Clinical Depression
ISSN: 2572-0791

Shaughnessy, Clin Depress 2018, 4:2
DOI: 10.4172/2572-0791.1000132

Review Article Open Access

Treatment of Depression: Emotional Concerns and Multimodal Assessment

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Received date: April 02, 2018; **Accepted date:** April 20, 2018; **Published date:** April 27, 2018

Abstract

In the treatment of depression, while an examination of cognitions and behaviour is surely in order, the therapist must not neglect the emotional realm and needs to delve into the emotional nuances of depression, as it may differ from dysthymia to major depression to depression caused by anaemia and other medical realms. This paper will examine and explore the "common cold of psychology", examining current issues and offering concerns about current cultural factors as well as concerns about suicide, resulting from depressive episodes.

Keywords: Depression; Treatment; Behaviour

Introduction

Major and minor forms of depression and their evaluation

In adults, there are variants of this clinical condition referred to as depression. DSM-V has major depressive episodes and on-going dysthymia. While cognitive therapy has some benefits and behavioural methods have also shown promise, a skilled clinician may first want to deal with the depth breath and scope of the emotional disorder. For some individuals, a multimodal approach is preferred so that a comprehensive treatment plan can be formulated. Arnold Lazarus has developed an approach referred to as "Multimodal Therapy" which requires the clinician to examine what Lazarus has referred to as the BASIC ID. This is an acronym to assist clinicians in comprehensively evaluated and addressing many different realms of the client's personality and condition. Each one of these will be summarily reviewed.

The realm of behaviour

The B in "BASIC ID" represents the client's Behaviour- The client who is depressed may engage in a wide variety of non-productive, toxic, or self-defeating behaviours. These behaviours will have to be addressed in order to bring about significant change. The counsellor therapist obviously wants the sad to be happy and the depressed individual able to engage in productive behaviours. Some of the behaviours that some depressed individuals engage in are as follows:

Overeating: This behaviour can cause obesity, and if the client consumes the wrong types of food, can impact their overall health and if they are diabetic, cause difficulties in that realm.

Alcohol abuse: Some individuals who are depressed and in unendurable psychological pain revert to alcohol to deaden or numb the pain. Some alcohol abuse may be minor (a few beers) and then progress to more major concerns such as abusing wine or whiskey or a combination of the two.

Drug abuse: Some depressed individuals will self-medicate or attempt to sleep as sleep is one way of removing themselves from the situation. In a sense, alcohol and drugs are both avenues of escape for some individuals. Drugs and alcohol remove them from the constant pain and awareness of their perceived inadequacies.

Sexual behaviour: There are clients who will seek out sexual conquest as a way to avoid dealing with their problems. For some individuals, there is risky sexual behaviour as some will avoid condoms and engage in risky sexual behaviour, or in multiple forms of sexual behaviour (oral, anal and intercourse) that in their minds, will rescue them from their depression.

Withdrawal: As the depression deepens, the client may withdraw more and more from their support network, or they may not have a support network to begin with. They are your "loners" who rarely have interaction with others (such as a night security guard) and they have minimal contact.

In all of the above-a treatment plan must address the above concerns. In multimodal therapy, a written plan is developed, and goals and objectives formulated so that these concerns can be addressed and alleviated. Periodically, each one of these realms may be re-evaluated and assessed. Some clients may have particular difficulty with one domain, and alternative strategies might need to be suggested or attempted. Just as we must monitor weight loss for the obese client over time, we may need to evaluate the degree of depression (on perhaps a scale of 1 to 10) over time. Responsibilities may need to be doled out so that the therapist is not doing all of the work, and if there is a caring significant other, this is also helpful.

