

BARRIERS TO PSYCHOLOGICAL TREATMENT OF DEPRESSION: CASE STUDY PRESENTATION OF INCOMPLETE EMDR TREATMENT

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INTRODUCTION

Sadness, low mood, loss of interest or enjoyment of daily activities (especially those which were sources of pleasure) are symptoms that sometimes overwhelm everyone but they eventually resolve. However, when such a state lasts and significantly affects the ability to perform daily duties, then it is probably depression. Depression is a mood disorder characterized by a constant low mood that is accompanied by feelings of great sadness and loss of interest in anything. A special feature of depression is the permanence of this condition, which does not actually go away and does not pass, lasting on average 6 to 8 months. According to the World Health Organization (WHO), depression is the most common disease in the world today and one of the leading causes of disability globally, affecting 350 million people worldwide (WHO). Professionals and scientists today agree that several factors can play a significant role in the onset and development of depression ranging from biological or biochemical (changes in certain neurotransmitters in the brain), genetics, personality traits to environmental factors. In addition to biological and genetic factors and personality traits, environmental factors such as continued exposure to violence, neglect, abuse, or poverty are certainly factors that can make some people susceptible to depression. Important symptoms of depression certainly are depressed mood, decreased interest or enjoyment in previously enjoyed activities, loss of sexual desire, unintentional weight loss or decreased appetite, insomnia (difficulty falling asleep and maintaining quality sleep) or hypersomnia (excessive sleeping), psychomotor anxiety, (restlessness), slowed psychomotor activity, (slowed movements and speech fatigue or loss of energy), worthlessness or guilt feelings, impaired ability to think, concentrate or make decisions, repetitive thoughts of death or suicide, or even suicide attempts. Research data from the USA indicate that approximately 1 in 5 adults experience at least one depressive episode during their lifetime with a tendency for long-term relapse which ultimately affects an individual's psychophysical ability (Hirschfeld 2012). Depression is often associated with

negative life experiences and events, especially those at an early age (childhood abuse and neglect).

Studies indicate that depression is often associated with early negative life events (Lenze et al. 2008, Syed & Nemeroff 2017, Wang et al. 2020), and that people with chronic depression report a higher number of previous adverse life events (Riso & Newman 2003, Wang et al. 2020). Early life events, whether positive or negative, beneficial or harmful, have a huge impact on an individual's development, behavior, and long-term health. In addition, negative/adverse life events, defined as potentially traumatic events experienced from birth to the age of 18 increase the risk of disease and behavioral challenges, such as obesity, depression, and alcoholism (Belazair 2018). Childhood trauma is a direct and strong risk factor in the development of depression later in life (Heim et al. 2008), its chronicity (Wiersma et al. 2009), early-onset (Bernet & Stein 1999) and more depressive episodes during life (Bernet & Stein 1999). Hence, depression is a complex disorder that can occur as a result of many different factors, including biological, emotional, and environmental.

The selection and application of depression treatment should be based on and tailored according to the factors associated with or even the cause(s) of depression because the preference and effectiveness of treatment for any disorder mostly depends on their cause or causes. Since depression, most often, causes psychophysical disability and reduces the ability to perform daily activities, it is commonly treated pharmacologically. However, although pharmacological options in the treatment of depression today are diverse and numerous, recent research suggests that the degree of efficacy for most antidepressants compared to placebo is more modest than previously thought (Cipriani et al. 2018) and most antidepressants have serious side effects (Uzun & Kozumplik 2009, Wang et al. 2018, Coupland et al. 2018).

On the other hand, the psychotherapy as a psychological treatment of depression is far more effective and yields better results. Psychotherapy, among other things, more likely helps and leads to probable changes in both the thoughts and emotions and the behavior of patients. In addition, as indicated by Yang and colleagues (2016),

it has been shown that the treatment of depression with evidence-based psychotherapy results in, brain changes and brain networks connectivity, recapitulating the idea of Hebbian synapses, “neurons which fire together wire together”, and increase neuronal plasticity (Koch et al. 2009).

