

A Sociological Approach and the 7x4 Field are needed in Dealing with Depression

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ABSTRACT---- *There are many arguments for the need of an overall picture in the treatment of depression. For example, various theories and practices encompass various lists of concepts which are then problematized, compared and classified – and thus an overview is required. This article is a continuation of the article "Overview of Depression with the Help of the 7x4-Field", in which the 7x4-field, therapy and psychology form a whole. Sociology and the 7x4-field also form an important combination in the treatment of depression.*

The 7x4-field is a tool for analysing and describing reasons for mental disorders, illnesses, abnormalities and malaise, as well as human distress in general. It has been developed on the basis of practical mental health work and numerous interviews as well as by using a factor analysis, for example. It is also suitable for dealing with various processes of distress and mental wellbeing. It provides a broader view of these processes than can be achieved with certain kinds of still images.

The first group of categories in this 7x4-field comprises the following factors: 1) Loneliness's, 2) Models, 3) Stresses and challenges, 4) Punishments/disappointments, 5) Losses, 6) Avoidance/coping, and 7) Changes in life situation. These are then related to the following four cornerstones of mental health: A) Human relations, B) Bodily functions/exercise, C) Rational action, and D) Irrational action based on one's view of life. The above categories can be cross-tabulated to form 28 cells or separate groups. The suitability of this field in the treatment of depression is examined in this article. To begin with, how the many theories of various schools of thought can be elucidated by means of the 7x4-field is presented. The following topics are discussed: dealing with the essence of depression; other disorders or illnesses involved in depression; whether depression is an actual illness; depression and self-destructiveness; self-healing; placebo treatments and their side effects; the threshold for seeking help for depression and remaining in treatment; and monitoring of the depression. The 7x4-field is made use of here in a similar manner to the periodic table of the elements, which has provided a central tool in chemistry.

It is concluded that the 7x4-field is widely applicable for the analysis of depression also as a cultural and social phenomenon. In addition, it can be used in preventive treatment of depression. In preventive mental health care today, the focus is on increasing early treatment whereas actions to tackle the causes are almost non-existent.

Keywords--- Dealing with depression, 7x4-field, taxonomy

1. INTRODUCTION

In dealing with depressions you meet via the observation of scientific examinations and practical working in therapy a starting point *depression as a social phenomenon, relating to economics and sociology*. Within it, there are then wide sectors, in which depression is considered an *unavoidable reaction to poor circumstances and treatment possibilities*. To educational sociology, refers for example *learned helplessness*. *Adverse organisation/distinction of relations of significance or the appearance of certain depression charts and their connections* are the basis of many studies in psychotherapy, which also refers to sociology.

When one looks at depression as *a imbalance in roles and similar subsystems*, it refers for example, to experiences of being a patient and a care producer, or even to social classes. A starting point focused on human relations is also *a gap between self-image and received ego-ideal*, which manifests itself when we examine the connection between envy and depression.

If you look at depression *a malfunction in biological regulatory systems*, you function, for example, within the pharmaceutical industry. *Manifestation of unmet life-needs*, which can be encountered, for example, in depression related to childbirth and breastfeeding, also refers to the biological starting point, which however has connections to *suclingculture* and other sociological shades.

On the point of view of life, depression comes from, for example, *a negative state in crimes, of being in life's debts, missed shots, collapses, failures and breaches of rules as well as times of adhering to the rules*, which are also treated in educational, even in theological studies. *Lack of enthusiasm for life and/or diminished faith in life* is a very old starting point in handling of depression. *Despondency and feelings of inadequacy that are unrelated to a lack of will* is a more modern way of examination. *Self-directed hate* is a significant starting point in investigations into depression and aggression. *The severity of the parent in each ego targeted at the weakness of the child in each ego* is a significant convention in investigations into problems of worldview and personality.

What is then the most productive of the many starting points? Which school of thought in depression research is to be supported? What is enthusiasm for life, faith in life, or the adverse organisation of relations of significance? What moves the hand that, for some reason, pulls the duvet up in the morning: disease, depression, brain processes, or personality? When is depression an illness? These are examples of difficult questions that need to be tackled when we seek consensus among different approaches and try to draw a holistic view of depression. Also by force to this complexity it comes with the outlining function. This activity can be aided by the 7x4 field. It was initially introduced in the journal *Psykologia* (Psychology) during the 1980's (Heiska 1984). The therapeutic point of view of it is presented also in Finnish journal *Psyk.fi* (Heiska 2013). *Asian Journal of Humanities and Social Sciences* has also published a psychological overview (Heiska 2014). Furthermore there is a sociological point of view, which opens from it, when one examines depression as a more extensive phenomenon than an individual pain. This article makes it more clear.

2. METHOD

The field in question in this presentation is a method or a tool, which is used to define and illustrate the causes of mental disturbances, illnesses, abnormalities, and lack of well-being as well as people's distress more broadly. In it 280 different reasons or variables to functioned completeness have been completeness have been outlined. It also enables a broader view of processes of distress than is achieved by certain still shots.

The seven groups of categories in the field (FACTORS) are 1) types of lonelinesses, 2) models, 3) stresses and challenges, 4) punishments/disappointments, 5) losses, 6) avoidances/copings and 7) changes in life situations. These also *increase or decrease* depression, which is manifested in four areas (CORNERSTONES OF MENTAL HEALTH): A) human relations B) bodily functions, physical activity and exercise, C) rational activity and D) irrational activity. These areas are an further elaboration to the classical sociological outlining *having, loving and being* (Allard 1972). The framework forms the following:

Table 1: 7x4-field
Cornerstones of Mental Health

Effectors:	A) Human relations	B) Bodily functions	C) Rational functions	D) View of Life
1) Loneliness's				
2) Models				
3) Stresses				
4) Punishments, etc.				
5) Losses				
6) Avoidances				
7) Changes				

The fields in the method are logical entities verified by factor analysis, and their classificatory reliability has received high readings in different practical situations (Heiska 1990). Its theoretical basis and development form their own body of ideas. It has been discussed in cognitive psychotherapy conferences in Corfu (Heiska 1994) and Prague (Heiska 2003), the Cornerstones of Mental Health congress in Lahti (Heiska 1997), a psychology congress in Turku (Heiska 2004), at three events for health nurses, most recently in Tampere in 2011 (Suomen Terveystieteiden tutkimuskeskus 2011), as well as at a congress on sustainable development and culture and pedagogy in Savonlinna in 2012 (Gröhn & Härkönen 2012). There are also plenty of examples of practical applications (Heiska 1998, 2002, 2010, 2012, 2013). An extensive 7x4-research file on the central issues is available, for example in e-book "Suunnistus ihmiseen 7x4-kentän opastuksella" (orientteering to a human being with guidance by the 7x4-field). In addition, a comprehensive report in English is available at www.juhaniheiska.com. These files contain hundreds of research results on the causes of mental distress, mental disturbances and abnormal behaviour, classified into groups according to the 7x4 field. It is remarkable too, that many of those examinations are sociological.