The affective domain

A=Affect: The depressed person is obviously depressed- but there are degrees of depression, and male depression may differ quite a bit from female depression, and in treatment, the issues of resolution may also be quite different. For some individuals the depression may be worse in the morning, or afternoon or evening, or perhaps for some, the weekend is a dreaded time period in that they are at home, with nothing to do, other than reflect on their situation. Other individuals

are depressed at certain times of the year-for example Christmas, Easter and other holidays or anniversaries that bring up certain issues. Some people may have suffered a great loss at a certain time of year- a loved one or a pet or some individual that has made an impact on their lives, such as a mentor or coach. Getting the individual to talk about their sadness, the weight that they feel and assisting them to describe the depression (as perhaps dealing with demons, addressing their own perceived inadequacies) is therapeutic in and of it. There are some therapists who advocate addressing depression as a good thing- in that it indicates to the person that something is wrong and needs to be changed-just as a toothache indicates a cavity that needs to be drilled and filled, depression may be an indicator that one needs to re-think where they are working, what type of job they are in, whether the job gives them any satisfaction or gratification or whether it is time for a career/occupational/vocational change.

Flach [1] has cogently indicated that depression can be a good thing-indicating that something is radically wrong in the person's life. Perhaps they are in the wrong job or perhaps they are in the wrong church, or perhaps they have married the wrong person, or are living in the wrong section of the United States and they may want to consider moving to a warmer climate.

Some individuals feel "locked" into a certain job- as they may have invested years pursuing a law degree only to find out that they do not like the work. Other individuals feel "trapped" in a job but they have put in 15 years and need 5 more to retirement.

Other individuals hate their co-workers and feel nauseous, (not depressed) when encountering these individuals at the workplace. In many instances, as a contemporary book states someone has "moved their cheese" Johnson [2] indicating that the job that they trained for and longed for twenty years ago has changed and now they are asked to re-tool and re-skill for another position, thus causing exasperation, frustration, and of course depression. In this rapidly changing world of computers and technology, many individuals are having to re-train and re-assess their skills and abilities, and are somewhat depressed by these ongoing challenges. Many individuals cope with such difficulties by simply retiring or taking a pay cut. Other individuals may not have such options or alternatives.

The sensory realm

S=Sensory: Depressed clients have sometimes very limited "sensory lives" if you will. They do not enjoy music, they do not see a beautiful sunset, they do not feel warmth and they have other types of sensory maladjustments. Some may not sleep well, and some are inattentive and "zone out" not listening to wives or other significant others. Their vision may be limited to what is directly in front of them, thus missing the beauty of a sunset or a wonderful flower or tree. As is often said they have to "stop and smell the roses" and many depressed individuals do not even see a marigold or a rose or a bouquet of wonderful flowers. They need to be prompted perhaps to go to a zoo, encounter some smells there to really appreciate a bakery where there is fresh bread being made. Some clients may need to be asked to immerse themselves in a certain sensory experience to "break the cycle" of depression. Asking a client to exercise by swimming and jumping into the water (hopefully they are able to swim-one should always check) or riding a roller coaster may provide a certain type of sensory stimulation not felt since childhood. We experienced a number of wonderful sensory experiences as children as we climbed trees and sat in a field to look at clouds- but we rarely engage in these experiences as adults (unless we perhaps go to Disneyland).

Imagery, imagination, fantasy, pictures and visual images

I=Imagery: The image, the pictures in one's mind, the movie that is playing in one's head has much to do with the emotional tenor of the person. A picture of oneself trapped in a dead end relationship or dead end job, or with a violent, aggressive, assaultive husband or spouse can replay over and over in one's mind and perpetuate that depression. The movie must stop and be replaced by other more pleasurable images (perhaps of lying on a beach in Hawaii or taking a long ocean voyage. One's images as to what is going to transpire at work-constant criticism, constant harassment-obviously can cause even the most mentally healthy among us to feel depressed.

The realm of cognition

C=Cognition: There is much written about the cognitive thinking patterns of the depressed individual. Beck and Shaughnessy [3], Ellis [4,5], Haight [6] and many others have written cogently about the irrational, illogical, unreasonable, unrealistic, inappropriate, warped, slanted, stilted thinking of the depressed individual, who thinks that they have always been depressed, are depressed, and this depression will remain with them in spite of therapeutic intervention.

