

# 4

## DEPRESSIVE DISORDERS

### The Case of James

*James, a 30-year-old man dressed in jeans and a rumpled shirt buttoned wrong, sat slumped in his chair at the counselor's office, wringing his hands in his lap and looking down.*

*"Can you tell me how you're feeling?" the counselor urged, and James finally looked up. His eyes were red-rimmed, and he struggled to blink back tears as he met the counselor's gaze.*

*"It's just getting worse," he said, his voice so soft that the counselor could hardly hear him. "I can't bring myself to even answer the phone when my friends call. They don't really want to hang out with me anyway, they just feel obligated. I've been missing work too."*

*"What's making it hard to go to work?" the counselor asked, keeping eye contact with James.*

*James shook his head sadly. "I get these terrible headaches, and I'm just so tired all the time, I can't think straight—so why bother trying to work? I'm failing at that—failing at everything."*

*"You're having trouble concentrating—anything else?"*

*James nodded, looking down again. "Sleeping, eating, thinking . . . you name it. I wake up at 4 a.m. and can't get back to sleep, thinking about how hopeless it all is."*

*The counselor leaned forward in his chair, speaking softly as well. "How long have you been feeling this way?"*

*James paused, then went on, even more softly.*

*"A long time—six months, maybe a year. Why do I even bother? Everyone would be better off if I wasn't even alive."*

### INTRODUCTION

We all experience feelings of sadness in our daily lives, especially when we are confronted with stressful life events, loss, or conflict, but these feelings tend to be fleeting. We occasionally feel

"down" or "blue," but those feelings tend to pass quickly. Depression, in contrast, lasts longer and interferes with daily living—work, school, concentration, eating, or sleeping. Depressive disorders are characterized by a sad, empty, or irritable mood as well as cognitive and physiological

changes. These symptoms have a significant impact on the person's ability to function, as we can see from the case of James.

In the United States, approximately 9.5% of the adult population in a given year are diagnosed with a mood disorder, which translates to over twenty million people (Kessler, Chiu, Demler, & Walters, 2005). Depression can be chronic (Spijker et al. 2002), and major depressive disorder is the second largest healthcare problem in terms of disability caused by illness, according to the World Health Organization (Levav & Rutz, 2002). Depression can cause physical suffering, such as headaches, stomach upset, or chronic pain, as well as emotional pain. Feelings of hopelessness, helplessness, and self-blame are common, and individuals suffering from depression may lose interest in daily activities, hobbies, and relationships. Depression can be overwhelming, keeping people from interacting with others and participating actively in their own lives. They may withdraw from family and friends, and this isolation can actually make the depression worse. Some depressed individuals may consider or attempt suicide.

Unfortunately, there is still some stigma associated with seeking help for depression, especially when viewed as a sign of weakness. Advice to “snap out of it” can lead to feelings of self-blame when depressive symptoms persist, but people with depression often cannot just “feel better”—if they could, they most likely would! When depressed individuals do not seek treatment, over time symptoms can worsen. Fortunately, depression is highly treatable, even when the symptoms are severe.

The DSM section on depressive disorders underwent some of the most controversial changes from DSM-IV to DSM-5, with several new disorders added and some removed. In addition, “Bipolar and Related Disorders” is now a separate chapter. In the sections below, we summarize the symptoms and characteristics of the depressive disorders that counselors most often encounter and treat.

### DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)

Disruptive mood dysregulation disorder (DMDD) was added in the newest edition of the

#### The Case of Jesse

*A counselor is meeting with the parents of Jesse, a 9-year-old who is struggling both in school and at home.*

*Mom: “I just don’t know what to do anymore. He’s out of control so often, and he’s getting too big for me to pick up and put in time out.”*

*Dad: “He won’t stay there anyway, not when he’s in one of his ‘moods.’ He doesn’t even seem to hear us when he gets like that.”*

*Counselor: “So Jesse has outbursts of temper and you can’t get through to him during those times? When do these outbursts happen?”*

*Dad: “When he doesn’t get his way. It can be anything—we can tell him it’s time for bed . . .”*

*Mom: (interrupts) “Oh God, bedtime, it’s become a nightmare. He just won’t go!”*