3. RESULTS: HOW 7x4-ANALYSIS PROMOTES THE DEALING OF DEPRESSION

In attempting to try to understand the essence of depression, depression and self-destructiveness, the threshold for seeking treatment for depression and staying in treatment, and the contents of depression therapy and the individual monitoring of depression, it is essential that we form different heading lists. The accompanying chapters contain examples of their definitions with the help of the 7x4 field. They also describe other results that can be achieved through this method. Stars in parenthesis (*) always refer to parts and definitions of the 7x4 field.

3.1. Dealing with the essence of depression

Important thesis, the depression process can already begin from childhood experiences, claims Aaron Beck. He defined depression through the following main points (Beck 1971): Loneliness in the form of absent parents, for example, surely has an effect. Disappointments, as well as other punitive experiences in human relations are part of the depression process. There is much empirical evidence about the effects of experiencing guilt in depression. Losses in human relations are almost self-evidently events that cause depression. These are contained in the squares marked with stars in the attached 7x4 field:

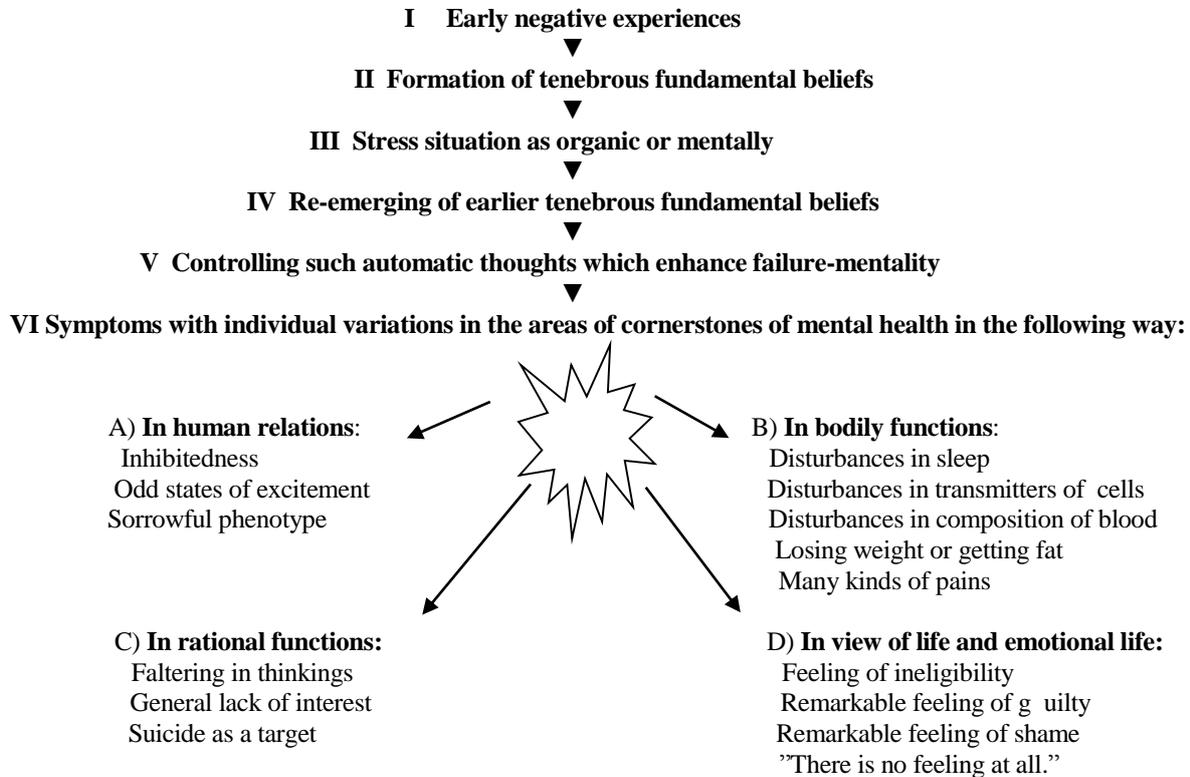
Table 2
 Cornerstones of Mental Health

Effectors:	A) Human relations	B) Bodily functions	C) Rational functions	D) View of Life
1) Loneliness's	*			
2) Models				
3) Stresses				
4) Punishments, etc.	*			*
5) Losses	*			
6) Avoidances				
7) Changes				

Beck's classification can be developed more broadly with the 7x4 field. Beck himself extended the bases of depression toward stresses (Beck 1982). For instance, light therapy in treating depression is also related to bodily functions, their stresses and changes, or the improvement of a poor economic situation is related to rational stress and surprising few have been treated for example with a "treatment method", which has used in Finland by the quite well known Veikko Hursti. He handed out money in a market place to individuals who felt self depressed (*). However in Sambia this method is used and you have got some positive results (Van Ufford 2004). In addition, many artists illustrate and have illustrated experiential aspects of life that can be found in the 7x4 fields. For example in Finland's national epic "Kalevala" you represent loneliness, which is connected to being mobile (*) or the description of a serious conflict of emotions, "Moments of joy are only borrowed time" ("on lainaa ilon sekunnitkin"), presented in a well-known musical speaks about irrational stress (* problems of self-value). The poet Kahil Gibran, in his poem "Seven times have I despised my soul", speaks in his own way about the factors in the 7x4 field. In addition, works of many visual artists can be understood to be examples of squares on the 7x4 field (Heiska 1998). For instance, the works of the famous Finnish painter Albert Edelfelt and famous Swedish painter Carl Larsson contain examples of each square. Therefore, we can establish a link to art therapy used in the treatment of depression.

The stages of the depression process are connected to learning from examples (*human relations, models) or other models for action (* worldview models) and through stress situations (*) can be placed in the 7x4 field in the following way:

Figure 1: THE STAGES OF THE DEPRESSION PROCESS



For instance, early negative experiences in school create a negative model (*), "I am no good". This bleak basic belief will then surface and gain strength through difficulties in finding employment. In this way, automatic thoughts are formed in stress situations in working life, and before long, the symptoms tell us that we are reaching the cornerstone areas (* the four areas in question). The catalogue of symptoms in the picture is a summary of many studies on symptoms.

