Section: Modern PPT practice

CONCEPTUALIZATION OF DEPRESSIVE DISORDERS AND THEIR TREATMENT IN POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY (PART 1)

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Abstract

In this article, the author attempts to conceptualize depressive disorders from the perspective of positive and transcultural psychotherapy (PPT), referring to the main assumptions of this approach and his own experience as a psychotherapist and psychiatrist. In part one, the etiology, symptomatology and cultural and social conditions of depressive disorders are reflected upon, with the idea of systematizing and operationalizing them.

Keywords: etiology of depression, symptomatology of depression, balance model, psychodynamic conflicts in depression, Positive Psychotherapy

Introduction

Depression is a common psychiatric disorder characterized by anhedonia, i.e., loss of interest and pleasurable sensations, and lowered mood with associated affective, cognitive, physical, and behavioral symptoms (WHO, 2019). These symptoms can be chronic or recurrent and lead to significant impairment in an individual's ability to carry out daily responsibilities and perform social roles (Dugal, Fertuck, Kuprich, 2021). In extreme cases, depression can end in suicide (Santomauro, et. al., 2021).

According to the WHO, as many as 350 million people worldwide (5% of the total population) suffer from depression, and this number is increasing every year. Depression is now considered one of the most common diseases of civilization and is second only to cardiovascular diseases.

Depression can be described by three criteria, which are:

(1.) symptoms (frequency and intensity);
(2.) duration of the disorder;
(3.) impact of the disorder on personal and social functioning.

The severity of depression is a result of the aforementioned factors and is graded using four categories:

(1.) subthreshold;
(2.) mild;
(3.) moderate;
(4.) severe.

Cultural context and depression

Given that Positive and Cultural Psychotherapy (PPT) is a culturally sensitive approach to the emergence, persistence, and treatment of emotional and mental disorders, I will devote some attention here to the cultural conditions of depressive disorders. Many studies

conducted in recent decades (Miller, Prentice, 1996) indicate significant differences in representatives of different cultural backgrounds in:

(a) ways of expressing emotions;

b) understanding and explanation of social phenomena;

(c) responses to stress and accompanying mental dysfunctions.

The same is true of depressive disorders; here, too, one can observe clear cultural influences on their etiology, expression, clinical assessment, and modes of diagnosis and treatment (Marsella, et al., 1985; Kirmayer, et. al., 1993; Hirschfield, Cross, 1982; Kleinman, Good, 1985). The most recognized difference in transcultural studies of depression turned out to be its relative rarity in Asian cultures (Marsella, 1980). This finding sparked further research that found significant cultural differences in the clinical presentation of depression (Parker, et. al, 2001; Ryder, et. Al, 2008; Hsu, 2008). Researchers have shown that somatization disorder, which is quite common in Asian cultures, may be a counterpart to endogenous depression diagnosed in Western societies. In addition, it turns out (Miyamoto, et al., 2014) that, compared to Westerners, Asians are more likely to accept negative emotions as an inevitable and inherent aspect of the reality around us. Moreover, Asians can perceive unhappiness as a desirable state, which becomes a source of motivation and inspiration for their further development (Uchida, Kitayama, 2009). The conclusion is that the negative emotions they experience are relatively less disruptive to their well-being. The findings of social anthropologists suggest to us that compared to Asians, Westerners are less accepting of negative emotions and place great emphasis on achieving happiness, devaluing the importance of unhappiness.

Social identity and depression

The relationship between social identity and depression is described by two distinctive concepts, i.e., social identity theory (Turner, Reynolds, 2010) and self-categorization theory (Turner, et. al., 1987). Both theories refer to the interdependence that occurs between individual self and social systems. The concept of social identity assumes that:

(1.) collective social phenomena cannot be fully explained in terms of isolated individual processes or isolated interpersonal interactions.

(2.) social groups shape the individual in psychological terms (perceptions, beliefs, values, and behavior);

(3.) if the values recognized by the collective are internalized by the individual then they affect the individual's sense of identity.

Paraphrasing the previous postulates, it can be concluded that the principles and values that define an individual are usually the result of his identification with a particular social group. Self-categorization theory explains the processes involved in defining oneself in terms of personal identities and social identities. It pays particular attention to when and under what conditions particular social identities become central to the process of defining oneself. It postulates that this is an interactive process involving matching and distinguishes two categories i.e., comparative, and normative.