If we consider that depression is often associated with, if not caused by, a high incidence of trauma (Fisher 2017), developmental trauma, in particular, the therapeutic approach should consider stress and trauma treatment alongside with depression. Eye Movements Desensitization and Reprocessing (EMDR) is certainly one of the most effective, evidence-based therapeutic approaches among psychological treatments intended to treat trauma and stress-related disorders (Hasanović 2014, Hasanović et al. 2018, 2021). Precisely this therapeutic approach was used as a psychological treatment of depression in this case. And, just as with any approach in the treatment of any disorder, despite the best efforts of psychotherapists, some clients do not show progress and /or react negatively to all psychotherapeutic interventions, sometimes. In such cases, therapy faces obstacles and barriers to effective treatment. Obstacles to treatment sometimes prevent clients from seeking help and might seriously interfere with the effectiveness and outcome of psychological treatment. If such obstacles go unnoticed, unidentified, and unaddressed on time they might cause treatment disruption and abortion. Here we will point out the obstacles that disrupt the effectiveness and outcome of psychological EMDR treatment of depression (Draganović 2018, Šabanović & Draganović 2018).

The aim is to present obstacles to effective psychological treatment of depression which developed during EMDR therapy

CASE STUDY

Female client presents with a range of depressive symptoms such as negative thoughts, sleep disturbance, feeling stuck, avolition, and some self-destructive behaviors over the past four months. In the first phase of therapy, a number of t-traumas were successfully resolved and the client reported feeling great. During the second phase of therapy, the client reports her condition is worse than ever. Together, the therapist and client make new therapy goals and EMDR processing begins during which the client dissociates, resists further processing. Next, the client attends therapy irregularly, cancels sessions frequently, and eventually aborts therapy. Upon the therapist's assertion on closure, the client comes to another session and reports strong negative beliefs about the positive outcome of the therapy and lack of motivation. The therapist gently and clearly agrees and verbally and nonverbally supports any client's decision, including discontinuation of therapy. However, a few days later the client called declaring a

strong commitment and willingness to continue therapy. The therapist uses Knipe's guidelines for recognizing and resolving blocking beliefs to address barriers to treat depression symptoms.

The client is 32 years old female, a senior student of a Master's degree in Art (Painting), currently employed as a tour guide, not satisfied/happy with the job, but earnings help pay the bills. Primary complains and reasons for help-seeking: lethargy, negative thoughts, lack of self-confidence, preoccupation with worries, too much of everything (overwhelmed), sleep problems, procrastinating in all obligations (studying, work, family, boyfriend relationship, cleaning the house (literally living in a mess at home), low mood, inability to focus (study) at night (because works during the day), self-loathing, finds everything hard, watches TV too much, eats when upset, no motivation. Sometimes thinks the world would be better off without her but doesn't think about suicide.

Considers painting hobby and therapy but not able to do it later, likes movies, (fantasy, sci-fi, horror), walking, reading, and being quiet, all this she almost stopped doing. In a relationship with a boyfriend for 6 years (my boyfriend lives in another city). Has a cat.

Appearance: client looks neat, comes to the sessions in black clothes mostly, wearing makeup.

Family: The client is a middle child in a family, both parents alive, has a sister (older, married, has two children) and a brother (married, has a child with disabilities). Sister lives in the same city and parents and brother not. Relationship with mother OK, talk regularly on the phone, every day. For the mother, the client says less negative, but negative, and father, emotionally unavailable, does not speak, does not call, that type. Calls the relationship between parents weird, married but divorced (unofficially), living together but everyone lives and leads own life, quarreling a lot, constantly (the thing the client remembers the most from childhood), father blaming the mother and them all for everything.

Brother, Client names him as "selfish, focuses on self", a different type, verbally aggressive, spoiled, everything he ever did was always approved and justified, shouts and yells when nervous (just like the father, even using the same words). Currently, brother lives together with the client in the apartment (because of work), and on weekends goes back home. The client is not OK with that. Brother does not like her cat, orders her to lock the cat in the room, and threatens to do something to the cat. The client claims her brother is an alcoholic, aggressive, violent, parents tolerate and justify all his behavior, always taking his side, constantly caring about him, and insisting that he be helped (because of his disabled child). The client claims to have a good relationship with the sister, but says, "We are the complete opposite." Sister wants to help her, but by helping she does more harm, pressures her by comments, “why are you behaving like that? How is

that possible? Snap out of it!". The client feels "not understood. "Client had experience with a psychologist before, did not like it, stopped going (her parents took her to therapy but argued in the car on the way and back).

