relapse rates compared to those who discontinue ADM after a successful response.[16] Despite this, in Australia less than a quarter of those who present to a general practitioner with depression will receive a validated psychotherapy, and figures in the United States are likely to be similar.[17]

In trials comparing CBT and ADM, treatment outcomes are commonly measured with the Hamilton Rating Scale for Depression.[18] It assesses the presence and severity of the typical symptoms of depression such as lowered mood, feelings of guilt, suicidal ideation, insomnia, anxiety, loss of energy or concentration, and indecision.[19] It also measures somatic symptoms such as reduced appetite, weight loss, or changes in bowel habit. There are several versions of the scale. The 21-item questionnaire has a maximum score of 66. A score of 12–16 indicates mild depression, a score of 17–23 indicates moderate depression, and score of 24 or greater indicates severe depression. For mild depression, neither ADM nor formal

psychotherapy is necessary. Good results can be achieved with supportive counseling and problem-solving approaches, implemented with the aid of a primary care physician.[20] In moderate depression, ADM and psychotherapy, including CBT and interpersonal therapy (IPT),[21] are equally effective.[22,23] The same is true for severe uncomplicated depression,[24,25] that is, severe depression without associated psychotic features, medical illness, or substance abuse. As a result, Australia's beyondblue guidelines for the treatment of depression in primary care recommend that practitioners can use either psychotherapy or medication in these grades of depression.[26] Similar recommendations are made in the national guidelines of the United States[27,28] and the United Kingdom.[29]

Although ADM and CBT cause equivalent improvement in depression symptoms on Hamilton Rating Scale measures, there are obviously major differences between them. Most notably, pharmacotherapy can lift mood independent of any requirement that the patient *understand* prominent facets of his or her depressed response. In particular, the clinical effectiveness of ADM does not require knowledge of the action of lowered mood on thought processes or that psychosocial stressors can trigger depression.[30] On the contrary, this knowledge is essential for CBT, which teaches skills to deal with distressing feelings, negative thoughts, and causal stressors. Recommendations that the two treatments are equally effective and that, quite simply, either can be used fail to accord importance to these clear differences.

In this book, I show these differences to be critical and to form the basis for a profound ethical distinction between the two therapies. I argue the understanding gleaned through CBT concerns facts that are material to people with depression. As a result, I hold that personal autonomy is promoted through the therapeutic process. In contrast, ADM administered alone, I argue, affords no such understanding and so promotes autonomy in a different way and to a much lesser extent. I show that depression is a disorder in which patient autonomy is routinely and extensively undermined and that, as a consequence, physicians have a moral obligation to promote the autonomy of depressed patients. I conclude that an ethical imperative holds for medical practitioners to prescribe psychotherapy, and in particular CBT, for depression.

To begin, in chapter 2, I examine hierarchical, historical, life plan, and reasons-responsive theories to derive a meaningful construal of autonomy that forms a basis for the arguments to follow. I show that common to each theory is a view that autonomy is possessed by agents, free from serious constraints, who are equipped with resources adequate to enable

actions that accord with deeply held values. I also note that serious disagreement exists on the precise properties of those desires that are possessed by autonomous agents. However, there is substantial concurrence that autonomous choice requires the agent to hold justified beliefs about facts that are material to the matter at hand. In refining an "epistemic" account of autonomy, I elaborate the nature of these beliefs, using the analogy of the informed-consent paradigm in medicine. I argue that a linear relationship holds between the number of material facts an agent grasps and the autonomy of his or her related decisions. I present this connection as a means of quantifying autonomy in depression, one with utility in the clinical context.

However, to ground the case for the moral obligation of practitioners to promote autonomy in depression, something must be said of why autonomy holds value, and the derivation of its normative force. To this end, I chart the rise of respect for personal autonomy as a guiding principle in medicine. I outline the attributes of autonomy that have fueled its recent prominence, over and against paternalism, in the physician–patient relationship. I highlight and explain the distinction, commonly drawn by philosophers, between the instrumental and intrinsic value of autonomy. I show that the normative force of autonomy derives from its capacity to further well-being, and from its association with personhood, a trait that confers moral status on the holder.

In chapter 3, I note that epistemic construals of autonomy have traditionally been concerned with beliefs about states of affairs that are external to the agent. For example, informed consent to surgery typically demands understanding of the incision site or the duration of the procedure. However, I switch the focus of material understanding inwards. Could accurate beliefs about one's emotional responses and psychological states also be important for autonomy? I answer this question in the affirmative, invoking three important facets of emotion in the process. First, I look at the evaluations integral to emotion. I argue that affective responses—those that entail "feelings"—provide evidence for the existence of characteristic triggering events and the value to the agent of their outcomes. The argument draws on "appraisal" theories suggesting emotions are set off by events that have critical implications for the agent's interests. Building on these accounts, I argue that facts about such events are material to the individual and that accurate interpretation of his or her affective response enhances the autonomy with which the agent addresses an emotive trigger. Two remaining facets of emotion add force to the argument. First, empirical evidence is adduced that emotion aids decision making and, indeed,

might be essential for it. Second, emotion is shown to be a powerful motivator of behavior. I argue that emotion's profound influence on decisions and action makes a skilled grasp of its evaluative content crucial for autonomy.