A follow-up study of female twins conducted in the state of Virginia also tells us as an example about the stages. In it, the process of depression was organised under conclusions reached through correlation multipliers into tables (Kendler et al. 2002), using an 18-square field. Its 13 frames can be included in the following squares of the 7x4 field relatively well:

Table 3
Cornerstones of Mental Health

Effectors:	A) Human relations	B) Bodily functions	C) Rational function's	D) View of Life
1) Loneliness's	*		*	
2) Models	*		*	*
3) Stresses	*	*	*	*
4) Punishments etc.	*			
5) Losses	*			
6) Avoidances				
7) Changes	*		*	

The last five are neuroticism, low self-esteem, proneness to anxiety, disturbing behaviour, and the abuse of controlled substances.

Here we find the area of observation of the causal factors behind depression, **other disturbances or illnesses**, which will, of course, have their own fields of causes. For example, the development of low self-esteem can be identified under relevant stages in the 7x4 field. Or alternatively: Under possibilities of avoidance, the grid has no stars, but the abuse of controlled substances is known to be an illness and/or avoidance reaction (*). A group of Finnish researchers confirms this (Torikka et al. 2001)

through material from 14-16 year-olds, which supports the claim that the use of alcohol increases depression, but that depression does not increase the use of alcohol. Also for example, diabetes as a loss of bodily functions (*), is closely connected to depression (Erikson 2001).

An important subspecies forms from that, when you take into consideration, that according different examinations 35-45 percent of people, who are left to care for a relative suffering from a mental disturbance, also fall into suffering from depression (Van Wijngaarden et al 2004). This process most often originates from stress in human relations (*), continues with stressful arrangements in daily functions (*), experiences of physical tiredness (*) and, in some points, is presented as a stress in the view of life (*).

When we then ask **whether or not depression is illness in general**, a subdivision of bipolar mental illness, an inevitable stage in recovery from psychosis, deep exhaustion, burn out, laziness, a part of the opposite of happiness, a part of the vicious circle of anxiety and depression, or, for example, a significant post-childbirth condition, the 7x4 field allows us to define the essence of depression in the following manner: A) K. Fulford's view is important both socially (*) and sociologically: When is grief following the loss of a loved one defined as an illness (Fulford 1989). B) The somatic (*) view is important in the clinical definition of depression as an illness and also, for instance, in examining the interaction between smoking and depression. C) Health care funding (*) and single-visit billing greatly depend on the clinical definition of depression. There is also much to discuss in practical fields, when different results of measuring methods, which concerns the depth of depression, have a surprising small correlation. D) In ethical conclusions (*) related to depression, we encounter the following research result: When the test subjects themselves and external observers both assess social competency, those experiencing depression and those living in that realm of perception self-assess, on average, more accurately than non-depressives (Lewinsohn et al. 1980). Thus, we have to face worldview-related and irrational stress (*). It is difficult to work with an accurate ethical sense of reality, which turns out to be bad or poor.

To the different squares of 7x4 field sharpens it then also the examination of E. Maisel. He completely demands, from depression, a radical reoutlining to direction of sociology (Maisel 2012). He even considers depression to be a big swindle (*), which is practised by supermedicalized society and the conductors of health care plus the inventors of medicaments. So by this way, the problems of depression will be solved remarkably by considering the viewpoint developed by Maisel as the starting point. For example he gives reasons to it, that you can create, in case of depression a new language (*), whose vocabulary serves better the large existential or view of life (*) questions that are presented by people nowadays. In addition, societies have unrealistic demands (*) concerning continual happiness. The basis of life's meaningfulness may very well be the finding of happy meanings, but also there Maisel presents the following allegory: Meanings are not oxygen, which you breathe, but water, which you not need drink all the time. An individual may have a personal (*) existential plan to meaningfulness such as the intention to rear his child with love.

Self-healing (*), placebo treatments (*), and the side effects of treatments (*) are also part of the processing of the essence of depression. For example, already during the 1980s, research on depression produced the following results: antidepressants always have some stressful side effects (* negative impact on blood consistency, general fitness etc.), and studies even showed equally good treatment results with the use of side effect producing placebos as with actual antidepressants (Thomson 1982).

In addition to all of the above, the essence of depression also includes **an evolutionary point of view** (changes) (*): depression as a phenomenon, with which materials inadequate for development are filtered out. The following observation from zoos is somehow significant here: Packs of wolves have patterns (*), where those with impaired legs are swiftly destroyed. When zookeepers isolate a wolf with a leg injury into a separate cage for healing, very often such a wolf will, somehow, slip back into its former pack. It, therefore, cuts off the branch from under itself - similarly to depressed people. In the point of a human being, there are some kinds of similarity with the following perception of examination: depressed women become objects of family violence two and a half times more often than "so called" normal women in the normal population (Trevillion et al. 2012).

3.2. Depression and self-destructiveness

According to different estimates, 30-40% of self-destructive people are not depressed. Suicidal thoughts may emerge during treatment and after treatment practices for example in hospitals. Suicide is often discovered when depression has partly receded. In addition defining suicide is tricky as a person can take their life in order to save someone else, or have an accident that appears to be a suicide or they may be able to hide the motive of the act. Furthermore, suicide attacks are in reality often the result of brainwashing, and therefore not actual suicides. In addition already during the 1800s, Emile Durkheim proved that it is surprising difficult to conclude, which is a situation of leading to despair when you observe different individuals (Durkheim

1979). In an experiment which he lead, the officials had to place on grounds of statutory examination records, the reasons for suicides that had happened in France in the 1800s into the following classes:

- 1) Lover's griefs, jealousy, unfaithfulness, bad life, physical sufferings.
- 2) Mental diseases, drunkenness etc.
- 3) Difficulties in family life
- 4) Different disappointments or resistances
- 5) Economical losses, poverty.
- 6) Unknown or reasons difficult to classify.

These kinds of points, which are also similar to the subjects of the 7x4-field, can also be considered nowadays to leads to desperate situations. This remarkable difficulty was observed then in a following way: The percent distributions stayed almost same, when you compared years 1856-1860 to the years 1874-1878, through during a later period, the suicide rate was double. Furthermore, during the later period, the percent distributions of the farmers and the free self-employed were almost the same, even though the life of farmers and the free selfemployers were very different.