*Dad: “He just lies down on the floor and pounds his fists and kicks his feet and screams—it’s like he’s a 2-year-old again.”*

*Mom: (nodding) “It’s terrible. And even when he’s not having a tantrum, every little thing sets him off.”*

*Counselor: “Jesse is easily irritated, would you say?”*

*Parents: (nodding)*

*Mom: “He’s just so angry all the time. What are we doing wrong? Why isn’t he happy?”*

*Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). This disorder typically presents in children; as a result it appears first in the Depressive Disorders section, and applies to children up to the age of 12. The addition of this disorder is in part a response to the increase in diagnosis of bipolar disorder in children and adolescents from 1994 to the present. However, standard treatments for bipolar disorder, such as lithium, were not effective for these young people, and many went on to develop depression or anxiety instead of bipolar disorder. This suggested a diagnostic gap for children with mood dysregulation and angry outbursts.

The core feature of DMDD is chronic severe persistent irritability, marked by temper outbursts (usually in response to frustration) that must occur on average three or more times per week for at least one year and in two settings (i.e., home and

school). The episodes of behavioral dyscontrol must be developmentally inappropriate. Another manifestation of the severe irritability in DMDD is chronic, persistently irritable or angry mood present between the severe temper outbursts, which must be present most of the day nearly every day and noticeable by others. When a child has DMDD, family and peer relationships are significantly disrupted.

DMDD must be diagnosed during childhood—before age 10, but after age 6. DMDD peaks during the elementary school years. Some children with Oppositional Defiant Disorder (ODD) may meet the criteria for DMDD; however, there is no requirement of severe anger outbursts three times a week or underlying irritable mood present in ODD, and not as many of the acting out externalizing behaviors. (In other words, DMDD is the severe end of the ODD spectrum.)

## PREMENSTRUAL DYSPHORIC DISORDER (PMDD)

### The Case of Genevieve

*Genevieve, a 25-year-old woman, sought counseling at a community behavioral health center. She is an attractive woman who holds a responsible position as assistant manager of a boutique clothing store in the city and is engaged to be married. However, despite Genevieve's many successes, she is having bouts of severe depression that are starting to adversely impact both her job and her relationship.*

*Genevieve: "I don't get it. Most of the time, I can deal with things just fine. But, sometimes it's like everything is horrible. I find myself crying for no reason one minute, and then I'm snapping at the customers the next. I'm starting to be afraid for my job!"*

*Counselor: "Are there any other symptoms you can remember that happen during these times?"*

*Genevieve: "I fight more with my boyfriend—it's like everything he does is wrong, and yet I know he's a great guy. I know he's not going to leave me, but suddenly I'm convinced that he's about to. Am I going crazy?"*

*Counselor: "Can you tell me if these symptoms worsen at the same time every month, perhaps around the time of your monthly menstrual cycle?"*

*Genevieve: "My . . . I never thought about that. I don't know—wait, actually, I think that might be true. It definitely happened this past month a few days before."*

*Counselor: "And when did you start to feel better again, more like yourself?"*

*Genevieve: "A few days after, I guess. Actually yes, I remember that by Thursday I was sleeping better again, and my fiancé and I went out to dinner and I could just enjoy myself."*

premenstrual dysphoric disorder (PMDD) was also added in DSM-5, formerly appearing only in the Appendix of DSM-IV. In general, the DSM-5 reflects the accumulation of research which indicates that medical issues affect mental health.

PMDD disorder requires significant affective symptoms in the week prior to the menstrual cycle that quickly disappear after the cycle, and that symptoms appear in all menstrual cycles over the past year. These include affective lability (mood swings, sensitivity to rejection), irritability and increased interpersonal conflicts, depressed mood (including hopeless and self-deprecating thoughts), and anxiety, as well as one or more additional symptoms. Some individuals report decreased interest in their usual activities, difficulty concentrating, lack of energy, change in appetite, sleep problems, feeling overwhelmed or out of control, or physical symptoms, such as breast or joint tenderness or feeling bloated. PMDD can occur any time after menarche. Symptoms may worsen near menopause and cease afterwards.