In making this case I deal with the inescapable reality that emotions can, and do, mislead. Emotion can reflect misunderstanding and skewed perception and sometimes bears little relation to events in the world. Agents then layer their interpretation on emotions, sometimes accepting at face value those that are wrong-headed or, less commonly, ignoring those that accurately render reality. I argue that autonomy is undermined when the agent uncritically accepts, and acts on, emotions that wrongly report environmental events. To clarify this claim, I conceive the "evidential value" of affect. Roughly, evidence adduced in favor of a proposition raises the probability, for the agent, that the proposition is true. I note that affect typically reinforces the conviction with which agents hold related beliefs. Thus, I suggest the affective response provides some "evidence" to the individual for the truth of his or her associated beliefs. I then propose that affect with a tendency to reinforce justified beliefs be construed as having high evidential value. Conversely, affect that tends to strengthen unjustified beliefs possesses low evidential value. I argue that because affective appraisals pertain to material states of affairs, the agent who unwarily accepts beliefs primed by affect of low evidential value is prone to hold unjustified beliefs about material facts. As a result, the autonomy of the agent's resulting actions is diminished.

In chapter 4, I apply this concept to affective disorder, arguing that affect in depression has poor evidential value, that is, it tends to reinforce unjustified associated beliefs. I show that two processes underpin this effect. First, negative affect drives information-processing biases that lead to unrealistically pessimistic predictions concerning the object of the affective response. Second, I present data showing psychosocial stressors trigger around 70 percent of depressive episodes.[31] I detail studies that strongly suggest many depressed people do not appreciate a causal role for stressors. Further, I show that, even when stressors are identified, negative affect mediates a biased appraisal of them. I conclude that depressed people are unlikely to hold justified beliefs about negative biases and the role of psychosocial stressors in depression. I show this information to be material and that ignorance of it undermines autonomy.

I move on to compare how ADM and CBT address the autonomy lapses seen in depression. In chapter 5, the focus is on negative biases. I explain how CBT teaches the individual to identify and challenge the unrealistic

beliefs that negative biases foment. I marshal empirical data supporting "debiasing" as integral to the mechanism of CBT. The unrealistic pessimism born of biased thinking is displaced, through CBT, by more reliable predictions, furthering autonomy. While acknowledging that ADM can also modify depressive pessimism, I argue that pharmacological debiasing is notably distinct, in two ways, from that achieved through psychotherapy. First, the person treated with ADM alone is denied an understanding of the negative biases associated with depressed affect. Because this understanding is material, ignorance works against personal autonomy. Second, depressed people treated with CBT appear to retain a facility to generate negative affect. However, for the person receiving ADM it seems a "floor" is put in place, below which affect cannot fall. Scope for negative affective swings is restricted by ADM. I argue, based on appraisal theory, that negative affect has utility as a marker of events that are material to the agent. The CBT-treated person, in virtue of his or her preserved capacity for negative affect, maintains an ability to identify events as material and, therefore, to flag them as meriting evaluation. I argue the ADM-treated individual is denied this opportunity and conclude that the person receiving CBT is more likely, as a result, to hold justified beliefs about materially significant affective triggers. Greater autonomy ensues for the recipient of CBT.

In chapter 6, I turn to the role of psychosocial stressors in depression. CBT invokes a problem-focused strategy to address stressors, an approach I show assists understanding of three salient facets of depression. First, depressive episodes are often brought on by stressors, and those stressors are typically bound to the depressed person's principal interests. Second, depression represents a maladaptive response to stressors, threatening the agent's related interests.[32] Finally, that dysfunctional response can be addressed through therapy in a way that protects the interests at stake. I show this broad category of information, and its peculiar content in the individual's circumstance, to carry material weight for the person with depression, whose autonomy is furthered through its understanding. Treatment with ADM alone furnishes no such understanding, grounding an autonomy advantage for those receiving CBT. I conclude that CBT promotes autonomy in depression to a greater degree than does ADM, but I concede that an obligation for physicians to prescribe CBT does not automatically follow.

In chapter 7, however, I present the case that medical practitioners are bound by a pressing moral obligation to recommend CBT in depression. I use "parity of reasoning" to argue that autonomy promotion through

informed consent and through chronic disease self-management forms an ethical template supporting autonomy promotion through psychotherapy in depression. I then argue that the autonomy threat posed by depression, manifest in high rates of relapse and recurrence, makes the degree of autonomy promotion seen with CBT both a proportionate and a warranted response. I acknowledge that autonomy is one of a number of principles that might properly influence the treatment recommendations of doctors. However, after examining notions of the proper goals of medicine, professional autonomy, cost–benefit utility, and beneficence, I affirm that autonomy remains of paramount concern in treatment of depression.

I conclude that a forceful ethical obligation exists for practitioners to provide CBT for their depressed patients. My entreaty comes in a Zeitgeist where pharmacotherapy dominates depression management and only a substantial minority of patients receives CBT. If I am right, this imbalance is cause for grave concern, with doctors failing on a vast scale to uphold their ethical obligations to patients with depression. I allude to a number of factors that might perpetuate the high incidence of pharmacotherapy in depression, such as direct-to-consumer advertising and pharmaceutical company sponsorship of medical education. I also note that many doctors may be impeded in efforts to provide psychotherapy through circumstances beyond their control. These include inadequate remuneration of physicians who wish to deliver psychotherapy as well as limited access to appropriately trained psychologists. However, my case should strengthen the resolve of those frustrated by resource constraints to agitate for wider access to psychotherapy. It will also, I hope, prod the conscience of any physicians who believe their duty to those with depression is adequately discharged by simply writing a prescription for antidepressants.