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# Review of "The Ethical Treatment of Depression: Autonomy through Psychotherapy"

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## Book Review | *The Ethical Treatment of Depression: Autonomy through Psychotherapy*

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***The Ethical Treatment of Depression: Autonomy through Psychotherapy*. Paul Biegler; Cambridge, MA: The MIT Press, 2011. 232 pages; \$35 paperback; 978-0-262-01549-3**

*The Ethical Treatment of Depression* is clear, thoughtful and well researched. However, ultimately it is unpersuasive in its argument that there are ethical reasons to advocate for cognitive behavioral therapy (CBT) over antidepressant medication (ADM) in the treatment of depression.

The text is divided into seven chapters. After a lucid introduction, chapter two, “Autonomy: The Importance of Justified Beliefs about Material Facts,” sets the stage by defining and providing an account of autonomy; Biegler traverses the philosophical landscape from paternalism to autonomy. The chapter’s core comes at the end (30-35) when he argues that autonomy, unlike paternalism, is both instrumentally (because agents “are best able to fulfill their interests” (30)) and intrinsically valuable. The main point of this chapter is that autonomous action requires agents to hold justified beliefs about material facts, with “material facts” meaning accurate information about the world.

In chapter three, “Autonomy: The Importance of Justified Beliefs about Affect,” Biegler moves from a discussion about material facts to facts internal to the agent. Here, he argues that, “greater autonomy in dealing with incidents that make us emotional is achieved through understanding the emotional response itself” (39). In this exceptionally well-researched section, Biegler weaves together theory and evidence that underscore his argument that emotion motivates behavior and guides decision-making. Biegler then

argues that justified beliefs about affect are vital for the autonomy of one's behavior and decision-making.

Chapter four, "Depression: Disorder of Affect, Disorder of Autonomy," presents evidence-based arguments that individuals who suffer from clinical depression usually do not hold justified beliefs about life events, and that affect adversely prejudices one's interpretation of events. Inaccurate assessment, in turn, undermines an individual's autonomy. Biegler argues that it is vital for a person suffering from depression to understand that a depressed affect adversely colors appraisals, and through this understanding agents can more accurately assess life events.

Chapter five, "Understanding Negative Biases Promotes Autonomy in Depression," details how autonomy impairment in depression is addressed in both CBT and ADM. Biegler concludes by stating that CBT has a "greater potential than ADM to augment the autonomy of decisions and actions made by the depressed individual in relation to negative affective triggers" (118). This argument becomes the bedrock for the final two chapters.

Chapter six, "Understanding Causal Stressors Promotes Autonomy in Depression," argues that CBT is better at promoting autonomy than ADM. CBT, Biegler argues, can help practitioners understand causal stressors, help patients develop strategies for navigating stress, and promote material understanding. The evidence Biegler marshals for CBT is current, the studies cited are rigorous, and he correctly identifies a solid body of literature that details CBT's efficacy. However, the evidence against the effectiveness of ADM is less solid, more controversial, and perhaps even subject to ideology.<sup>1</sup> It is doubtful that this was a deliberate strategy on Biegler's part—to cherry pick data that support his thesis—but a deeper and broader examination of some of the peer-reviewed literature in favor of ADM (and a methodological analysis of those studies that challenge ADM) is essential given that his thesis rests, in part, upon calling into question certain orthodoxies related to ADM's efficacy.

The final chapter, seven, "A Special Duty to Promote Autonomy in Depression: The Moral Case for Psychotherapy," argues that because CBT is more effective than ADM at promoting autonomy, health care professionals have a *moral* responsibility to provide CBT to patients who suffer from depression. The promotion of autonomy should be at the forefront of treatment, as the "principal goal" of those suffering from depression.

ADM's effectiveness is a matter of controversy. Whether or not ADM or CBT is more effective at treating depression is an empirical question, but it is one that does not lend itself to an easy answer. In the context of the Biegler's argument, that health care professionals ought to advocate CBT over ADM, let us sidestep this controversy altogether and accept by fiat that each are equally effective (163) in all patients

(“effective” meaning each achieve the same outcome in regard to patient’s self-reports of their depression). Given this hypothetical egalitarianism of outcomes, should a patient be steered towards CBT or ADM? Is there even a correct answer to this question?

