

Lynn P. Rehm

Depression



**Advances in
Psychotherapy**

Evidence-Based Practice

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Depression

About the Author

Lynn P. Rehm, PhD, ABPP, obtained his doctorate in Clinical Psychology from the University of Wisconsin – Madison. He has been on the faculties of the Neuropsychiatric Institute at UCLA and the University of Pittsburgh in Psychology and Psychiatry. He recently retired from the Department of Psychology at the University of Houston after 30 years as Professor. His research and clinical interests center around the psychopathology and treatment of depression. He has published widely on his self-management treatment program for depression and on psychotherapy for depression generally. Dr. Rehm continues to be active professionally and is currently President of the Division of Clinical and Community Psychology of the International Association of Applied Psychology.

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Depression

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Depression is a worldwide health and economic burden

A series of national surveys provide estimates of the incidence and prevalence of mood disorders

The more recent the decade of your birth the more likely you are to experience depression in your life and the earlier you are likely to have a first episode

1.3 Epidemiology

Depression is often referred to as the common cold of mental illness because of its high prevalence. The World Health Organization ranks depression as the fourth largest global burden of disease based on years lived with disability (World Health Organization, 1992). Over the last few decades, several large-scale epidemiological studies have assessed the prevalence of depression and other disorders in the United States and in the world. In the late 1980s, the National Institute of Mental Health (NIMH) Epidemiological Catchment Area study results were published (Regier et al., 1988). This study analyzed community samples from five catchment areas around the US: New Haven, Baltimore, St. Louis, Durham, and Los Angeles. The study reported 6-month and lifetime prevalence of all affective disorders as 5.8% and 8.3%. For a manic episode, the figures were 0.5% and 0.8%; for a major depressive episode they were 3.0% and 5.8%; and for dysthymia they were 3.3% and 3.3%. Affective disorder rates were second only to anxiety disorder rates. Women had a 1-month prevalence rate of 6.6% compared to 3.5% for men.

Results of the National Comorbidity Study were published in 1994 (Kessler et al., 1994). This study interviewed a national stratified probability sample of noninstitutionalized individuals aged 15 to 54. Rates for any affective disorder were lower than for any anxiety disorder and for substance-abuse disorders. Twelve-month and lifetime prevalence of 11.3% and 19.3% for any affective disorder were reported. For manic episode, the rates were 1.3% and 1.6% (women 1.3% and 1.7%, men 1.4% and 1.6%); for major depressive episode they were 10.3% and 17.1% (women 12.9% and 21.3% and men 7.7% and 12.7%); and for dysthymia they were 2.5% and 6.4% (women 3.0% and 8.0% and men 2.1% and 4.8%).

Most recently, the National Comorbidity Study has been replicated (NCS-R) in a national face-to-face interview survey of a probability sample of respondents age 18 and older. This survey yielded a 12-month and lifetime rate of MDD of 6.6% and 16.2% (Kessler et al., 2003). Bipolar I disorder was found to have 0.6% and 1.0% prevalences; Bipolar II was 0.8% and 1.1%, and subthreshold Bipolar was 1.4% and 2.4% (Merikangas et al., 2007). Overall, the reported 12-month and lifetime prevalences of mood disorders was 9.5% and 20.8% (Kessler et al., 2005; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). Statistics vary among studies because of minor differences in instruments used, training of interviewers, participation rates, and other factors, along with random error. Rates of MDD are consistently higher than either bipolar or dysthymia, and women have consistently higher rates of MDD.

1.3.1 Age Cohort

One of the interesting findings in the NCS-R study (Kessler et al., 2003) arose from the interviewers asking participants the age of onset of their first episode of depression while determining lifetime prevalence. Data were plotted for age cohorts of age 60 or greater, 45–59, 30–44, and 18–29. These curves are progressively steeper, i.e., the younger you are the earlier the onset of your

first episode of depression and the higher the probability that you will have an episode in your lifetime. From their graph, a total of about 13% of 60+ year olds reported lifetime depression, and just over 20% of 45–59 year olds, 24% of 30–44 year olds, and about 25% of 18–29 year olds reported depression already in their lifetime.

