The Importance of Adverse Childhood Experiences in Depression and Recommended Psychotherapy

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Depression is one of the most common mental illnesses which persistently harm cognitive well-being, often resulting in lower productivity and a lesser quality of life. Given the serious consequences of untreated depression, many tests have been developed to predict its prevalence and spot contributing factors; one of the strongest being the ACE, or adverse childhood experience, test. The ACE test uses a point system to calculate a sum of traumatic childhood experiences ranging from various types of abuse to familial dysfunction. These scores indicate the likelihood to develop illnesses such as depression. Once an illness is developed after early adversity, an appropriate course of treatment should be chosen so that rehabilitation and therapy can promote well-being. Adverse childhood experiences resulting in depression should be treated with cognitive behavioural therapy (CBT) since it provides the client with the most utility to reverse harmful tendencies. It is important to recognize that new waves of CBT require the utmost professionalism and awareness from clinicians to maintain therapeutic integrity.

Unfortunately, it is not surprising to see that childhood adversity can result in depression since depressing events logically evoke depressing feelings. However, the ACE test is not a guaranteed predictor of future mental illness despite proving its validity in flagging contributors to depression. Frampton et al. (2018) analyzed a study by Felitti involving 8506 patients from the Kaiser Permanente Health Appraisal Clinic who completed an ACE test focusing on seven childhood experiences: psychological, physical, and sexual contact, household substance abuse, household mental illnesses, domestic violence, and criminal activity. Felitti concluded that participants who indicated at least one experience of adversity were more likely to develop illnesses such as depression (p. 45). Felitti's conclusion is not shocking since it is common to run into adversity while living with others; however, neither time spent together or instances of

adversity can guarantee clinical prevalence. According to the ACE test, someone surrounded by abuse is more likely to develop depression but may benefit from early therapy to process harmful trauma. The ACE demonstrates the important impacts of maltreatment on psychological growth which promote the right kind of early therapeutic treatment. To further prove this correlation, Li et al. (2015) conducted a systematic review and meta analysis of the relationship between early abuse and development of depression. The results were astonishing and showed neglected participants were 1.75 times more likely to develop a later mental illness, such as depression.(p. 724-725). The relationship between mental illnesses and past adversity (revealed in the ACE test) is important to understand for choosing the most appropriate psychotherapy to process trauma before the illness begins.

Depression is a dimensional construct where clients experience different forms and intensities of depression for different lengths of time. It often feels like an overwhelming sense of sadness or a colourless world where sites and smells that were once exciting seem empty. Individuals often function at a lower level where self care and hygiene are neglected due to a lack of motivation or purpose. Depression may begin with a small feeling of sadness which can quickly escalate into a full-blown physical shutdown, or potential suicide. If a client is overwhelmed with negative feelings, it is important to detect any early adversity and prevent future damage in therapy. Understanding the serious consequences, contributors, and risks of depression can make it easier to choose the right treatment the first time. Given the severity of negative thoughts and neglected health, cognitive behavioural therapy seems to be one of the best treatments in the reversal of suffering from early adversity and treatment of depression.

Cognitive behavioural therapy, or CBT, is one of the most common psychotherapies for treating depression. Different kinds of CBT are used for different illnesses depending on the severity of the illness, medical history, and nature of adverse childhood experiences. Treatment as usual (TAU) is another form of psychotherapy which typically involves some type of medication or counselling from different medical care providers. TAU is equally as common, if not more than CBT, but has been recently ridiculed over efficacy and overall client well-being post-treatment. It is important for a client to understand the nature of treatments and possible risks so that they choose the best fit. The National Institute of Health Care Excellence (NICE) has recommended self-help, computerized, individualized, and group format CBT for the treatment of depression which was supported in a study conducted by Watts et al. (2014). In said study, one group of adult participants with either anxiety or a depressive disorder were given no treatment, treatment as usual, delayed treatment, or CBT to later compare symptom results through short-term tests, such as the Beck Depression Inventory (Watts et al., 2014). Interestingly enough, the medium effect size for the CBT group was heavily dependent on the nature of TAU; meaning that those with TAU under a personal provider displayed a smaller effect size than those with multiple referrals from unfamiliar faces (Watts et al., 2014). These results do not suggest that TAU is an inappropriate method, but rather that clinicians ought to look closer at the nature of applied treatment and the emotional effect it has on clients. Depression often makes one feel meaningless so it is important for a treatment to create meaning, which TAU lacks. Perhaps CBT had a larger effect size because of its genuine nature; there is an effort made to truly understand the client and conquer their cognitive issues.

The concept of assigning the right client to the right form of therapy has long been a concern in psychology. It is crucial to the wellbeing of the client and integrity of the clinicians to ensure that this process is analyzed thoroughly. Boschloo et al. (2019) compared the use of medication (TAU) and CBT in an Individual Patient/Participant Data Meta-Analysis (IPDMA) which stressed the importance of 'precision psychiatry'. Precision Psychiatry is aimed at informing clinicians of precise treatment courses based on prior symptomatology; which was important to Boschloo et al. (2019) because of its personalization for clients with individual experiences with mental illnesses. Amy, with a history of schizophrenia, may benefit more from medications in TAU due to her prior symptomatology. She may have more severe psychotic symptoms which require medication; but Ben, with no prior symptomatology, may benefit more from CBT for acute depression. Prescribing potentially risky medication may introduce serotonin syndrome-like symptoms and increase a client's self consciousness of mental illness. Boschloo et al. (2019) wanted to avoid worrying people like Ben and believed that precision therapy would create more form fitting psychotherapies. Boschloo et al. (2019) also found that medications work for only four of the twelve depression symptoms, which are largely physical, indicating that CBT might be better for depression due to its less invasive/extreme nature.