Biegler’s response, framed in the context of his arguments for autonomy, would be that CBT is the better alternative because it allows for patients to take control of their affliction and better self-manage their condition. However, it is not clear to this reviewer that there is any moral imperative with regard to selecting a particular treatment modality, even if that treatment increases one’s autonomy. Examples in other medical contexts may help to clarify this claim.

Biegler uses the example of diabetes and diabetes self-management towards the end of the text (149). He correctly notes that people suffering from type 2 diabetes can, through diet and exercise, mediate many of its adverse and often debilitating effects. Through lifestyle changes, like being more active or working out at a gym, and moderating diet and caloric intake, many diabetics control their illness. This is an example of patient autonomy: Managing one’s illness, becoming more self-reliant and less dependent on a physician.

But what if, for example, one could simply go to one’s physician and be given a pill that would eliminate all symptoms? What if one bartered away one’s autonomy—by continuing to maintain a dependence on one’s physicians and the drugs they dispensed—but in return one could eat what one wanted and not slave away at the gym? What if one valued desserts and a sedentary lifestyle, even if this came at the expense of one’s autonomy?<sup>2</sup> Conversely, what if one privileged one’s autonomy, lived a healthy lifestyle, and consequently became less reliant on the medical establishment? Why should one of these paradigms and value systems trump another as a “principle goal of treatment” (163)? Autonomy is a value, one that is both instrumentally and intrinsically good, but it is still a value and thus subject to individual vagaries on a self-perceived hierarchy of values. There are undoubtedly other values that are more important to some individuals than autonomy, and these values may also be instrumentally and intrinsically good.

For example, Biegler correctly notes that CBT is hard work (166). What if one is not willing to do this hard work (or if one simply cannot muster the resolve)? What if the very idea of self-work is an intellectual and emotional anathema to one’s notion of well-being? What if one prefers avoidance and the maximization of one’s personal comfort? Why should these values hold less weight than autonomy?<sup>3</sup>

Even if ADM and CBT are equally effective in the treatment of depression, it is unclear that the choice between the two should hinge on which provides more autonomy. This is true even if, using our hypothetical example, the ante was upped and instead of a pill one required weekly outpatient surgery to mediate the effects of one’s diabetes. The values

one invokes when making a therapeutic decision do not rest so easily as to be reducible to a sole criterion, even if a solid body of evidence supports that criterion.

If this rebuttal is correct, and autonomy, while important, is not universally held as a fundamental value, then not only would it be problematic for a patient to feel compelled to do emotional work, but it may also be morally questionable for a health provider to urge a treatment that may make a patient feel emotionally compromised. This in no way demeans the efficacy of CBT, or the value of self-reliance, or the aggregate, systemic health care savings of migrating patients to CBT. Nor does it relativize treatment for depression by catering to patient's irrational preferences. It does, however, question the CBT imperative.

Rather than reading *The Ethical Treatment of Depression* as a call to health care professionals to advocate CBT over ADM, the text may serve as a siren call against *only* offering drugs to treat depression. CBT, after all, could certainly be suggested in conjunction with ADM or as a standalone treatment, but maybe not for everyone.

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<sup>1</sup> Kramer, P. (July 9, 2011). In "Defense of Antidepressants." *New York Times Sunday Review*. Accessed July 2011: <http://www.nytimes.com/2011/07/10/opinion/sunday/10antidepressants.html?pagewanted=all>

<sup>2</sup> It should be noted that this is a radically non-Kantian picture. Recent work in neuroscience and psychology, such as that of Jesse Prinz, has cast doubt on both the accuracy and desirability of the view that humans are fully autonomous agents.

<sup>3</sup> There is an ongoing debate in philosophy about the role of autonomy. It is not obvious that autonomy should be heralded as a "principal goal of treatment" (163). For an alternative view, see Andrew Fagan's 2004 article, *Challenging the Bioethical Application of the Autonomy Principle within Multicultural Societies*, in the *Journal of Applied Philosophy*, V21, 11, 15-31.