The self-statements made by the depressed person are often gross exaggerations. The world for them is terrible, awful and horrible, and the problems insurmountable. The situations are problematic and intricate and confusing, and remedies are nowhere to be seen (except for the remedy, in their minds of suicide). Depressed individuals all present the possible threat of suicide or even homicide. Thus, therapists must be extremely careful to ascertain if the person has access to guns or an inordinate amount of medication which could be used to overdose.

The interpersonal realm-friends, family and co-workers

Interpersonal relations: The depressed individual may not have friends, or they have one friend and that friend has no friends, or that one friend is never available for comfort, consolation, nurturance and assistance and support or the depressed individual has no friends that are able to provide the uplift required or simply do not have the skills that are needed to help a friend who is depressed and has been depressed for many years. Further, that friend may not have the ego strength to make sure that the depressed individual gets to a local doctor for at least a trial of some anti-depressant medication. While therapists cannot recommend that a person join a church, they can ask if the client attends one, and if so, if there are caring individuals that can provide some solace or comfort in difficult times. While prayer may not always solve all problems, and Bible study may not alleviate all difficulties, these things do serve as effective distraction avenues in some cases.

In this day and age, television commercials are typically replete with a number of drugs being advertised, with their resultant side effects and encouraging words of support. In preparation for this article, this writer reviewed 79 different anti-depressant medications from the Internet- (there are more but some are duplicates-and some transdermal and some are used off label-for example, a smoking deterrent is also used for depression-why it works for some is not exactly clear-but bears examining. Sadly, such television commercials do not mention that lifestyles changes are sometimes needed, that philosophies of life have to be addressed, that toxic relationships may need to be abandoned and idiotic hobbies jettisoned so as to enhance the quality of life for some people.

The domain of drugs, medication, self- stimulants and the like

D= Drugs (or the need for drugs or the abuse of drugs): While this arena may seem like the realm for a psychiatric referral or intervention or medical consultation, the psychologist or therapist should ascertain if the person is already on some type of medication or if the client is using some drugs (perhaps procured from a spouse or significant other) or some stuff from a health food store that was intended to alleviate their mood swings (such as St. John's Wort).

Often a full medical evaluation including blood work is warranted to assure that the person receives a "clean bill of health"as they say. Quite often a family practitioner will determine that the depressed person is actually diabetic or anaemic, and treatment can begin or progress. Blood work nowadays can reveal much more than perhaps 10 years ago and can pin point an allergy or some other condition previously overlooked.

While the BASIC ID provides a framework for evaluation, there is a Life History Questionnaire that facilitates and expedites treatment. The Life History Questionnaire provides an overview of past treatment and past events that may be relevant in the person's life. A skilled clinician can procure some insight by reviewing this history and then focusing on major relevant events or experiences. The Life History Questionnaire also saves time in that a client can be asked to fill it out prior to seeing the therapist, thus expediting the therapeutic process. Not all clients appreciate having an extensive case interview conducted so that the therapist can "get the background of the case".

Lazarus [7-10] has edited an excellent volume of papers that focus on using multimodal therapy with agoraphobia, (Rudolph) depression and obesity (Brunell) with children and enuresis (Keat) anorexia nervosa and somatization disorder (Roborgh and Kwee). In the multimodal approach to the treatment of depression, the clinician would attempt to develop a treatment plan or intervention for each of the above named realms. Thus there would be an objective in the realm of Behaviour, Affect, Sensory, Imagery, Cognition, Interpersonal Relationships and perhaps examine the need for Drugs (or conversely, the fact that the client may be self- medicating and is already using drugs).

Some therapists may have been trained in behavioural methods and thus gravitate toward the Behavioural realm. There are often good reasons for gravitating toward behaviour because if the depressed person can act "as if" they were happy, the prognosis may be improved. Further, behaviour and behavioural homework can change long established patterns of behaviour and perhaps expose the client to a new world. Over focusing on one realm may actually be counterproductive in some instances, for example, over focusing on cognition may cause a person to ruminate about negative past events, and not necessarily prepare them for the future.