Current complaints and initial assessment

In addition to the self-described and reported symptoms that match the diagnostic criteria for depression, the client's score (35) on Beck's depression scale indicates severe depression.

Case study conceptualization

Although the client appears somewhat functional, works, maintains some form of a regular relationship with her boyfriend, self-loathing, lack of motivation and self-confidence, indecision, and reluctance prevent her from completing Master studies, find adequate employment, dare and take control of her life. It is estimated that the client's depressive state is associated with negative life events in early childhood, constant parental quarrels to which the client was constantly exposed to (her words), disturbed family dynamics, parental dysfunctional marriage, and their preoccupation with the son because he constantly caused problems, and parental concern about son's marriage, his child, future (he is irresponsible towards his family, spends everything on alcohol, quarrels with his wife constantly), her experience that she was not noticed, accepted, seen, neglected (NC I am invisible, I am a reject) and her brother's aggressive behavior throughout life, today even, and sister's misunderstanding and helping in the wrong way. During history taking, the client seemed very calm, showed no signs of anxiety or sadness, even numb.

It was estimated that it is necessary to start with psycho-education to help the client understand what is happening to her and validate her feelings and symptoms before moving on to processing current and previous stressful and traumatic events. Hence, after thorough history taking, the EMDR therapy course takes place through: phase two, preparation through destigmatization and psychoeducation, phase three, assessment, phase four, desensitization and processing of t-trauma by EMDR, during which blocking beliefs were identified and addresses using Knipe's blocking belief protocol, and continued EMDR processing on the road to cure.

EMDR treatment of depression

The standard EMDR protocol for most complaints is implemented and used in three phases, known as the three-pronged protocol: targeting past events; targeting current stimuli that activate the client's current dysfunctional reactions; and building and establishing

positive future patterns for acquiring new adaptive responses for appropriate future action through standard eight phases protocol (history taking, preparation, assessment, desensitization, installation, body scan, closure and reevaluation). The first two EMDR phases went smoothly, history taking and preparation when a safe place was installed and resource building done. However, during the third phase, assessment and desensitization, the client's present triggering event (conversation with the sister) naturally immediately triggered the past events. Although past events remembered with difficulty, in eight (60 minutes) sessions, the client wonderfully and with ease processes numerous developmental traumas upon what declares feeling great, reborn, truly OK, no need to do more work. By mutual consent, two weeks break is agreed (to check what happens), after which, the client comes back again, and declares "feeling worse than ever"...

Now, the second phase of EMDR therapy begins at this point, when therapy barriers occurred. The client targets a lack of self-confidence and self-loathing hatred, disbelief that she can get through the problems, but demands an answer to why she feels this way. In this part of the therapy, the therapist to do psycho-education about trauma and its effects again. The client begins to nod and report I get it. A new target list is made to be processed but the client refuses and insists on talking about problems (for several talk sessions) during which client describes and explains, rationalizes, justifies, and claims to understand the problem, understands why family treats her that way and declares a desire to change. The client reports no one to rely on when calls or asks for help. On the therapist's question "how does that make you feel", answers terrible. Affect bridge is done here, and the client feels overwhelmed (avoids), declaring, "I can't do it". Does not want to do EMDR and chooses to make a list of things she wants to change (start cleaning the house, painting, going to college to see what her status is, asking for help from sister when she needs it), defining and planning how to accomplish tasks. For a week client is consistent, works on assigned tasks (cleaning the house), she sends evidence of progress every day, she declares she feels better but totally fails at school tasks, what wants to change that the most. The therapist again suggests EMDR and BLS and the client refuses, stating to prefer to "talk", from then onward, coming less regularly to sessions, frequently canceling until she stops coming to therapy.