This is not a new finding. Very similar cumulative graphs were published in 1992 (Cross-National Collaborative Group, 1992). Both participants who were born from 1905 to 1914 (then averaging about 65) and those born before 1905 reported lifetime totals of depressive episodes of about 1%, compared to about 3% for those born from 1915 to 1924, about 5% for 1925 to 1934, about 9% for 1935 to 1944, about 9.5% for 1945 to 1954, and already 6% for 1955 or later (roughly 25 year olds) that also showed the steepest upward curve. With the exception of some Hispanic samples, the same sets of curves were found around the world in nine epidemiological studies and three family studies.

These findings must be interpreted with some caution. Many possible artifacts could be influencing these graphs. Even though participants were asked about times when they experienced specific symptom clusters, older people may be less likely to label their recollections as episodes of depression and may be more likely to forget they had them. Younger people may be more aware of the diagnosis of depression. In succeeding generations, it has become progressively more socially acceptable to identify oneself as depressed. Also, some of the more severely depressed individuals may not have survived into the older age groups.

Despite these caveats, the evidence is too consistent and comes from too many findings to dismiss it. *The more recently you were born the more likely you are to develop depression in your lifetime, and the earlier in your life you are likely to experience a first episode.* Why should this be? Depression has a biological component, but I have not heard anyone suggest that genetics or biology has changed so rapidly in only a few decades. In fact, the increase in depression raises some questions for the biological perspective on depression. Does it mean that the biological predisposition has been carried by a larger segment of the population and stress has simply increased its effect on people? Most people would attribute these dramatic data to changes that have taken place in society.

Martin E. P. Seligman (1990) proposed an answer to the question “Why is there so much depression today?” He proposed that the increase in depression corresponds to changes that have taken place in our society that increase a sense of personal responsibility for negative events, and a similar change in which communities have lost their ability to respond to problems. Seligman

Seligman suggests that the stress on individuality in the US is responsible for increased rates of depression

Clinical Vignette

Self-Diagnosis

An older psychiatrist once told me that he used to see patients who would say “Doctor, I am not sleeping well, I have lost my appetite, and I am really feeling badly about myself.” He would reply, “Oh, you must be depressed.” He said that today patients say to him, “Doctor, I am depressed,” and he says “Oh, are you not sleeping well? Have you lost your appetite and are you feeling badly about yourself?” People today are much more ready to self-diagnose.

suggests that we are living in an “age of the individual” in which our society stresses the responsibility of the person, giving him or her both credit and blame. He attributes this emphasis largely to the prosperity of the United States, which allows individuals to make a wide variety of individual choices in their lives. At the same time he cites a lessening of community responsibility. As our population becomes more mobile and families are fragmented, our sense of belonging to a community decreases. We do not have stable living communities, and communities built around institutions such as schools and churches have lost their power as well. Seligman also sees historic events in the United States as contributing to our sense that society cannot solve its problems. He uses the political assassinations of the 1960s, the Vietnam War, and Watergate to illustrate his point that most people have lost faith in the country’s ability to find solutions to problems.

The result is that individuals feel the full weight of responsibility for their choices and for their successes and failures. A child who does poorly in school is seen as a personal failure while the family, the school, and the community take little responsibility for this problem. Individual responsibility makes us more vulnerable to take responsibility for failure and to feel helpless to change our lives. Seligman views helplessness as a central element in depression. His helplessness theory of depression will be reviewed in a later chapter.

Seligman’s explanation for the increase in depression focuses on historic events in the United States. However, the phenomenon of increases in the rates of depression is found elsewhere as well (Cross-National Collaborative Group, 1992). Some of the places where increases in depression have been reported (e.g., Italy, Lebanon, Taiwan, and New Zealand) have very different social climates and histories. The sense of individuality, for example, may be less prevalent in Taiwan and in New Zealand. These other countries may also have experienced frustrations with national solutions to problems, but one would not expect these events to coincide with the problems the United States has faced. One problem with Seligman’s explanation of the change in society is that it focuses on issues during a particular historic period: the 1960s. If the 1960s were a turning point, then the various cumulative curves for the different age cohorts should become steeper when that cohort was living through that era. Such inflections in the curves are not obvious. If an increase in helplessness and loss of control over our lives is the cause of the increases in depression, it has to be an effect that is gradual and worldwide. The Cross-National Collaborative Group (1992) suggested that empirical studies of how various demographic, epidemiological, economic, and social indices are related to increases in depression in different countries might shed light on the relevant causes.