Two key words in multimodal assessment are bridging and tracking. Although interpreted differently by different clinicians, these two key words attempt to make sure that the client is being "heard", and understood, and listened to and validated and regarded. Basically, if the client reports "thinking" about something, the therapist may want to stay in the cognitive realm. If the client discusses friends or lack thereof, the Interpersonal realm bears examination. If the client is discussing their extreme feelings of loneliness and sadness, the therapist ought not to "switch gears" and attempt to get the client to a local amusement part for a ride on the roller coaster to stimulate him or herself. While these things may seem common sensical-they bear repeating. Following the "train of thought" and also following the train of behaviour, interpersonal interactions, senses, images and other modalities is often therapeutic in and of itself. On some occasions, a client may venture off into the realm of religion and or spirituality and thus, counsellors and therapists need to be prepared for such a tangential area and not all therapists are necessarily prepared to deal with concepts such as sin, or eternal damnation or angels or hell or demons.

In some instances, couples therapy may be warranted. The client's problems may stem from toxic interactions with a mate, spouse, and significant other or even loved one. The dynamics or lack of communication may be at the source of a major depression. Often in marital dyads, neither of the individuals is willing to compromise, negotiate or find a middle ground.

Extreme Depression

There will be cases of extreme depression which require very simply major intervention. Some of these cases are exacerbated by other health or medical conditions. The depressed female who is 500 points and morbidly obese, will perhaps have to be hospitalized. One can discuss which came first-the depression or the obesity- but the issue is to attempt to intervene and begin a process of recovery. The same holds true for the long term alcoholic-perhaps in their mind, they have a right to be depressed-"after what happened to them" but a major intervention such as Antabuse or Alcoholics Anonymous and a major commitment from family and friends is needed. Long term depression is a problematic concern but unfortunately for some people, their depression is a life-long friend and companion and they cannot conceptualize life in any other way. Loved ones surround this person wanting them to "get well and better" but there is no "better" in the mind of the chronic deeply depressed individual. To get them out of their quagmire of despair and into the valley of light and pleasant endeavours is a major undertaking. Such major changes are few and far between. But, they do exist and have happened.

The field of psychology is replete with such major changes, brought about by a major skilled therapist who just happens to say just the right thing, in the right tone of voice at the right time.

The names Viktor Frankl, Carl Rogers and many others are associated with some brief intervention that helped bring about a major change. One wonders what has been said, or was it the manner in which it was said- or some emotional concomitant that brought about the change, often seen by therapeutic magicians if you will.

We still need to do research on what seems to be needed by certain clients at certain points in their therapeutic journey to try to ascertain what is most beneficial and what is most therapeutic for a male or female, of a certain age, confronted with a certain problem at a certain point in their lives.

The Treatment of Depression in Children and Adolescents

The treatment of children and adolescents is obviously different than the treatment of adults and geriatric individuals.

The symptoms that are looked for in children and adolescents are:

- "Anhedonia (inability to experience pleasure in all or nearly all activities).
- Depressed mood or general irritability.

- Disturbance of appetite and significant weight gain or loss.
- Disturbance of sleep (insomnia or hypersomnia).
- Psychomotor agitation or retardation.
- Loss of energy, feelings of fatigue.
- Feelings of worthlessness, self-reproach, excessive or inappropriate guilt, or hopelessness.
- Diminished ability to think or concentrate indecisiveness.
- Ideas of suicide, suicide threats, or attempts, recurrent thoughts of death.

For children and adolescents, their depression may be quite temporary, and transient, but they could also be the victims of child abuse, neglect, or even sexual abuse. Clinicians need to be quite careful to ascertain if the depression is due to some outside factor, or parental abuse or neglect. In many cases, there is a specific trigger such as school difficulty, the loss of a friend in this transitory society, and some experience of failure. Acceptance or rejection by the peer group is of concern in adolescence, and in a very basic sense, the need to be loved by another human being seems to be increasingly paramount in the lives of adolescents.