Upon therapist's checking and suggesting closure, the client comes back again, reporting a strong negative belief "I don't believe I can be helped", followed by, "Okay, now I know why I'm like this" and "that's it, that is me, it is enough for me to understand why I am like this". When asked, "Was that the goal of the therapy", the answers no, "I want to change" but states "I believe I can't be helped" (therapist identifies blocking belief) and "I don't think I need therapy anymore". The therapist

acknowledges this all, validates the client's feelings, and offers options, to end the therapy, gently and clearly voicing out "I am here and I will support and respect your every decision whatever you decide", and so the session ends. A few days later the client calls expressing strong commitment and desire to continue the therapy again. At this stage of therapy, the therapist used Knipe's instructions for identifying and resolving blocked beliefs, addressing each one with BLS successfully.

Identifying and addressing blocking beliefs as therapy obstacles

Before addressing the blocking beliefs, the client reports recalling the events from the past and agrees with the proposal to do EMDR and BLS to process them, which again she does successfully. During BLS she recognizes the thought which comes to the surface, "I am constantly criticized, and today even, insulted, belittled, and justify it. To the question, "how does it feel?" the client reports, "I can't describe how I feel." The therapist gives her paper and pen to draw, and the client draws a dark patterned circle, something that she feels in her entire body. On an attempt to process that again, reports "it's hard, I can't".

(Note! Flash or Knipe's Back of the head scale would be very at this stage but, unfortunately, the therapist did not know about it at that time).

Using dialectical and ego therapeutic techniques, the client is instructed to approach it with curiosity and describe the experience. Here the client declares "It's a horrible feeling, as if I'm alone somewhere, abandoned, in terrible pain" (visibly upset, sad, crying, breathing deeply, as if processing). The client is asked to tell that part that she knows how she feels, to tell her with her feelings, while the therapist closely monitors the client's process, tapping her, sees changes. She goes through it and reconnects with that part, upon which declares feeling "Liberating!, I have never been able to do this until now, because I am used to avoiding, it was easier for me to avoid, now I feel liberated. "

Next, identifying blocking beliefs according to Knipe's instructions started. From the list client chooses the following blocking beliefs:

"I'm not sure I want to solve this problem (and adds, because I believe I can't).",

"I say I want to solve this problem but I don't actually do it" and

"If I solve this problem, I will lose part of what I actually am" and rates all three with 7 on a scale of 1-7 (1 completely untrue - completely true 7). When asked "what you would like to think instead", she states:

"I am certain this can be solved",

"This problem can be solved", and

"I will be ok if I solve this problem", each processed by several sets of bilateral stimulation (eye movement) what ended with the strong statement "I feel even more

that it is possible to solve this problem", (BLS accompanied by a smile) and concludes, "I believe I can solve this problem (VoC 7). Then, second blocking belief processing "If I solve this problem, I will lose a part of myself" (rated maximum 7). Upon "What would you like to think instead" this statement is immediately with first sets of BLS turned into "Well, that is not me, I'll be (real) me again", "I will be me again". Here below we present this part of BLS:

Client (C): "...something prevents me from getting rid of it (as if aliens came and took over me, that's why I'm like that) ",

T (T): "Just go with that" continues BLS

Client: "...still something prevents me (now, it is a being)",

Therapist: "Go with that", continues BLS,

C: "Still prevents me but now looser",

T: "Go with that", BLS,

C: "Now I want to vomit it all".

T: "Go with that", BLS

C: "I'm vomiting (a little)"

T: "Go with that" BLS, "that's good".

C: "I vomited everything"

T: "Go with that", BLS,

C: "I'm better now, I'm OK now."

(Visibly relieved, smiling, declaring fatigue and drowsiness (can be noticed on her). The client declares feeling good, relieved, as if "something" has disappeared from me, "now I am the real me. So, this is how Knipe's blocking beliefs protocol was used to help the client got unstuck and ready to move on. The therapist also considers the need to combine EMDR with other therapeutic techniques (ego or dialectical therapy) to help the client address and resolve early childhood traumas.