In addition, the claim that self desired euthanasia is not suicide is disputed by many. These kind of matters make it difficult to follow quite a known problem: It is very difficult to compare the suicide statistics of different countries, though you know, that the suicide index is very competent indicator in describing wellbeing. Then when you aim at similarities in comparisons, you can use the 7x4-field. In this sense, the definitions should include the following thought structures, which have already been found during the 1960s (Litman 1961): 1) I wish to atone or sacrifice according to a certain worldview. 2) I wish to seek revenge or punishment even beyond the grave. 3) I wish to rejoin my lost beloved. 4) I wish to escape/sleep because I have no longer have strength. 5) I wish to be born again, begin a new life, or something like that. These can be placed in the following 7x4-squares:

Table 4
Cornerstones of Mental Health

Effectors:	A) Human relations	B) Bodily functions	C) Rational functions	D) View of Life
1) Loneliness ⁷				
2) Models				1*
3) Stresses				
4) Punishments etc.				2*
5) Losses				3*
6) Avoidances				4*
7) Changes				5*

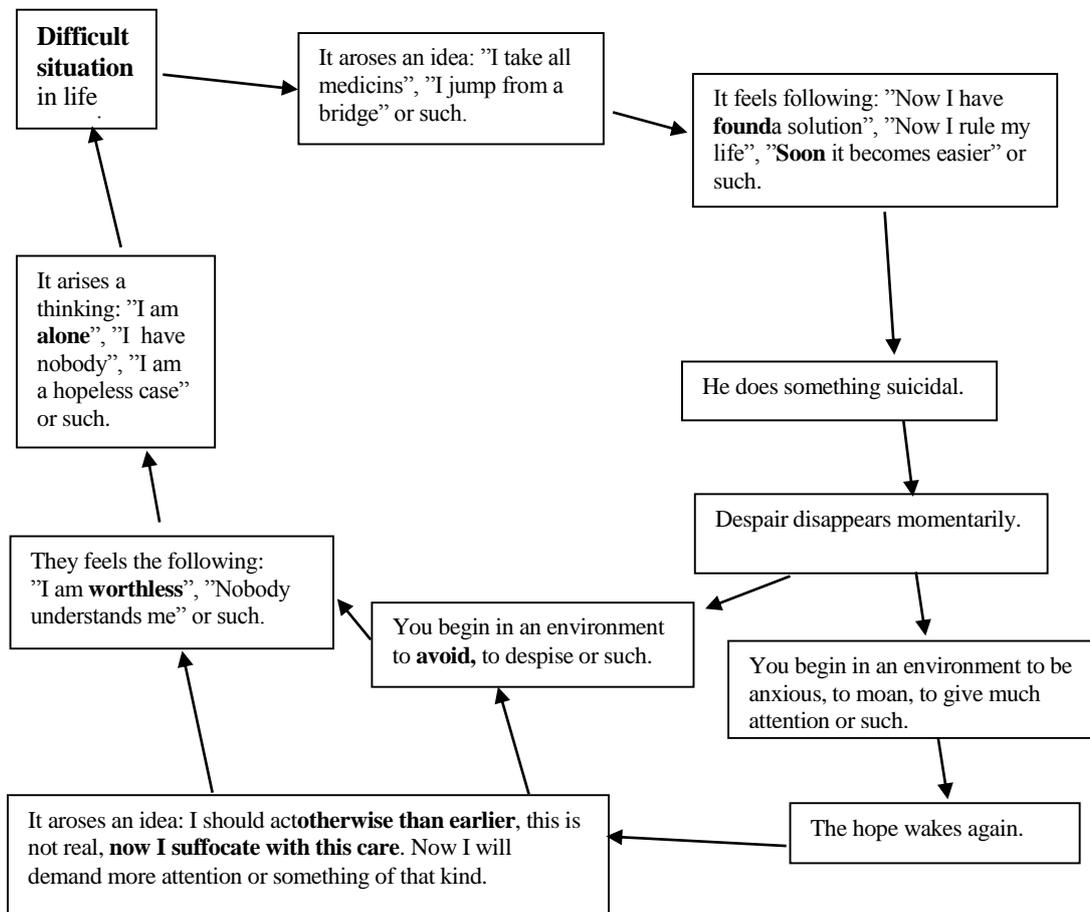
The equivalents in the 7x4 field's verification list are thus 1) Models for handling feelings of guilt, 2) Situations of unforgiveness, 3) Loss of identity, 4) Opportunities to avoid thinking about life's so-called big questions and 5) The emergence of new ideologies in the life field. These thought structures naturally include individual specifications.

The phrases used by those who went through with their suicide, spoken in significant situations and gathered from recollections of those close to them (Mikkelin läänin työryhmä 1988) give an even more accurate picture of the organisation of the thought structures of self-destructive people:

- 1) Loneliness (*) related to the following: "Father, take me away". "I am a rock in the open sea". "I have no place in the business world, or in the city". "Because I feel that even God is not helping".
- 2) Distorted models of thought (*) are the following: "If the sauna (the steam bath that is a culturally and spiritually significant place for Finns), booze and women do not help, then the disease is fatal". "I have my own solutions" (in seeking treatment). "Until I do not see you again" (a phrase repeated while leaving the rehabilitation clinic). "What if something happens to me" (after receiving prescriptions and assurances that there is nothing bad happening in the body). "I will no longer be torn apart in operations, I wish to die as a whole". The individual used obscure allusions, to which no clarifications or explanations were received.
- 3) Exclamations belonging to states of excessive stress (*) are "I can't take it any more" and "I don't want to live, as I have so many faults".
- 4) Experiences of punishment/disappointment (*) involve the following: "I am so ugly and skinny" (viewing oneself in front of the mirror). "Shut your mouth. I will shoot".
- 5) The following relate to loss (*): "Now the ridge of our home's roof has cracked". "I had the strength to live for mom's sake". "Dad, why did you leave me!"
- 6) Defensiveness (* main class avoidances) is reflected in the following: "I have completed my tasks in this world". "I will not attend that court". "You can take from there" (referring to a bank statement). "It won't be needed much longer" (about a purchased book of hymns).
- 7) Related to change (*) "I want to be with Dad" and "take good care of S".

Also, this chart of the vicious circles of self-destruction (Meretoja & Laakso 2002) contains parts of the 7x4 field. They are indicated in bold letters in the following figure:

Figure 2: THE VICIOUS CIRCLE OF SELF-DESTRUCTION AS A PSYCHOLOGICAL AND SOCIOLOGICAL



This vicious circle process begins at the point of a difficult situation (*), continues to the point "despair disappears momentarily", and then continues along three different paths.

3.3. Threshold to seeking help and remaining in treatment in the treatment of depression

B. Brenner, for one, has described the following conformity in depression processes: Of depressed people, a clear minority seek professional help for their depression, but they do seek it for other problems (Brenner 1985). These avoidance functions (* mistakes, side effects or other factors in treatment that enable an avoidance reaction) can be clarified with the following examples from suicide cases (Mikkelin läänin työryhmä 1988):

Human relations (*) related:

- Over the last year, he only visited the health centre once -- and then only during the Sunday reception hours with his partner. Only insomnia and tiredness issues were revealed. They did have serious problems with sex.
- He only cried out for help among friends -- and the cries were masked. He only told the General Practitioner about his urination problems and shoulder and neck muscle pains. There were two visits to the school/university nurse, but without any problems related to depression.

Bodily functions, physical activity and exercise (*) related:

- He had annual treatments for prostate problems that he did not even reveal to his wife.