Similarly, in PPT we seek a more complete understanding of the genesis of depressive disorders in the context of social phenomena. A useful theoretical construct in this case is the microtrauma and psychodynamic conflict theory of N. Peseschkian (1987, 2013). It has a universal and practical application but does not fully explain the differences in the individual pathomechanism of depression or the associated differential expression in selected cultural circles.

Originally, social identity theories were developed to seek explanations for such phenomena as discrimination, stereotyping and prejudice occurring within and between groups and communities. Over time, however, researchers have also begun to use them as a theoretical frame of reference for a more complete understanding of, among other things, depressive disorders. For today - according to the results of meta-analyses conducted by Haslam and his team on social identity (Haslam, et. al., 2009), the following conclusions appear in the context of the emergence of a person's depressive disorder:

(1.) It constitutes a psychological resource, in the sense that it provides communal perceptions of oneself, others and the world at large.

(2.) It provides easier access to various forms of social support i.e., emotional, psychological, intellectual, or

material (the so-called healing properties of social capital).

(3.) It is the basis for exercising social influence i.e., undergoing processes of modeling and influence in terms of thoughts, feelings, and behavior.

(4.) It provides a sense of belonging to a social group (social embeddedness in this world).

(5.) Social ties increase mental resilience to stressful situations and strengthen immune resistance to infection.

Etiology of depression

Studies indicate (Saleh, et. al., 2012; Saveanu, et. al., 2012; Caspi, e. al. 2010) that depressive disorders have a multifactorial etiopathogenesis. The main role in this case is played by genetic conditions and physical, psychological, and social stress, which act through specific pathophysiological mechanisms. These consist of:

(a) decreased activity in noradrenergic and serotonergic neurotransmission;

(b) decreased levels of brain neurotrophins;

(c) overactivity of the stress axis, i.e., the subthalamic-pituitary-adrenal axis;

(d) increased reactivity of the immune response and inflammatory processes.

Stressful situations (micro- and macrotraumas) usually initiate a depressive episode. Such events as the loss of a loved one, chronic illness, relational difficulties, unemployment, financial problems, and life setbacks can initiate the development of depressive symptoms in an individual regardless of ethnicity.

Methodology

PPT DEVELOPMENTAL MODEL OF DEPRESSION (Ciesielski, 2024)

The developmental model of depression as understood by PPT follows the tenets of microtrauma and psychodynamic conflict theory by N. Peseschkian, the founder of PPT. (Peseschkian, 1987, 2013). Its contemporary form (Fig. 1), supplemented by new clinical reports, is described below in several key points.