1.3.2 Gender

Beginning in adolescence, women have higher rates of depression than men

The prevalence of depression is higher among women than among men. The DSM (American Psychiatric Association, 2000) cites women/men ratios of between 2:1 and 3:1. The National Comorbidity Survey reported a ratio of about 1.7:1 for both lifetime and 12-month prevalence (Kessler et al., 1994). The NCS-R study found about the same lifetime ratio and a 1.4:1 ratio for 12-month prevalence (Kessler et al., 2003). In contrast, *the rates for Bipolar*

Treatment

4.1 Methods of Treatment

4.1.1 Therapy Packages

One of the major developments in the treatment of depression over the last several decades has been the codifying of treatment procedures into therapy manuals. As new theories of depression have been developed, therapy procedures that follow from the theory have been worked out and examined in research trials. It has become a standard part of this process to write a manual in sufficient detail that others can replicate the therapy with a minimum amount of training.

Virtually all of these therapies are package programs. They are made up of therapy components that are presented in sequence in the manuals. I have tried to give a sense of these components in my earlier discussion of theories of therapy. Many components of therapy may be developed from a particular theory. In addition, manuals often contain elements that are not necessarily associated with a particular theory, but are helpful topics to be covered in dealing with depression, such as reviewing the symptoms of depression in an early session. Manuals also contain procedures that have more to do with the structure of therapy sessions than with the content of the theory from which the therapy is derived. For example, manuals may include recommendations for review of homework, agenda setting, or reviewing topics covered in therapy. Nearly all of these therapies are psychoeducational or partly psychoeducational in nature. They teach the patient about the nature of depression as viewed by the particular theory and may introduce a set of constructs and a vocabulary to explicate the therapy.

Therapy manuals share many similar elements with different rationales and theoretical origins. Also, some elements are recommended in one manual and discouraged in another. In one manual the therapist is encouraged to grant the patient the sick role, whereas in another the sick role is discouraged. In one manual childhood history of the client is explored extensively, whereas in others the therapist is advised to avoid the topic. One manual has the patient self-monitor situations in which they feel particularly bad, and another has them monitor positive events. Therapists of any orientation who read widely and who may want to draw from a variety of manuals understandably find this confusing and discouraging.

Manuals also tend, in part, to be “one size fits all” programs. Although components may be adapted to the individual, the same components are applied to everyone. In a social-skills component, the individual’s interpersonal

Manualized therapies are complex treatment packages

Manuals share similar elements

problems may be identified and form the basis of role-play exercises, and in a goal-setting component, individuals select the goals they want to work on in their lives. Nevertheless, all are receiving social-skill training and goal setting.

Although the empirical literature on matching does not yield evidence of matching effects, in the sense of matching behavior-therapy elements to individuals with behavioral deficits and cognitive-therapy element to those with cognitive deficits, it makes sense to use the program components that fit the client's problems. Depression clients vary immensely in symptom patterns, in the life events and daily hassles they are facing, in the interpersonal environments and problems they face, and in their personal skills and coping styles.

Therapy components

In this chapter, rather than review the brand-name therapies as packages, I am going to attempt to review components of therapy and discuss what one can learn from the ways in which the components are handled by different therapies. I will give examples of the types of presenting problems to which these components are likely to best apply. To some extent I will also discuss the logic of sequencing components and elements of therapy for depression. My intent is not to present a new therapy package program drawn from other programs, but simply to identify basic therapy components that can be abstracted from different therapies. *Any therapist who is competent in these components could treat most depressions competently.* Most of these components are also applicable in doing therapy for other problems, but they have a particular place in the array of techniques that are applicable to depression.

Relationship factors are important in all forms of psychotherapy. Building rapport, establishing trust, and establishing a working alliance with the person that includes agreement on a clear set of goals, are all important as a basis for therapy. These factors are generic to all forms of therapy. My goal here is to describe and discuss therapy components that are most relevant to depression, even though they, too, may have wider applicability.

4.1.2 Education About Depression

Education about depression is a common first step in therapy

A number of therapy manuals include in a first session a discussion of the symptoms of depression. This seems like a natural place to start therapy, and it may have therapeutic value in a number of ways. Research suggests that if you ask someone to identify the symptoms of depression, they can do a fairly good job, but when you ask them to judge whether they themselves or someone they know well is depressed, they have a much harder time putting the pieces together. So the first effect of such an educational exercise may be to help people see that the parts of what they are experiencing are connected under the broad umbrella of depression. In our self-management therapy groups I have often heard clients say, "I haven't wanted to call up my friends lately, but I did not realize that it was part of my depression," or "I have had that tired feeling, too, but it did not occur to me that it was part of depression."