Rational activity (*) related:

- He had not visited any health care facilities in ten years. While drunk, he nonetheless often barged into his siblings' homes, asking for help when in a rage, and was naturally turned away.
- There were 14 visits to the social services centre during his final year and only due to financial matters.
- He complained to his mother about a migraine, but no note of any migraine exists in the treatment centre records.

Worldview activities (*) related:

- He visited a spiritual healer, unsuccessfully, to receive help for his headaches, which had been treated at the neurology clinic two months earlier.
- He got in touch with a former classmate, a priest, who realised too late that these were calls for help.

When planning actions regarding seeking treatment for depressed people and remaining in treatment, the examples above and their organisation are central.

In addition, there is organisation into the cornerstones of mental health. For example, the monitoring of medical treatment related to bodily functions (*) tells us that unmedicated depressed people (N= 484) and medicated depressed people suffering from medium depression (N= 3671) have states of health that allow the following conclusion: That depression not recognised in basic health care does not lead to serious negative consequences (Goldberg 1998 and Pigott et al. 2010).

3.4. The contents of depression therapy

The starting position in depression therapy is known already in the Old Testament (Job 16: 2-5). You tell us of the exclamations and internal speech of a depressed Job in the following manner:

- 1) I have heard these words before! (the alone-together phenomenon)(*).
 - 2) Well, that's some consolation! You just add to my pain! (wrong model of approach)(*).
 - 3) Are you done, or are you still talking nonsense! (the stress of beginning)(*).
 - 4) Why do you always disagree with me! (experiences of disappointment in treatment or treatments)(*).
 - 5) I could speak just like that too! (bad examination of losses)(*).
 - 6) If you were in my position, just how skilfully I'd speak to you! With my condolences, I would nod to your accident. (bad examination of defences)(*).
 - 7) I would encourage you with kind words. I would console you with the speech from my lips! (little hope for the future)(*).
- This description classifies in a significant way the picture of modern theories from the beginning of treatment too.

Current treatments of depression certainly fall under many labels. The rational-emotive learning therapy, gestalt therapy, reality therapy, logotherapy, medical treatment, or even psychoanalysis and spiritual healing tell us surprisingly little about the caretaker's "official" school of thought. The analyses of videotaped therapy sessions strongly point to this (Ablon et al. 2006). However, depression therapy's four sections and the seven active elements of a psychotherapist's actions can be specified in a 7x4-form, in the following way:

A) The language used:

- * Shared concepts or form of expression through which the sufferer and the therapist understand each other.
- * Shared concepts or form of expression through which the therapist can communicate with other experts about the progress and results of the therapy.

B) Discovery

- * New insights, reshaping and procedures
- * Mental activity, from which insights, reshaping or other such discoveries follow.

C) Structure:

- * The therapist and patient's meeting places, meeting situations, and meeting times.
- * The theoretical basis, classification method or the like of a therapist's actions.

D) Mood:

- * Opportunities to progress in the internal actions between the therapist and the client.
- * Operational and confronted values, limits of actions and the like.

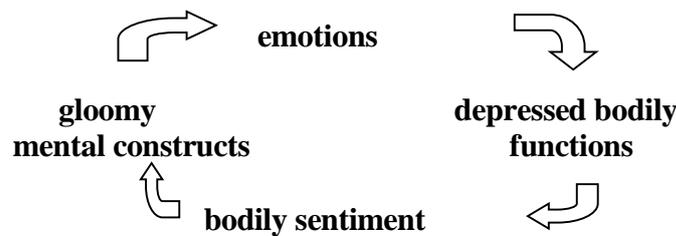
- 1) Unconditional and respectful attitude: For instance, taking respect into account in the realisation of the initial interview.
- 2) Empathy: For example, dealing with transference, i.e. the transfer of feelings felt toward a person.
- 3) Acknowledgement of realities and limits: For instance, the so-called dynamic and cognitive handling of problems and their limitations.
- 4) Striving for sincerity: For example, utilising speech from different levels of the ego.
- 5) Setting for confrontation: For example, utilising desensitisation or the so-called thought-stop practise.
- 6) Avoidance of games: During sessions, clients easily play, for example, the 'yes yes -but' game, in which excuses are made. For example, suggestions to increase exercise are often met with sentences such as 'yes, but there is this...' and a certain victory is gained from bewildering the person who made the suggestion. This is one of the so-called Berne's games that was handled in therapy sessions as early as during the 1950s.
- 7) Striving for concreteness: For example, utilising symptom control programmes.

In addition, general principles of depression therapy once again manifest a functioning 7-part classification:

- 1) In the handling of individual beliefs (*), the attempt is to create an atmosphere of understanding.
- 2) A psychotherapist's main visible forms of action (*) are asking, nodding, explaining and commenting.
- 3) The more difficult (*) the depression or self-destructive the effort, the more active the carers.

- 4) Judgmental/ stigmatising (*) utterances are minimised.
- 5) Interpretative utterances are minimised, so that trust is not lost in the beginning (*).
- 6) Utterances intended as means of adjustment, such as 'cheer up' are terrible suggestions to a depressed person. They are not to be presented.
- 7) In the treatment combining physical well-being with psychotherapy, it is clarified that depression essentially includes bleak thought structures and the functions of a depressed body (Scott 1993). Through the emotions and bodily sensations, they form a stress situation (*), in which bleak thought structures affect depressed bodily functions and vice versa. The vicious circle in question is the following:

Figure 3:



In treating depression, the vicious circle is slowed down with medication, regarding the bodily functions, and with psychological means, regarding the depressed thought structures. It is also significant that the vicious circle in question operates in the case of rational stress (*) in the following way: assistance event → economic plan → financial resources → spent money → assistance event. Therefore, a bleak assistance event, in which the one who assisted or the one paying for the assistance feels "pointlessness" in the beginning, and this may deprive financial resources from another assistance attempt, that nonetheless is acutely needed.

The therapies of depression also manifests much of the content of the 7x4 field, when you handle sufferers' problem lists about problematic symptoms, life situations, thoughts and feelings of hopelessness. The following is the analysis of them:

Human relations (*): Difficulty in accepting the break-up of a romantic relationship, difficulty in surviving alone (*) from the break-up and difficulty in finding a satisfactory intimate relationship.

Bodily functions & exercise/movement (*): Stressfulness of required daily mobility (*), inability in almost any activity and diminished sensations of pleasure in the body.

Thinking and immediate survival (*Subcategory of loneliness: lack of practical support from immediate surroundings that could be given for treatments): 'The inability to express myself is horrible', difficulty in expressing one's wishes and the mulling over of the same thoughts.

Values and worldviews (*): Feelings of inferiority and worthlessness as a human being, 'I am a bad mother' and 'no one likes me'.