Impact of processing blocking beliefs

Processing blocking beliefs unstacks the client and she recalls events from the past, which she wants to process with EMDR now. In subsequent sessions, she chooses to start with the current stressful situations (brother's abuse of his wife, their quarrels), which triggers her of parental constant quarrels, father blaming them (mother, client, and sister) for everything. In an attempt to process these events, the client sees images of what is happening, but "I don't feel anything", "that's how I see myself, I see myself coming home, prepared in advance not to feel anything, in order to prevent it from impacting me (avoidance), as if it doesn't happen to me" (depersonalization), "because if I feel, if I'm not careful, I'm gone, it will destroy me." An affect bridge brings her to the event, "brother comes home at 4 in the morning, drunk, aggressive, client in her room). NC: "I can't protect myself", PC "I can learn to protect myself", (VoC 2), emotion fear, all over my body, SUDS 10 (wants to avoid, the therapist gently explains what is

happening to reassure the client that she is safe now, just go with that, a few sets of BLS- EM), “now I see their faces, mom is constantly crying, dad, yells, brother is crazy”, (same cognition and emotion and SUDS). Next, she sees herself coming home with a shotgun, aiming at them, killing them all, brother still twitches, shooting him one more time, joy on her face but declares, but...

C: "But it's not normal",

T: "It's okay, it is just imagination, it is not real", and continues with BLS.

C: "I'm ok now", “Aham, I can call the police, I cannot let him into the house”, (BLS),

C: “The rings, I don't let him into the house, I tell him, sleep in the car, father gave you the car anyhow, turns off the doorbell, goes to sleep, wakes up in the morning, I can leave, I don't have to be there, I can go out, I can tell Dad, I have the right not to let him into the house when he is like that (drunk and aggressive). The client finally smiles, noticeably ok, relaxed, and not disturbed any longer, “I can learn to protect myself” (VoC- 7). SUDS 0.

Now, recalls and successfully processes (with EMDR) more events from the past. After processing, reports feeling empowered, no longer helpless, and begins to remember that she is actually happy, cheerful, likes to joke (what, till this moment, she could not, could not remember anything nice about herself, positive, nothing she is good at, never knew how to do something for herself, how to leave and react in moments of violence (helplessness), chooses to stay in unfavorable circumstances and always felt bad, how she pushed others away from herself (boyfriend), therapy. Now, in her own words, “I see differently, I see”.

At the end of this session, "I needed to talk about it, needed to hear them me I was ok, that it was okay to feel that way (validation need she never got from anyone), that is why I needed to talk about it here in therapy, to hear from you (therapist) that I wasn't crazy”.

The session ends successfully with the therapist's praising the client, client visibly satisfied and happy, face glowing and eyes shining.

DISCUSSION

Depression is a serious disorder with a wide range of symptoms that make it impossible for a person to perform daily activities and causes serious mental suffering and pain that manifests itself in a lack of will, motivation, enjoyment of things and events previously enjoyed etc. Psychological treatment of depression usually yields good results in the sense of curing a client's complaints and symptoms. However, occasionally, despite psychotherapist's best efforts, some clients fail to show progress and/or react negatively to all psychotherapeutic interventions. Such clients are most commonly referred to as oppositional, reactionary, unyielding, unattractive, and unmotivated (Dowd 1989)

and, overall, difficult clients (Steele et al. 2017). The behaviors that such difficult clients exhibit are often collectively referred to as resistance. In clinical terminology, resistance is defined as the process of avoidance or reducing the sharing of processing material because it can potentially cause discomfort or anxiety to the client (Pope 1979). Resistance is therefore an active process that potentially can, not only become a fundamental barrier to a positive therapeutic outcome, but also interfere with the perceived therapist effectiveness, disrupt client motivation, and undermine the process of change (Nystul 2001, Steele et al. 2017), during therapy. Whilst an underlying process in psychoanalytic therapy, resistance refers to anything that prevents progression or prevents clients from reporting and processing events, be it a thought, an idea or attitude, feeling, or action (conscious or unconscious) that helps maintain the status quo and prevents progress during psychotherapy (Corey 2009).

The client's resistance manifestation in this case is reflected in session cancellation, the desire to quit therapy, avoidance, poor cooperation, lack of desire and motivation to change. In general, the reasons for clients' resistance during therapy are numerous, from unrealized expectations, disbelief in the possibility of personal change (due to blocking beliefs), lack of motivation, and effort due to the current ongoing family dynamics stressors beyond the client's control.