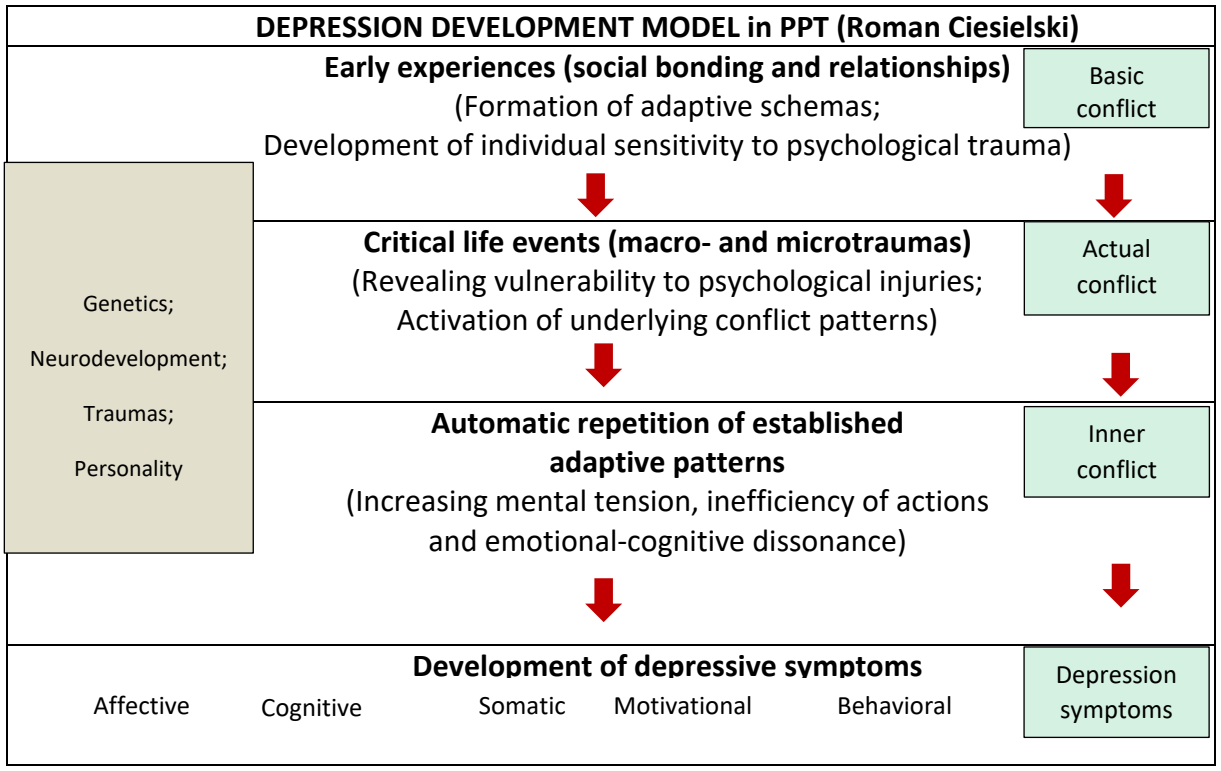

Figure 2. Depression Development Model in PPT (R. Ciesielski)

(1.) EARLY CHILDHOOD EXPERIENCES (BASIC CONFLICT)

During the formation of attachment relationships with caregivers and the establishment of the first social relationships, the child unconsciously internalizes basic adaptive patterns (basic conflicts) that serve to satisfy his existential needs and develop social skills. Secure attachment fosters the embodiment of capabilities that ensure proper development (trust, hope, acceptance, reassurance, etc.) and serves to model healthy interactions in the relationship with the caregiver. The child learns quite quickly that punctuality, for example, can serve to satisfy hunger, and that physical and emotional contact provide a sense of security. On the other hand, however, selectively adapted and overly rigid patterns of functioning (basic conflicts) narrow his repertoire of coping strategies later and determine his vulnerability to selected traumatic situations. In extreme cases of the so-called "insecure attachment " the situation is even more complicated, as the child has no opportunity at all to embody the core capabilities that are essential for his further development and the formation of psychological resilience in him. Thus, his vulnerability to psychological trauma increases significantly. Several studies (Lee, Hankin, 2009) indicate that insecure attachment is a serious predictor of the development of depression in adolescence or full adulthood.

However, it is difficult to determine conclusively what interactions occur between gene expression and the social environment, and how these interactions determine the development of depressive symptoms later in life. Nevertheless, researchers distinguish (Farabaugh, et. al. 2004) certain personality traits that have their genesis in childhood, which sensitize an individual to microtrauma and favor the onset of depression. These include introversion, neuroticism, dependency, and narcissism.

(2.) CRITICAL LIFE EVENTS (ACTUAL CONFLICT)

Most models of the development of depression refer to an individual's susceptibility to selected stress factors. This susceptibility is determined by genes and is neurodevelopmentally determined, as well as by the environment in which we live daily. Among other things, hyperreactivity of the amygdala and its links to the gene responsible for the synthesis of serotonin transport protein at neuronal synapses are mentioned here.

N. Peseschkian (Goncharov, 2020) emphasizes the importance of an individual's interpersonal functioning and preferred actual capabilities present in social interactions as a sensitive predictor of his or her response to critical life events (macro- and microtrauma theory). Contemporary researchers (Jolly, et. al. 1996; Moore, et. al. 1994) point to a predisposition to depression in so-called sociotropic individuals, who base their sense of worth and competence primarily on close relationships with other people. As clinical observations show, in a situation of relationship rupture, exclusion or separation, they react with a marked lowering of mood. Regarding the adaptive patterns described in PPT, it is important here to emphasize the importance of the unmet need for social contact, acceptance and recognition as capabilities predisposing to the development of depressive symptoms.

Critical life events according to PPT concepts are not only large and significant traumas, but also micro-traumas occurring in an interpersonal context. They involve a few secondary capabilities that constitute one's "emotional Achilles' heel," e.g., sense of justice, adherence to order, obedience, loyalty, etc.

(3.) AUTOMATIC REPETITION OF ESTABLISHED ADAPTIVE PATTERNS (INNER CONFLICT)

It is hard to disagree with the observation that adaptive schemas internalized in childhood do not apply universally. Our observations indicate that the adaptive schemes used in the past to satisfy sociotropic needs in depressive patients are too general and excessively rigid. Their automatic repetition in microtraumatic situations, therefore, does not have the intended effect and intensifies the fear of losing important ties with loved ones on whom these patients depend for their own sense of value and meaning.

