

**Paul Biegler**

*The Ethical Treatment of Depression. Autonomy through Psychotherapy.*

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The mark of a *useful* work in applied ethics is that the moral recommendations it makes should be robust. Robust recommendations are ones the reasoning for which is compelling, and based on premises the credibility of which is unaffected by the answers that may be given to still-controversial deep questions in ethics, value theory or other related disciplines. Thus, a conscientious practitioner can take the advice with confidence, whatever the resolution of these deep questions may turn out to be, and whatever her or his own opinions about these resolutions. If the work is also guided by evidence about the effects of the choices currently available to the practitioner, given the state of her or his art, it is even more useful. Of course, it need not be the final word: new evidence may become available about the results of proposed options, or about side-effects not previously accounted for. Moreover, of course, the art itself may change: new techniques and procedures may turn out to be better than those previously available. Beauchamp and Childress' work on medical ethics (*Principles of Biomedical Ethics*, OUP 1994) is a classic example of a work that aspires to usefulness: by appeal to four mid-range principles said to apply to medical practice (beneficence, non-maleficence, respect for autonomy, and justice) the authors hope to provide means to arrive at ethically defensible recommendations that are largely unaffected by whatever deep ethical theory may ground them. If the principles apply, robustness should only fail where a different priority would be assigned to the principles by one basic theory than by another. Biegler's book argues in a way characteristic of a useful work in the field of the ethics of mental health care.

The mark of a philosophically *interesting* work is that it raises new issues in an area of philosophy, or provides new approaches to addressing one or more issues in a field, or employs novel and impressive arguments to support some proposed resolution, or uses available means to secure a striking result. The "or" is inclusive here: a work could achieve several of these aims. Since this standard is independent of the standard of usefulness, a useful work in applied ethics need not be philosophically interesting, and a philosophically interesting work need not be useful for a practitioner. The merit of Biegler's work is that it appears to meet both standards: it guides the practitioner in a way that make no assumptions about the answers to some big theoretical questions, but in doing so, it advances our thinking about some very important ones, namely, the character and value of human autonomy and the connection of our emotions to our cognitive capacity.

Biegler's concern is with the proper approach to the treatment of moderate-to-severe but uncomplicated depression. These conditions are widespread in the developed world (1–2), but there are effective ways of managing them. However, there are two very distinct modes of treatment that have approximately equivalent effect in alleviating depressive symptoms: the wide range of anti-depressant medications (ADM) and psychotherapy, particularly in the forms of Cognitive Behaviour Therapy (CBT) and Interpersonal Therapy (IPT) (3–4). Are there moral reasons (assuming no counterindications or history of unresponsiveness) to offer one of these

modes rather than the other? Biegler offers an argument for CBT and related forms of therapy as the proper first choice. He maintains that while there is no significant difference in symptom remission, non-pharmaceutical treatments offer additional benefits, since they enhance patient autonomy.

To establish the premises in this argument, Biegler offers reasons to consider enhanced autonomy a benefit and to regard CBT as enhancing it. The arguments for autonomy as a benefit are quite secure: on any reasonable characterization of it as negative liberty coupled with other conditions, it is desirable either as a means to improved personal satisfaction, or as an end in itself, or both (30–35, 146). Moreover, this case can be made without a complete account of autonomy so long as it is conceded that it is enhanced by improved capacity to employ information about facts material to a decision in deliberations about that decision (20–21, following Faden, Beauchamp, & King, *A History and Theory of Informed Consent*, OUP 1986). Material facts are facts that, if known, would be significant in a decision maker's reasoning, given her or his interests and values. It is hard to dispute the claim that a person's capacity to manage her or his own affairs is enhanced by improved capacity to employ information that matters to his or her deliberations about decisions. Notions such as this justify informed consent policies, plain language in government documents and legal agreements, and calls for transparent governance, access to information, and even truth in advertising. The consequence is an advance in an account of autonomy (one is more autonomous if one is better informed about material facts), implicit in a range of well justified social norms and practices, achieved without that full deep theory of self-command that may be powerfully desired but is difficult to achieve. This result is interesting and robust.

Biegler considers CBT to be a corrector of certain cognitive styles characteristic of depressed patients. The styles lead the patients to misinterpret a variety of material facts in their decision-making. For example, depressed people misunderstand the role of environmental stressors in producing their unwanted moods and bad decisions (82–95). CBT has the capacity to correct this (Chapter 6). If Biegler has the facts down—I am not competent to judge—then we have a useful result: CBT offers one apparent autonomy-enhancing advantage. Moreover, depression produces negative biases in information processing. CBT can correct these by training the subject in a metacognitive awareness of the tendencies to bias, and in overall mindfulness (Chapter 5). In addition, depressive cognitive styles both produce and stimulate the misinterpretation of emotive states of low evidential value (Chs. 3-4). This means that depressed people persistently misjudge their own circumstances, and so cannot make good decisions about how to address their own interests. CBT is alleged to improve one's understanding of the evidential value of a range of negative emotional states without an effect common to ADMs: the flattening of our capacity to have them (sometimes they do provide important information). If we understand what our emotional states are likely to mean, we will be better judges of what is in our interests, and our autonomy will be enhanced in this second way. Another useful result.

This result is also interesting for what it suggests. It is fair to say that many philosophers fret about human emotion. Its dangers are fairly obvious: it can lead to actions bad for the agent, and bad for her or his neighbours, human or environmental. Even when the importance of emotional life is conceded, many wish to keep it under the firm control of reason. This may be right, but it neglects the (admittedly defeasible) role our feelings play as a source of information

about our own circumstances, our relations to others, and even the supportive or hostile features of our own surroundings. Fear and disgust, for example, are reasonably good indicators that their objects should be avoided. Emotions can, and should, be schooled, and can only count as heuristic at best, but they are central to our management of our lives. Biegler's treatment of the depressed person's troubles employing emotion reminds us that it also has a place in our cognitive lives.

There are objections to be addressed. ADM induces neurophysiological changes that are associated with *both* mood improvement and better decision-making (111–118, 130–141). Biegler hypothesizes that these changes may well be mimicked by CBT over the long term, while it does not produce a range of response incapacities associated with some ADMs. He struggles with the patient who, once given information, may prefer ADM to CBT, a case where the beneficent act of autonomy promotion may conflict with proper respect for patient autonomy (157–158). This matter can probably only be decided if deep conflicts between utilitarian and deontological theories are settled and a thorough account of autonomy given. Finally, while Biegler thinks that a cost-benefit analysis will resolve the objection that CBT may do more but at a disproportionately greater cost (160–162), he does not confront one objection seated in the medical practitioner's obligation to so justice. Even though CBT is a therapeutic technique that requires relatively brief treatment at a manageable cost, it does require specially trained therapists. I suspect that this is a limited resource, inadequate to the number of treatment seekers. Training takes time and costs money. Is it not possible that the best way to ensure that all benefit from a decent level of treatment is to use medication as the first line of care? I would like to hear arguments on this subject.

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