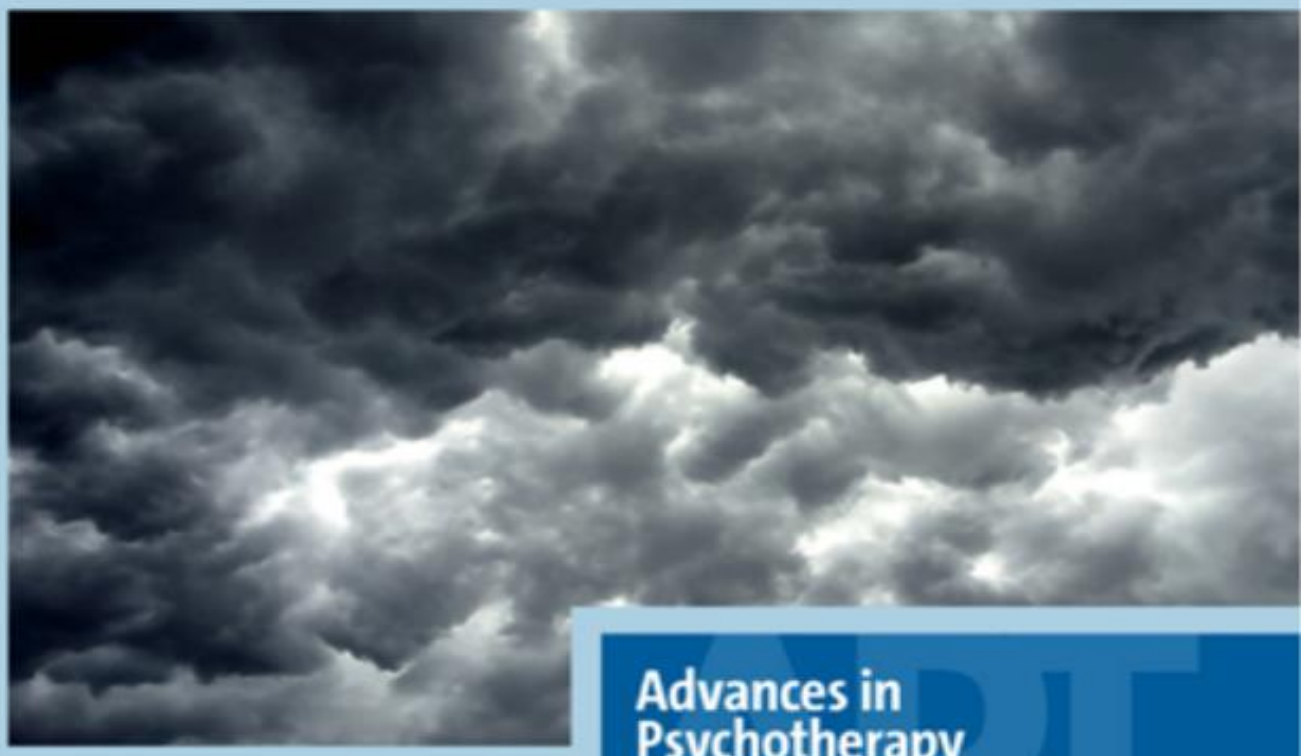
Lynn P. Rehm

Depression



Advances in Psychotherapy

Evidence-Based Practice

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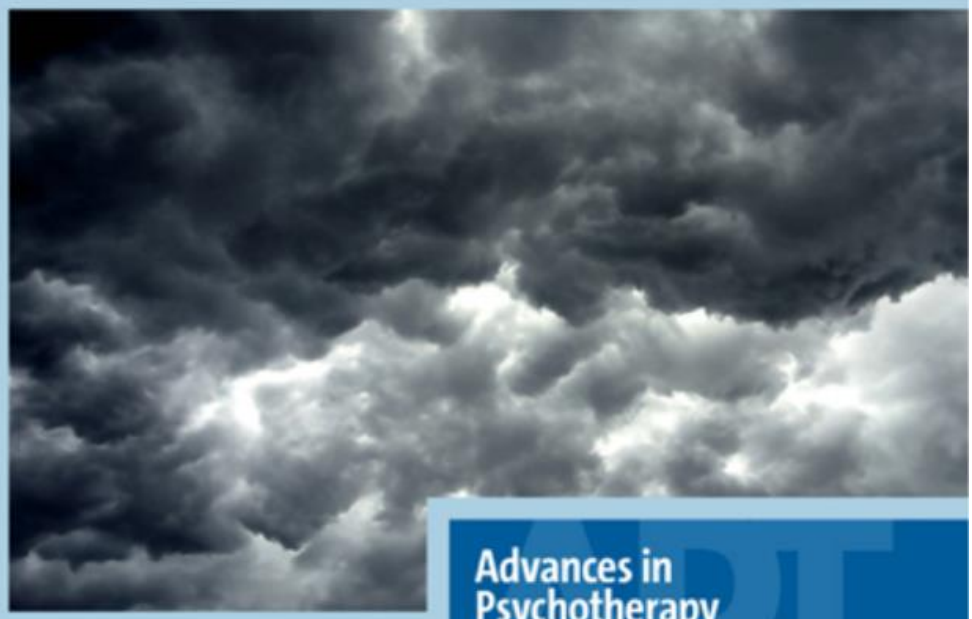

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About the Author

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.

Advances in Psychotherapy – Evidence-Based Practice

The basic objective of this series is to provide therapists with practical, evidence-based treatment guidance for the most common disorders seen in clinical practice – and to do so in a “reader-friendly” manner. Each book in the series is both a compact “how-to-do” reference on a particular disorder for use by professional clinicians in their daily work, as well as an ideal educational resource for students and for practice-oriented continuing education.

The most important feature of the books is that they are practical and “reader-friendly:” All are structured similarly and all provide a compact and easy-to-follow guide to all aspects that are relevant in real-life practice. Tables, boxed clinical “pearls”, marginal notes, and summary boxes assist orientation, while checklists provide tools for use in daily practice.

Depression

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Library of Congress Cataloging in Publication

is available via the Library of Congress Marc Database under the LC Control Number 2010926904

Library and Archives Canada Cataloguing in Publication

Rehm, Lynn P.
Depression / Lynn P. Rehm.

(Advances in psychotherapy-evidence-based practice ; v. 18)
Includes bibliographical references.
ISBN 978-0-88937-326-6

1. Depression, Mental. 2. Depression, Mental--Treatment. I. Title. II. Series: Advances in psychotherapy--evidence-based practice ; v. 18