CLINICAL EXAMPLE

I recall that whenever, in the past, I lost my self-confidence and became depressed, I recovered mentally quite quickly when I offered to help my parents with their garden work. I then performed reliably what they asked me to do, and in return they praised me and were proud of me. My self-esteem grew, and with it my mood increased. I just don't know why it doesn't work now. After all, I suggest to my supervisor at work that I would be happy to take overtime and he rejects my offer, not knowing why, and suggests that I rest more and take care of myself. (Mr. T, 29, single, works for a security company).

As can be seen, Mr. T. is trying to recreate his childhood adaptation pattern. Apparently, at that time it was an antidote to his depressive feelings, but in his new life and work circumstances, it has stopped working. For the moment, not finding new ways to satisfy his need for contact and recognition, the patient falls into a vicious cycle and loses his sense of self-efficacy. In addition, this adversely affects his self-esteem. Prolonged over time, this type of situation causes an increase in psychological tension, and with it increased cognitive-emotional dissonance.

(4.) DEVELOPMENT OF DEPRESSIVE SYMPTOMS

As of today, it is impossible to demonstrate a clear link between selected psychodynamic conflict patterns and different types of depression. However, the most observed internal conflict pattern underlying depression concerns the area of attachment and individual autonomy. In other words, it is about belonging and independence.

a) In people with a predisposition to depressive disorders, their attachment style can be described as highly dependent, resulting in rejection from loved ones. This is because they are unable to live up to excessive expectations in terms of love and care.

(b) On the other hand, the other pole of conflict, i.e., the desire for autonomy, is associated in patients predisposed to depression with a strong need for achievement. However, it is accompanied by excessive criticism of the self and the social environment. Self-criticism causes permanent dissatisfaction with oneself and fear of loneliness. And criticism and exorbitant expectations of those around them cause disapproval and withdrawal.

In summary, it can be said that people with the risk for depression exhibit a high fear of abandonment and loss of contact (Shahar, et. al. 2003; Nietzel, Harris, 1990). However, their search for contact to satisfy their desire for love and care is so intense that they end up achieving the opposite effect, further reinforced by their inflated expectations and increased criticism. In this situation, the depressed person usually withdraws defensively from the social environment and from contact. The specifics of the inner conflict of people predisposed to depression in relation to the Balance Model according to N. Peseschkian is included in Figure 2.

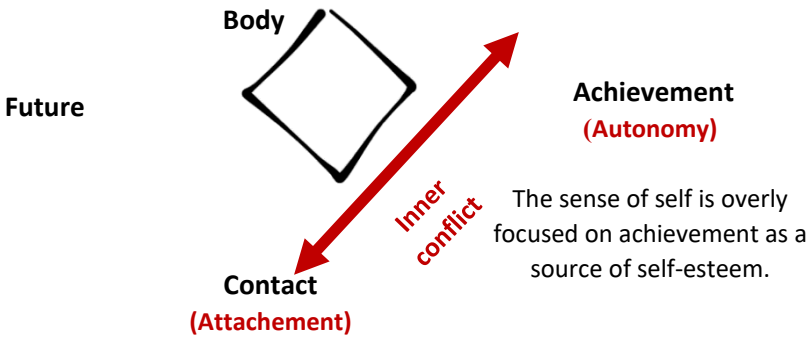

Figure 2. Diagram of inner conflict in depression (R. Ciesielski, 2024)

This conflict can be paraphrased:

Neither can I satisfy my need for contact (no one can guarantee me unconditional love!), nor can I become fully autonomous through my own achievements, for I am perpetually dissatisfied with myself (I cannot give myself full acceptance!).

As written earlier, the persistence of this inner conflict over time breeds strong psychological tension and eventually leads to depressive symptoms. We are not aware of the mechanism that ultimately determines what kind of depressive symptomatology will manifest in a given patient. This is undoubtedly due to his varied genetic and personality predispositions, as well as personal, social, and cultural experiences.

Depression symptomatology

The following types of depression are distinguished (Angst, et. al. 2000):

(1.) endogenous depression;
(2.) dysthymia (neurotic depression);
(3.) bipolar affective disorder;
(4.) agitated (anxiety) depression;
(5.) reactive depression;
(6.) postpartum depression;
(7.) seasonal depression;

Regardless of the common classifications of depressive disorders of a clinical nature, in PPT we additionally use a typology that refers to the Balance Model (Figure 3). This division considers the etiology of the disorder.