Clients also learn that they are not alone, and that depression is a syndrome shared by many people. Clients often feel that they are the only ones to experience what they are going through, and believe no one else could understand what it is like to be them. Education helps patients understand that many people have these experiences, and that others can understand them.

Education also includes a discussion of the causes of depression. Many individuals come to therapy with misconceptions about the causes of depression. It is not unusual for clients to have read or seen media accounts that say depression is a “biological imbalance” or a “brain disease.” Other common conceptions are that depression is a response to stress, or it is solely the product of maladaptive thinking. Some people come in with psychodynamic ideas about childhood problems in their upbringing or religious ideas about punishment for their sins. It is a good idea to review a biopsychosocial model to give patients a more realistic view and help them understand that depression has multiple causes.

Biology represents only one set of causes. Genetics does make some individuals more prone to depression, and changes in brain chemistry and physiology occur in depression, although it is not clear whether they are cause or effect. Psychology represents a second set of causes. A pessimistic outlook, low self-esteem, and a sense of powerlessness are some of the tendencies that may contribute to depression. Many of these tendencies may be acquired through experiences early in life. The environment, especially the social environment, represents another set of causal factors in depression. Negative life events, losses, or prolonged stresses can precipitate depression. Some forms of depression may be more biological, some more psychological, and some more environmental, but most depressions are caused by some combination of the above factors.

At another level, people can be educated about normal mood and what influences it on a day-to-day basis. Again, biology is only one factor. Feeling tired or distressed can lead to a down mood. The environment is a contributor, but environment affects our mood by the way we behave in response to an event or how we perceive and think about the event. Thus, biology, behavior, and thinking influence mood directly. The idea of therapy can be introduced from this perspective. Mood can be improved through changes in biology, as with rest or medication. Mood can also be influenced by changes in behavior and changes in thinking. Psychotherapy uses the latter two routes to change mood and thus treat depression.

Introducing a biopsychosocial model is important

Mood is influenced by behavior, thinking, and biology

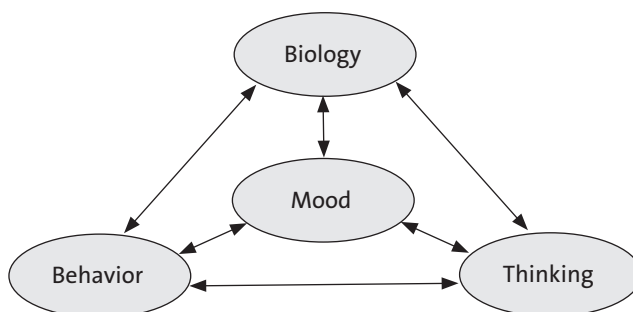


Figure 1
Influences on Mood

“Professor Rehm manages to cut right to the heart of the disorder and shines a light on the essence of the different approaches to its treatment. The treatise makes a real contribution to the literature for the neophyte and experienced clinician alike.”

*Steven D. Hollon, PhD, Professor, Department of Psychology,
Vanderbilt University, Nashville, TN*

“Lynn Rehm has spent most of his productive career studying and treating depression, and now, in an extremely well written and concise book, he shares the wisdom he has accumulated over the decades with us. As one of the originators of modern day psychological treatments for depression, few individuals are better positioned to guide clinicians in the difficult task of assessing and treating depression. This brief guide should be on the bookshelves of every clinician who assesses or treats depression.”

David H. Barlow PhD, ABPP, Professor of Psychology and Psychiatry, Director, Center for Anxiety and Related Disorders at Boston University, MA

Based on years lived with disability, the World Health Organization ranks depression as the fourth largest global disease burden. Depression is one of the most frequent problems seen in psychotherapy. This book takes the reader through the central issues of diagnosis and treatment of depression. It begins with definitions and a readable explanation of the intricacies of depression diagnoses. Instruments for assessing depression as a diagnosis and as a dimension are described with their primary uses. Major theories are presented with their conceptions of depression and the implications of the conceptions for treatment. Today's empirically supported treatments for depression tend to be complex packages with sequences of different interventions. This book identifies the basic and common components of therapy for depression, i.e., the basic competencies that will allow professionals to treat most cases of depression. The book is aimed at students and professionals, giving them a comprehensive and up-to-date overview of psychopathology, assessment, and treatment of depression.

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