RC537.R445 2010 616.85’27 C2010-902782-5

Cover picture: © 2005 Tomasz Wojnarowicz, available from www.Fotalia.com

PUBLISHING OFFICES

USA:	Hogrefe Publishing, 875 Massachusetts Avenue, 7th Floor, Cambridge, MA 02139 Phone (866) 823-4726, Fax (617) 354-6875; E-mail customerservice@hogrefe-publishing.com
EUROPE:	Hogrefe Publishing, Rohnsweg 25, 37085 Göttingen, Germany Phone +49 551 49609-0, Fax +49 551 49609-88, E-mail publishing@hogrefe.com

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EUROPE:	Hogrefe Publishing, Rohnsweg 25, 37085 Göttingen, Germany

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SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, CH-3000 Bern 9

Hogrefe Publishing
Incorporated and registered in the Commonwealth of Massachusetts, USA, and in Göttingen, Lower Saxony, Germany

Format: EPUB
ISBN: 978-1-61334-326-5

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Description

1.1 Terminology

The term *depression* may refer to the normal human emotion of sadness that occurs in response to loss, disappointment, failure, or other misfortune. Dictionary definitions refer to the act of, or the state of, being pressed down. Thus, metaphorically, depression is a mood that has been pressed downward by some force. We refer to sadness as feeling “low” or “down.” Depression as a form of emotional disorder is a severe and prolonged form of feeling down that is out of proportion to the force pressing on the person. Mood can go in two directions, down and up, and the emotional disorder of mania is an excessive and prolonged period of an elevated mood. Although the focus of this book is depression, it is necessary to talk about both kinds of disorders of mood to place depression in a context among psychiatric disorders.