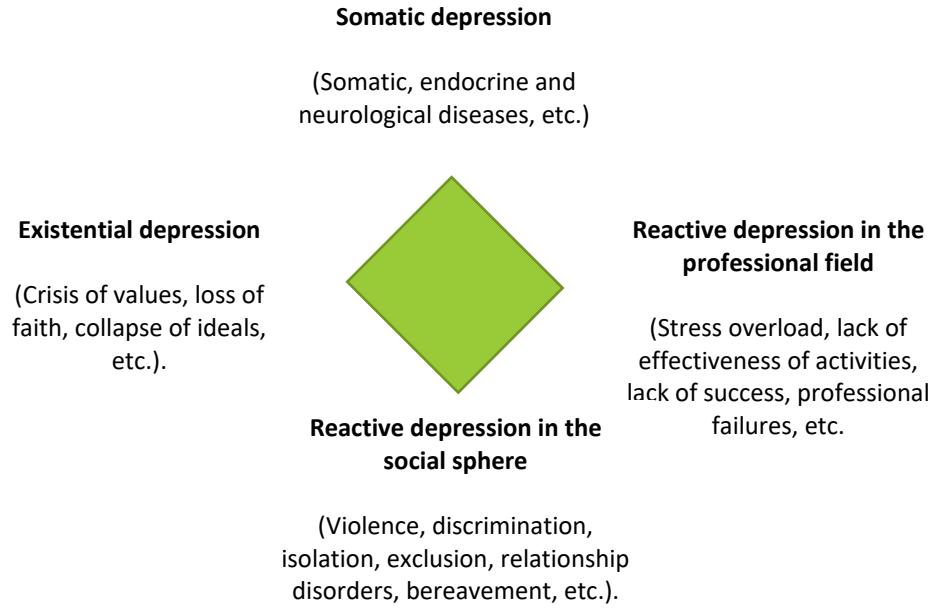

Figure 3 Types of depression according to PPT according to etiology (R. Ciesielski)

n PPT, depression symptoms can be divided into four categories corresponding to the four dimensions of the Balance Model (Fig. 4).

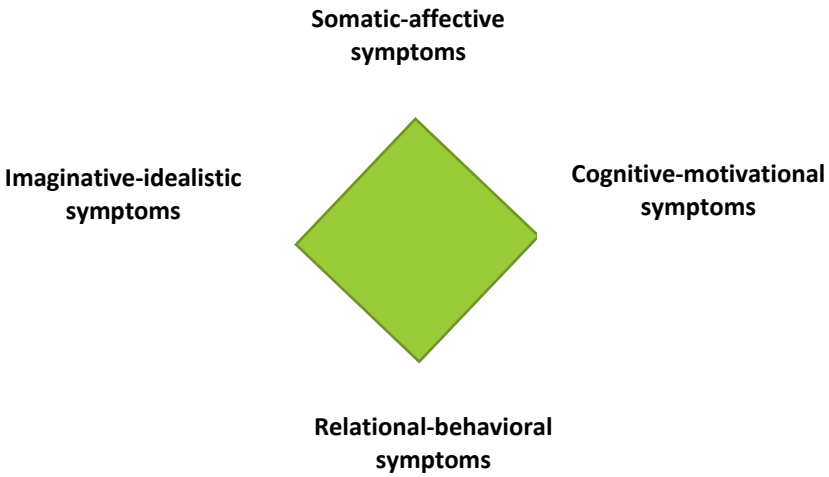

Figure 4. Four dimensions of depression symptoms in PPT

The most common characteristic symptoms present in each of the areas listed are summarized in Table 1.

Table 1.
Four dimensions of depression symptoms - examples

SYMPTOM CATEGORY	SYMPTOMS
1. Somatic-affective	• sleep and appetite disturbances; • feelings of fatigue; • decrease in vital energy and libido; • apathy, emptiness, indifference, anhedonia.
2. Cognitive-motivational	• disorders of memory, concentration and attention; • disorders of motivation and decision-making; • thinking disorders/quantitative and qualitative decline; • narrowing of perception.
3. Relational-behavioral	• decrease in psychomotor drive; • motor and speech inhibition; • avoidance of social contact; • an attitude of passivity and dependence.
4. Imaginative-idealistic	• loss of hope and feelings of helplessness; • increased feelings of guilt, self-criticism; • resigned and suicidal thinking; • nihilistic delusions

Conclusions

Considering that PPT is a clinical field, the conceptualization of depressive disorders takes into account their etiology, typology, symptomatology, and the mechanisms of their onset and maintenance. This knowledge is used to develop an individually-oriented treatment plan that considers neurodevelopmental, personality, stressors, as well as family and social cultural factors. Treatment of depressive disorders will be the topic of the second part of this article.

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