Depression therapy also encourages the assessment of the proposed therapy model through certain questions and proposes alternative models of operation to replace bleakness (*). In particular Gestalt therapists explain many shaping phenomena. In addition the directing of thoughts towards a positive future (*) is crucial, because then extreme hopelessness, i.e. losses (*), are dealt with as soon as possible, thus enhancing authoritativeness.

The therapist's level of directiveness, weekly issues, homework and feedback queries are parts of a plan in which the cognitive therapist deals with the object mode, as well as the metacognitive mode with the language of the client, and the transaction analyst handles the adult-child system. In any case, the sufferer's independence (*), unambiguous rationality (*) and experiences of success (*) are central issues to be taken into consideration.

The cognition and consistent monitoring of distorted and bleak thoughts is connected to possibilities of avoidance on the part of the depressed (*). At this time, one seeks reasons for depression and ignores the thoughts immediately related to the depression. Thus, we encounter the following metaphor: "When the fire brigade arrives, what takes priority - putting out the flames or finding out who started the fire?". Furthermore, several therapy sessions are spent teaching that it is possible to think about thinking. It may be significant that this is also the special area of NLP-therapy. The most significant automatic but adjustable thought distortions are models of rational and worldview activity (*), which therapy researchers deal with. For example, Beck has found a model *All or nothing* (Beck et al. 1979), manifested in the exclamation 'Because I did not fully succeed, it makes no sense to try anymore.' His other findings include *overgeneralisation* (Beck 1976): 'Because I had a setback, I am a wholly failed human being and certainly not someone who has committed only one mistake.' *Self-blame* (Beck et al. 1979): 'Everything that goes wrong here is probably my fault.' *Hasty, crippling conclusions* (Beck et al. 1979) are the following: "I can tell by the tones of their voices that they will abandon me.", and *Catastrophe thinking* (Beck et al. 1979) means 'No point in trying, because even worse things are coming.'

Other researchers have found the following: *I must-think* (Ellis & Grieger 1972): 'I must do this so that at least someone could love me.' *Overstating and minimisation* (Burns 1980): 'My own failures are greater than those of others, and my successes are smaller than those of others.' *The invalidation of positive aspects* (Meichenbaum 1977): 'As a whole, the successful experience is only examined in light of the one negative aspect, somehow staring at it.' *Automatic reduction of worth* (Katajainen et al. 2003): 'She is just trying to be polite, it is part of her job.' *Emotion-focused reasoning* (Goldman & Greenberg 1997): 'I feel guilt - I must have done something wrong.'

These harmful models discovered by researchers are found through the sufferer's own examples. In addition, an action model (*), combining issues, is important in every therapy. For example, the sufferer is asked to describe unpleasant feelings and situations connected to them, and these are written on a large piece of paper. Then dark thoughts are observed and connected to feelings by drawing arrows between sentences.

Once the sufferer can identify and correct immediate and automatic negative thoughts related to situations of depression, we can move on to the so-called *dysfunctional basic assumptions* (Beck et al. 1979). They characteristically include the forming of obstacles, the development of unnecessary anxiety and inadequate observations of reality - all of which are shared challenges among different approaches to therapy. For example, the belief "one must be strong and capable" displaces the essential aspect of vulnerability belonging to man. Also, changes in circumstances (*) are disregarded along with unnecessary extreme feelings. Therefore, depression and despair are more likely outcomes than sadness and grief. In addition, dysfunctionality often manifests without words and it does not diminish in solitude (*) or through one's own means. The following contains specifications of dysfunctionality:

- 1) There is hope for acceptance, respect, love and the like, but the feeling is that the needs for security or care cannot be dealt with when lonely (*), and they cannot even be expressed.
- 2) Overambitious norms of achievement (*) confuse one's goals. For example, the following thought structure: "I must always carry out my work so well that everyone respects me, or otherwise I am insignificant or worthless", would be the following in the non-dysfunctional form: 'No matter how well I perform my duties, not everyone's appreciation is guaranteed. "I can accept that one can only slightly influence the judgment of others".'
- 3) While attending to the needs of others, one strives to cope (*) alone infinitely. For example, when reminded of childhood, that "one had to always please parents," the transference situation of pleasing is a stress (*), where the transfer of emotions brings continuous strain.
- 4) Holistic self-assessments, such as stupid, childish or some diagnostic term one has heard reflect irrational thoughts of punishment (*), of which we have the following examples: "When I feel poorly, I gain more rights and power to punish (*)", or "all those who try to love stupid me shall be punished" or "The Hell I know is better than the heaven I don't".
- 5) Human relations games that take the form of a vicious circle become apparent (Berne 1967). For example, being lonely (*) relates to the square avoidances/human relations, (*) i.e. a certain human relations game, where the attention, empathy and the like that the depressed receives strengthens the depression. This also illustrates depression treatment's special point of view. Empathy is often considered to be a natural part of treatment, but communality is more complicated here than is assumed.

These sections can be placed in the following areas marked with numbered stars:

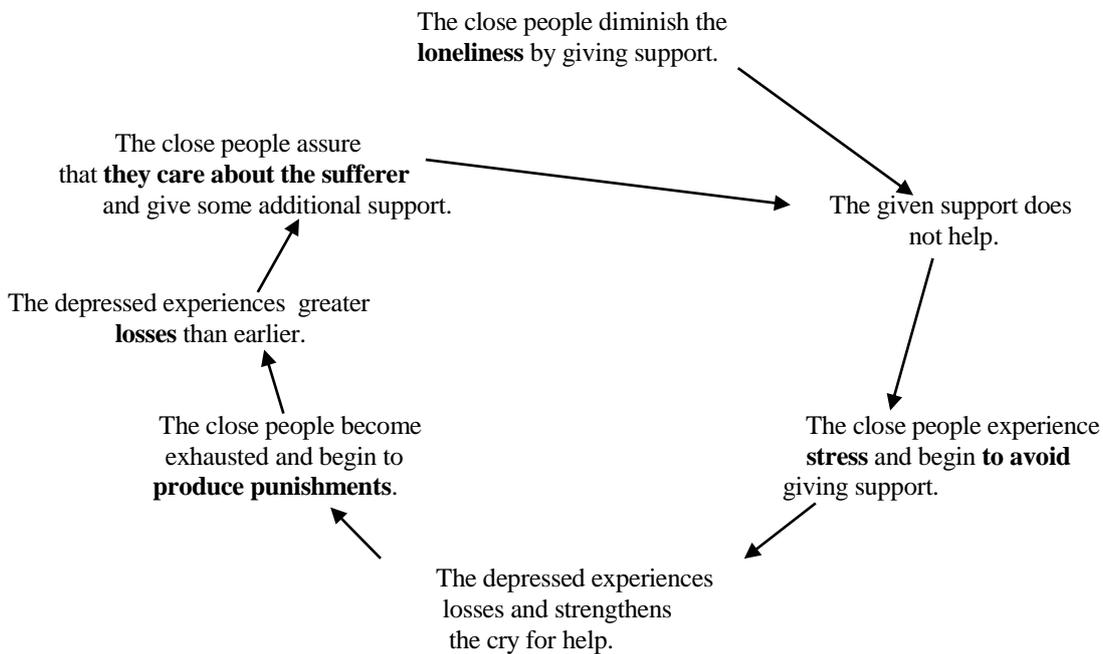
Table 5
Cornerstones of Mental Health

Effectors:	A) Human relations	B) Bodily functions	C) Rational functions	D) View of Life
1) Loneliness's				1*
2) Models				2*
3) Stresses				3*
4) Punishments etc.				4*
5) Losses				
6) Avoidances				5*
7) Changes				