The client's reporting strong blocking beliefs presence report indicates an obstacle to effective treatment of depression. Blocking beliefs are sometimes obvious and explicitly stated but sometimes they are hidden from both, the client and the therapist. In this case, the client was not aware of the presence of blocking beliefs until the moment when the therapist requested a closing therapy session when the client presented blocking beliefs. Depression symptoms themselves are manifested in a form of negative thoughts, lethargy, sadness, and pain. Blocking beliefs can therefore be symptoms of depression and obstacles to effective treatment, and intertwine together. This makes the therapy process perplexed and complicated impairing the treatment. Some obstacles to effective treatment can be overcome through a quality therapist-client relationship and the mirroring process, and some require a more studious approach. When depression is rooted in developmental trauma (as is the case here) treatment requires a more gentle approach, therapist's mindfulness, and kind understanding the client's state. It should be understood that the client's avoidance and resistance and even refusal of professional help is an adaptive and learned self-protection and survival mechanism and the need to take necessary measures to prevent being injured again.

On top of this all, depression treatment can be further complicated by current ongoing stressors coming from dysfunctional and disturbed family relationships and family dynamics. Studies confirm the relationship

between dysfunctional family relationships and depression and anxiety (Guberman & Manassis 2011). Early childhood experiences of rejection, neglect, invalidation by significant others (parents and loved ones who should be a source of love, support for safety) are the root in the development of a negative self-image and lack of self-confidence. Childhood trauma (developmental trauma) is a direct and strong risk factor for depression development later in life (Heim et al. 2008). And also, studies point to the link between the number of adverse childhood experiences and an individual's response to them with lifelong depression (Chapman et al. 2004), which may be a determinant of its chronicity (Wiersma et al. 2009), early-onset (Bernet & Stein 1999), number of episodes during life (Bernet & Stein 1999) and resistance to treatment (Kaplan & Klinetob 2000).

From the above all, we can note that depression and traumatic events are closely related. According to Fisher (2009) and Knipe (2018), many clients seek help after feeling overwhelmed and “kidnapped” by traumatic reactions and implicit memory of the animal part serving as a defense, and others when their attempts to exclude or deny traumatic reactions cause them chronic depression or depersonalization. Cognitive symptoms of depression manifesting in a form of negative and blocking beliefs permeate and constantly intertwine. Negative and blocking beliefs can be triggered by current stressful events that, in turn, can trigger their recent and stronger recurrence, causing the emergence of depressive prejudices or blocking beliefs. It seems that in this case, the client seeks help precisely because of chronic depression and depersonalization caused by attempts to exclude from and deny the trauma.

Negative depressive prejudices (which are blocking beliefs actually) might result in barriers perceived (e.g., everything seems more than a struggle) and reduced motivation (I can't do this anymore) associated with depression symptoms what eventually can result in avoidance of processing traumatic material (because it's too painful) and resistance. Thus, depression and all that comes along with it might increase patients' perceptions of the exaggerated severity of the problem putting therapy at a stance. This is an obstacle or a barrier (blocking beliefs) which might reduce the client's motivation necessary for effective psychological treatment. Although, it is sometimes hard to distinguish depression symptom from blocking belief, using Knipe Blocking beliefs protocol can be handy to identify and address persistent blocking beliefs if depression is to be effectively treated.

CONCLUSION

Barriers to psychological treatment identified as resistance during therapeutic work, although inevitable, seriously disrupt the course of therapy. Therapy barriers and resistance not only interferes with the perceived

effectiveness of the therapy and therapist but also impairs the client's motivation and undermines the process of change during therapeutic work. The term resistance itself refers to anything that impairs the therapy process and progress or prevents clients from reporting (disclosing) and processing events and even causing therapy abortion. It is extremely important to timely recognize and adequately address obstacles and resistance during psychological treatment. In this case, the client's resistance caused by blocking negative beliefs, which are also intertwined with the very symptoms of depression, caused therapy halt and therapeutic blockade (the client had almost given up). The client's blocking beliefs were triggered by current stressful events stemming from dysfunctional family relationships, having strong roots in early childhood events, causing therapy resistance and obstacles to effective treatment. Resistance emerging in a form of avoidance and refusal to process current and past events with EMDR is actually the client's adaptive learned survival mechanism. Identification and resolution of the client's blocking beliefs led to a new twist during therapy. With processing blocking beliefs client got unstuck, and was finally ready to, successfully and efficiently continue processing negative events with EMDR.

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