While antidepressants are an important part of treatment, not every client may respond to them nor should they be used as a first response; it is equally important for clients to work on negative cognitions with a therapist. All too often mental illness is looked at as a problem which can only be solved with medication. Medication has many potentially harmful risks (insecurity from social stigma, addiction, added medical problems) which should be thoroughly thought through before prescriptions are given. Ebert et al. (1997) studied the effects of fluvoxamine, a

common antidepressant, on 170 men and 30 women who were each given a mean dose of 150-300mg/day for 41 days (pg. 72). In just 14 days on 150mg dosage, a male aged 35 began to experience paranoia, agitation, insomnia, and hallucinations after his mildly depressive state was resolved. Forty-eight hours after fluvoxamine was stopped, the male no longer felt symptoms of serotonin syndrome (Ebert et al., 1997, pg. 73). Many other participants also felt psychotic symptoms before their depressive symptoms were alleviated, which is no better than remaining depressed (Ebert et al., 1997, pg. 73). Quality of life is important in psychotherapy; if one problem is solved with three new issues, perhaps harmful side effects in antidepressants are not worth it. Precision psychiatry is important and potentially life-changing for clients; if the treatment is not worth taking, the client should have a better option. Medication does not teach one to prevent depression or understand why it is there, which is not helpful for remission.

While TAU is a great option for severe symptoms of depression, there are more sustainable options as a first response. Hawley et al. (2017) incorporated the Mind Over Mood protocol for outpatients aged 18-65 with clinically-diagnosed major depressive disorder (pg. 31). In nine sessions, patients completed the Beck Depression Inventory and reported their use of CBT skills: behavioral activation, cognitive restructuring, and core belief strategies (Hawley et al., 2017, 31). Interestingly enough, Hawley et al. (2017) found that behavioural activation worked better for patients with mild depression, cognitive restructuring was associated with a decrease in depression, and core belief strategies were best used as symptoms intensified (pg. 40). Hawley et al. (2017) also found that switching from different CBT skills or using each in continuation may be more harmful for symptoms as each skill correlates with a type of depression (pg. 41). Using the concept of precision psychiatry from Boschloo et al. (2019, one

can see the importance of assigning the correct type of theory to a client; someone with mild depression may not benefit from core belief strategies, as they are meant for more severe symptoms. Much like its title, Mind Over Mood, reflects the initiative of CBT which is to improve mood by using the mind to control harmful thoughts.

Third wave CBT represents a new generation of therapy, much like the Mind Over Mood protocol, which consists of new forms such as: acceptance and commitment therapy, mindfulness-based CBT, and compassionate/competitive mind training (Churchill et al., 2013, pg. 5). Acceptance and commitment therapy teaches clients to use skills such as: cognitive defusion, acceptance, contact with the present moment, and committed action to increase self-awareness and realization of a better self by taking power away from negative thoughts (Churchill et al., 2013, pg 8.). Meditation is a non-reactive tactic used in mindfulness-based CBT which teaches a client to be aware of present thoughts and feelings without an overwhelming sense of judgement (Churchill et al., 2013, pg 8.). Meditation is often difficult for depressed individuals to do as their sense of concentration may wander to negative cognitions; but in combination with methods such as acceptance and commitment therapy, clients may learn to work through concentration issues by accepting them as insignificant to their overall capability. The study conducted by Churchill et al. (2013) compared TAU to all CBT methods and favoured third wave tactics with more participants going into remission, better responses to treatment, lower BDI scores, and better social adjustment as measured on the Work and Social Adjustment Scale (WSAS) (pg. 19). While third wave tactics are relatively new to psychotherapy, there is hope that treatment may broaden to fit the entire dimension of depression. It is promising to see a psychotherapy that teaches acceptance and forgiveness to clients which may need it the most.

While methods of CBT clearly bring about positive change, clinicians must still abide by core principles of psychotherapy to maintain integrity. Remaining professional and non-biased is key to the continuity of success in CBT and its reputation as a plausible course of treatment. It is important to understand how it may be easier to stray from therapeutic principles in something as fluid as mindfulness meditation. Clinicians must focus on the two outcomes of therapy: low symptoms and positive wellbeing, but realize that they are qualitatively different constructs of mental health (Camacho et al., 2021, pg. 779). A client can have lower symptoms without an overall positive wellbeing, as demonstrated with fluvoxamine. This distinction is especially important to understand in CBT where lowering symptoms may be more difficult without immediate medication. Camacho et al. (2021) also found that patients experience lower symptoms once a manageable level of wellbeing has been reached (pg. 784). This might give clinicians a better idea of how to approach CBT which might prioritize wellbeing. Afterall, it makes sense that a client would genuinely learn more with a positive mindset.

CBT is in partnership with precision psychiatry and is a very important relationship for treating depression. Expanding the personalization and efficacy of treatment encourages genuine success and the client back control over their own health. The prevalence of depression is very high and something clinicians ought to be the utmost prepared for, with adverse childhood experiences being one of the earliest opportunities to do so. Noticing possible contributors to mental illness and providing a vast range of personalized treatment is the most important takeaway. Hopefully with more sympathy and kindness, the rates of mental illnesses will drop; but for now, the best we can do is give those around us the best kind of treatment they deserve.

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