The mood disorders are made up a complex set of diagnostic criteria, subtypes, and specifiers in the American Psychiatric Association’s *Diagnostic and Statistical Manual (DSM)*, currently in its fourth edition with a text revision *(DSM-IV-TR;* American Psychiatric Association, 2000). The World Health Organization’s *International Classification of Diseases* (ICD) also has a complex system for naming and classifying mood disorders. In addition to these two authoritative sources there are a number of other terms and

concepts related to the mood disorders that have historic, research or clinical practice importance.

Depression, as a word to describe low spirits, has been in the language for several centuries. An even older term is *melancholy* or *melancholia*, which goes back to Middle English. The word derives from the Greek for black bile or black choler, one of the four humors of the body in ancient physiology. Melancholy represented an excess of black bile, placing the person in an “ill humor.” In the earlier editions of the *DSM*, depression was referred to as *depressive reaction* or *depressive neurosis.*

1.2 Definitions

Types of episodes:
– Depressive
– Manic
– Hypomanic
– Mixed

There are various ways to define depression. As a diagnosis in the *DSM* of the American Psychiatric Association, it is one of the more complex categories. To begin with, the diagnostic criteria define mood episodes: **Major Depressive Episode** (MDE), **Manic Episode, Hypomanic Episode,** and **Mixed Episode.** See Table 1 for the full set of criteria for MDE. A Manic Episode consists of a distinct period of elevated, expansive, or irritable mood that lasts at least one week (less if hospitalization is required). In addition, three of the following symptoms are necessary (four if mood is irritable): inflated self-esteem or grandiosity; decreased need for sleep; more talkative than usual; flight of ideas or racing thoughts; distractibility; increase in goal-directed activity; and excessive involvement in pleasurable activities. The episode is Manic if it leads to impairment in functioning or necessitates hospitalization to prevent harm

to self or others. If the same criteria are met for at least four days but the impairment criterion is not met, then it is a Hypomanic Episode. Mixed Episode, as the name implies, has mixed symptoms of depression and mania and the criteria for both episodes are met. People in Mixed Episodes describe the feeling as being “wired,” i.e., they report being uncomfortably agitated and unable to sit still.

Table 1
Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for commit; suicide

B. The symptoms do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., drug-of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Diagnoses depend on the history of episodes

The history of episodes is then examined to determine the diagnosis. If only MDEs have been present, the diagnosis is **Major Depressive Disorder** (MDD). If one or more Manic Episodes has occurred, the diagnosis is **Bipolar I Disorder.** If one or more MDEs and one or more Hypomanic Episodes have occurred with no full Manic Episode, then **Bipolar II Disorder** is the diagnosis. Although it is not in the *DSM*, some researchers and clinicians also refer to **Bipolar III Disorder.** If only MDEs have occurred, but there is a family history of Bipolar Disorder, the person might be diagnosed Bipolar III. The implication is that this person would be better treated with medications targeting Bipolar Disorder. Medications targeting MDD may produce manic episodes in people with underlying Bipolar Disorder (I, II, or III).

MDD is diagnosed as either **Single Episode** or **Recurrent.** Further, if the current episode meets the full criteria, it can be further described by the following episode specifiers (Table 2): (1) Mild, Moderate, Severe With Psychotic Features, or Severe Without Psychotic Features; (2) Chronic; (3) With Catatonic Features; (4) With Melancholic Features; (5) With Atypical Features; and (6)