Here, as well as in the previous placings in the field, we find a problem that can be described by a comment from part one: "When a person feels that their needs for safety or care are not met and cannot really be expressed, it is not a question of loneliness in the worldview sense, but a misunderstanding or the like". The situation is similar to the scoring of projected test answers. There, the consensus among classifiers improves when scoring, i.e., placing answers into certain boxes, is studied. Equally, there are instructions for specifying the 7x4 field, which take into account Carnap's principle from philosophy - "each can make their language their own" - and that different mental health workers have many concepts that can be understood in the same way. That is, those handling depression have their own premises and criteria of action, which they wish to maintain. We then encounter a situation known in the history of science as "only insiders are allowed to speak". What is then present is the square avoidances/rational activity, which clarifies the section 'the abuse possibilities of power'.

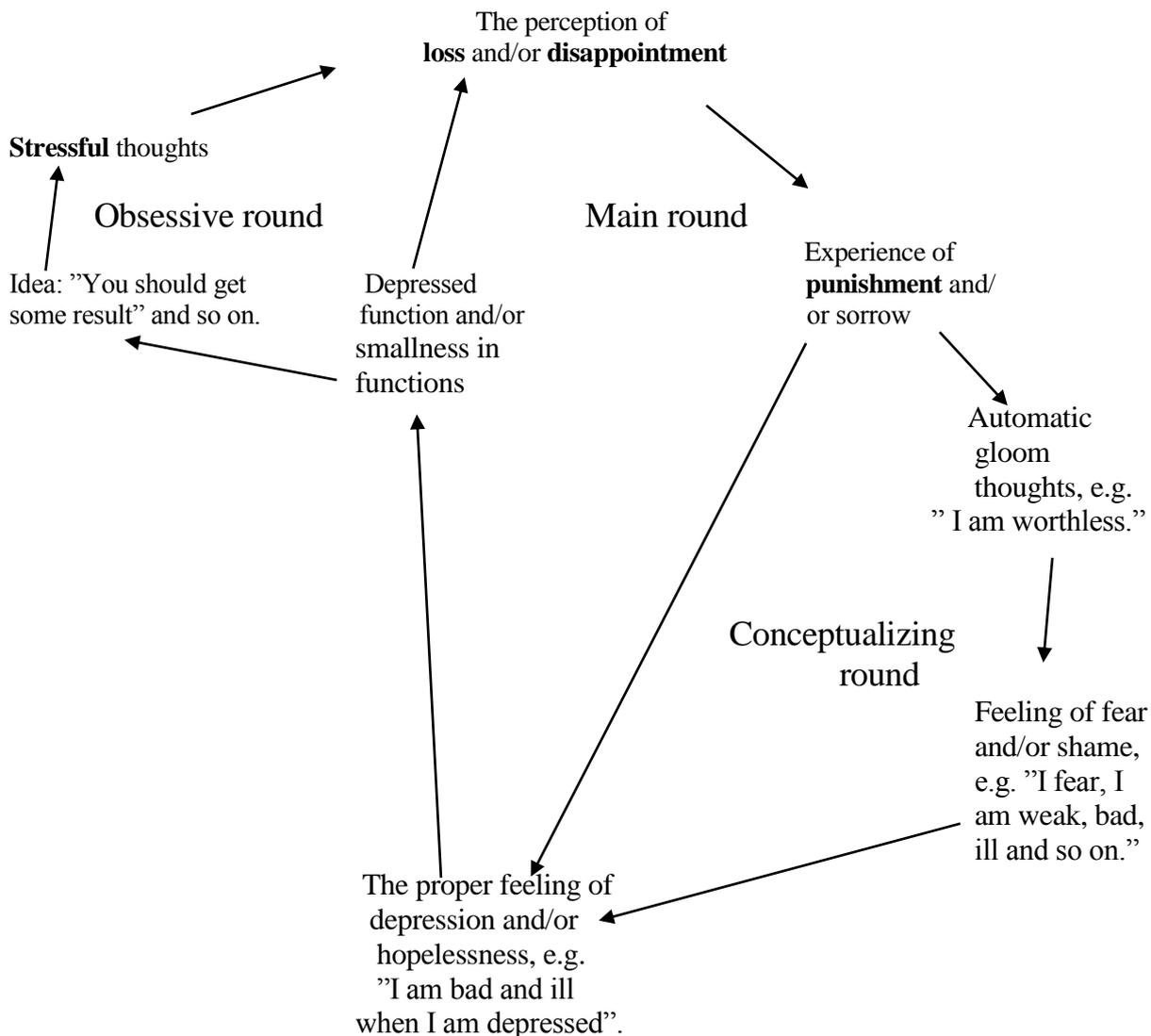
Different labels are used for the specifications for circular models (*), but an essential point of origin is the supporting role of close relatives (*) (Mc Daniel & Cambell 1990). The operation of this vicious circle contains elements that share the following with the 7x4 field:

Figure 4:



The mind's internal circular model (*) (Greenberg & Paivio 1997) is also significant, as it contains an unconscious main vicious circle and a conscious attempt to conceptualise (What am I now?) or an adjustment method (*). In addition, it is related to an enforcement circle sidetrack (I have to, I have to!) in the following way:

Figure 5:



The acknowledgement of the dysfunctionality in these vicious circles, through one's own examples, is often a necessary prerequisite in the slowing down of other vicious circles. This is because the depressed person often deals with a large chunk all at once that deepens depression when left unstructured. To this point is connected also an important sociological phenomenon called by the name information overload (*). It is one of stressing situations in rational function. It forms in different practical functions the reason of depression and the information overload is facilitated then if you approve the 7x4-field for the starting point (Ekholm 2001).