There are intimacy needs, and even sexual needs that may not be being met or sublimated. Many adolescents struggle with gay/lesbian/bisexual or transsexual issues and these concerns are being verbalized more than ever before. Physical issues such as anorexia nervosa or bulimia need to be considered as some individuals will not discuss these issues. Other adolescents may engage in self-stimulatory behaviour or self-injurious behaviour in an attempt to procure help or get attention from what they see as a cruel uncaring world.

Schools and School Shootings

In today's day and age, children and adolescents are somewhat apprehensive about their school being invaded by someone with an assault rifle or other weapon. Television and other media communicate about these events, and many students are perpetually concerned, anxious, and in many cases, depressed. In specific instances, some children, while not killed- may have been wounded by a bullet, taken to the hospital, and have physically recovered but some are still in a state of shock and disbelief. Indeed, some individuals may never recover from such a massive event in their young lives. It is unclear at this time, how many individuals will later be diagnosed with post-traumatic stress disorder, or has some variant of "survivor" syndrome. Some individuals will manifest hyper vigilance and have sleep disorders or require counselling or therapy.

Abraham Maslow has written about basic needs and the need of the individual to get their basic needs met. While many children are getting various basic needs such as food and water and shelter met, they may not be having a feeling of safety in the schools in the world today. Indeed, in many classrooms, teachers are stressed out and stretched to the max and are not always able to provide the individual attention that many children need. Children often are depressed when parent's divorce. While this is understandable, children often need to learn coping skills to deal with the painful experiences that have to be endured as they progress through life.

Communication between children and specifically adolescents and their parents need to be explored. Some children do not talk to their parents, and parents do not know how to open communication channels with their kids and adolescents are often further withdrawn from their parents for varying reasons.

Music, Art and Other Therapies

For children, traditional talk therapy may be beneficial, but often it is necessary to examine other formats such as music therapy, or art therapy or even physical therapy for those who may have some type of medical condition which interferes with their optimal functioning. Music therapy can help some children relax; making them more amenable to conversational therapy or music therapy can provide an outlet for anger and frustration. Art enables children to examine and explore their inner world and a good projective psychologist is able to glean a good deal of information from the house or tree or person that is drawn. The colours uses may also reflect much on child or adolescent emotional life. Children who draw everything in black are obviously quite depressed and other colours such as red, green, blue, violet and orange reflect some basic emotional patterns. Not all therapists are trained in such interpretation, but often in discussion or conversation some insights can be gleaned. Books have been written on the treatment of depression in children from various points of view Freudian, Adlerian, Jungian and the list goes on. Each area offers certain understandings and theoretical underpinnings that are often effective, but often it is the skills of the therapist or counsellor or the therapeutic relationship that is the healing factor.

Future Directions and Recommendations

While there has been some recent research in this realm, it has been disjointed and sporadic. There may be other clinicians doing anecdotal research and sharing their results at conferences or conventions. There need to be more communication among clinicians as to what is effective and for colleagues to share their interventional expertise. For example Little et al. [11] shared an excellent pilot study and Meyer et al. [12] have explored specific pediatric domains; large scale studies have not been forthcoming. Smart et al. [13] most recently have investigated the realm of biological cycles and their impact on depression. There should be more comprehensive sharing of information, given the immediacy of the Internet and various forms of social media. Obviously, confidentiality must be maintained and ethical integrity monitored [14-16].

Summary and Conclusion

The treatment of depression remains a major concern and while advances have been made in psychotropic medication, there is still concern about long term prognosis and recovery. This paper has briefly reviewed a multimodal approach which can be used with men, women, children and adolescents, which provides a comprehensive framework for examining all of the realms that perhaps need to be explored and examined.

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