What is significant in these charts describing vicious circles is that although they are necessary from the perspective of treatment, they appear as complexities to the depressed and, thus, as new stress situations (*) that easily evoke a bleak thought like this: "I fail even at this, because I don't understand such figures". This vicious circularity in the essence of depression and in the social surroundings of the depressed person brings out the following thesis: The core of the problem field of the depressed person cannot be understood by anyone else, though one can get close to it. It is still possible to help. Somehow, there needs to be a slowing down of the vicious circle called general — specific — simple — general (Thorngate 1976): Person A makes a claim about the general principle regarding realising treatment. Then, person B refutes this principle, calling for specifications. When A then presents specifications, the presentation becomes too complicated, and we must return to the general level.

4. MONITORING DEPRESSION

In tests and interviews measuring depression, the contents of questions often reflect the seven classes of factors. For example, (LKDA) the short (Lyhyt) mapping (Kartoittava) depression (D) scale (Asteikko) used in Finland has seven questions and, at

the same time, parts of the 7x4 classification. Also, 20 segments of the more recent CES-D scale (Radloff 1977) can be easily similarly classified.

An important example is provided by a study (Williams et al. 2002), in which the depression of navy freshmen was monitored with tests that measured loneliness (*) (Loneliness Scale, RULS), models (*) (Sense of Belonging Inventory, SOB), stresses (*) (Perceived Stress Scale, PSS), losses (*) (List of Threatening Experiences, LTE), coping mechanisms (*) (Coping Inventory, CISS) and changes (*) (Global Assessment of Functioning, GAF). Results with good validity were gained precisely by these tests.

Measuring depression with the 7x4 as its basis also clarifies the following obscurity: The positive views of the patient about received treatment correlate very little with the success of the treatment (Viinamäki et al. 2002). It could be that the mere feeling of loneliness (*), "no one knows what I feel", is the central aspect in the patient's mind when assessing the treatment, and so the question of whether the symptoms of depression have receded is left hidden in the questionnaires about treatment satisfaction.

5. CONCLUSIONS IN SOCIOLOGICAL MEANING

In the handling of depression, we encounter those parts of the 7x4 field, also sociological that have been described above. It fits the following: New data about depression fits the old when utilising the boxes in the following way: In the development of cognitive psychotherapy, J. Young has published an 18-box classification on "maladaptive schemas" (Young et al. 2003), in which factors are described in the same manner as in Berne's transaction-analytical, 9-box models (Parent-Adult-Child and their clarifications) already in the 1960s. In these comparisons, we can utilise similar procedures as in the discovery of chemical elements. Indeed, it features an agreed upon theoretical framework - the periodic table of elements - that guides research. Thus the 7x4 field works as the framework for depressions treatments.

What is significant is also that similar classifications as in the 7x4 field are already in use. For example, in Finland, J. Kontunen has developed the so-called IPT (interpersonal) therapy (Kontunen 2010). In it, we always focus on one of the four problem fields: Lack of human relations (human relations loneliness) role conflicts (human relations stress) unfinished grief work (losses) and changes in roles (human relations changes).

Also, when it was perceived already in the 1990s in mental diagnoses, that they fit bad to daily cares, so you founded a vitalfour-course, which is relatively similar with the cornerstones of mental health A, B, C and D. In that action, you give up from psychiatric diagnoses and use, instead of them, the concept formulation. The formulation it is then used to examine observed individual factors in care situations, among other things, which are outlined in the following way (Weerasekera 1995): A) Psychodynamic or connected to human relations B) Biological or connected to body functions and mowing C) Active or connecting to rational functioning and D) Cognitive. This fourth point however holds an irrational sphere, which has, for example negative automatic things and schemas. In depression therapy, automatic things you see are considered to be irrational and attempts are made to make them rational.

When we then consider whether physical exercise helps cure depression or only produces muscular, depressed people, it is important that we define physical exercise as a certain type of cornerstone, not as a factor. The road may also be the reason for a road accident but you cannot put remove the road. It is "a cornerstone".

Research on the interaction between the mind and brain also reveals commonalities with the 7x4 field. For example, the psychoanalyst J. Lehtonen has described the so-called matrix of the mind (Lehtonen 2011) in a way that reveals the following entities of activity:

A Receptive sensory part. (Human relations)

B Executive motoric part. (Physical exercise and mobility)

C A broad-ranging network of nerves, composed of different parts and functions of both the mind and the brain, which sustains the integration of brain functions into a whole and maintains an integrated consciousness. (Rational activity)

D An experiential part composed of basic feelings of satisfaction. (Irrational activity).

These main sections include changes in interactions and bodily states.

In addition, the following is important: The schools of thought dealing with depression resemble political parties or church congregations that aim towards the common good, but "only our classifications are correct," and furthermore, depression is handled by many in positions of power but with little expertise. It is also then possible that the 7x4 field has useful application areas, as it allows theories and thought structures to be brought together into an integrated whole. When we also consider the conformity already discovered by George Miller in the 1950s (Miller 1956), that the limit of the working memory of human beings is roughly seven records, and also that ancient Greek civilisation consisted of A) theatre B) stadium C) gymnasium and D) temple (Amandry 1984), then the classification can reach an almost universal status. Consequently, the 7x4 field can be used in the treatment of fears, in addition to observing depression (Heiska 2004).

There is stress in the view of life during the organisation of depression dealing (*): There are not enough caregivers for all. The plans from depressionnurses, who have limited training, will be then dealt with well, if you take into consideration the whole field as described above. For example, for different chiropodists it is possible to limit the training and the necessary equipment to caring for foot, but in depression, the reductions in question demands know how, which is more difficult to restrict in the same way as in chiropody.

By making use of the squares of the 7x4 field, preventive mental health work could also gain a more robust scientific basis and practical work could be defined with functional points of emphasis. Currently, anticipatory mental health work in practice surprisingly often consists only of trying to get citizens to seek treatment (early intervention), and an organised tackling of causes is almost entirely missing. This kind of extension in function demands variation in schooling too. The same is indicated in the suggestions by Felicia Huppert from Cambridge University that are explained by Jussi Valtonen in his article 'How to Make Better Psychology?' in the *Psykologia* journal. (Valtonen 2009). To this, you can add: How to Make Better Sociology? By exploiting the 7x4-field.

In preventing depression the functioning always contains some strategy. It has always some implementers. It has some targets, to which it connects the 7x4 field. Such as it is, it forms the following figure for practical work:

Table 6

		S T R A T E G I E S			
		Prerequisite functions		Actual functions	
I M P L E M E N T E R S	Organized Non-organized	Individual level		Group and community level	
		Promoting healthy growth	Reducing causes of disturbances	Promoting healthy growth	Reducing causes of disturbances
	Creating new posts etc.	TARGET: 7x4-field of individual		TARGET: 7x4-field of group and community	
	Supporting voluntary work etc.	TARGET: 7x4-field of individual		TARGET: some part of 7x4-field	

In Finland, this kind of outlining has been used and the functioning is followed. In practice this is a better outlining than the traditional promotion, primary prevention, secondary prevention, tertiary prevention.

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