While PMDD is not a culture-bound syndrome and has been observed worldwide, nevertheless the ways in which the symptoms are expressed and interpreted is related to the client's social and cultural background, family and religious beliefs, and the culture's norms about gender, sexuality, and help seeking. In Genevieve's case, she was open to the diagnosis of PMDD once the counselor brought it up, and even appeared relieved to have an explanation for her confusing mood swings. Other clients may not be so open to a PMDD diagnosis, or may not want to pathologize what they view as normal biological functioning. PMDD is distinguished from Premenstrual Syndrome (PMS) by severity of symptoms and significant impairment or distress, but counselors are cautioned not to pathologize normal functioning.

### **MAJOR DEPRESSIVE DISORDER (MDD), INCLUDING MAJOR DEPRESSIVE EPISODE (MDE)**

James, the client we met at the beginning of this chapter, is experiencing a major depressive

episode (MDE), which is defined in DSM-5 by a depressed mood or a loss of interest or pleasure, plus four other symptoms. These include middle insomnia (waking in the middle of the night) or terminal insomnia (waking in the very early morning), psychomotor retardation or agitation, fatigue or loss of energy, difficulty with concentration, or suicidal ideation. It's important to note that a client can meet criteria for a MDE without depressed mood, but instead with irritability or loss of interest or pleasure in life, especially for children or the elderly, for whom loss of interest and somatic symptoms are common. Clients must exhibit these symptoms for at least two weeks, and there must be clinically significant distress or impairment in social, occupational, or other important life roles. Risk of recurrence is greater the longer the depressive episode is sustained. If even mild symptoms of depression remain during remission, the risk of recurrence is increased.

The DSM-5 requires clear-cut changes in mood, thinking, and neurovegetative functions for a diagnosis of major depressive disorder (MDD), and these symptoms must remit between major depressive episodes. A client can be diagnosed after a single episode, but major depressive disorder is often recurrent.

Symptoms include depressed mood most of the day nearly every day, which can be described as "feeling flat" or without feelings, or can manifest as irritability in children. A lack of interest or pleasure in activities that the person used to enjoy is also a symptom of depression, which clients sometimes describe as "I just don't care anymore." Unintentional weight loss or change in appetite, sleeping too much or difficulty sleeping, and changes in level of activity (unable to sit still, or fatigue and low energy) are symptoms of depression as well. Clients may report feelings of guilt or worthlessness, have difficulty concentrating, or report thoughts of suicide.

Depressive symptoms can appear at any age, although the incidence of MDD appears to peak in the twenties. The course of MDD varies across individuals. Some people have isolated depressive episodes that are separated by several years

throughout which mood is normal, while others suffer clusters of major depressive episodes that occur tightly together. Still others with Major Depression experience increasingly frequent episodes as they grow older.

It's important to rule out a bipolar disorder diagnosis whenever a client presents with depression symptoms. Asking the client if they have ever had a period of time where they felt the opposite of how they feel now is helpful; for example, when they felt really good, didn't need as much sleep, and other people noticed their mood was different. When working with an adolescent, keep in mind that the individual may not have had a manic episode yet, but could develop one in the future. The "with mixed features" specifier is used to indicate the presence of coexisting manic or hypomanic symptoms, such as rapid speech or reduced sleep, when there are not enough of such symptoms to satisfy criteria for a manic episode. The use of this specifier allows for the existence of manic features in clients with a diagnosis of major depressive disorder. These symptoms may indicate the need for different or a combination of medications, or may suggest a risk of bipolar disorder in the future.

A significant change to the DSM-5 was the removal of the "bereavement exclusion," which applied if depression symptoms began within two months of the death of a loved one. The change removes the implication that bereavement tends to last only several months, and recognizes it as a serious stressor that can precipitate a major depression episode. While most people experience bereavement without developing depression, individuals who have a history of past depressive episodes are at greater risk of becoming depressed after the death of a loved one. Symptoms similar to depression are common in the months following any sort of significant loss, whether from death, divorce, retirement, loss of functioning, or a serious health diagnosis. Instead of broadening the exclusion, the DSM-5 simply removed it, along with the two-month restriction. However, it is important to consider recent losses when diagnosing depression, since symptoms of grief may resemble a MDE. When MDD occurs with bereavement,

there can be even greater pain. If a client had recurrent depressive episodes over their life span, they may be more likely to develop a MDE after a loss event. With grief, the predominant feelings are of emptiness and loss; with a MDE, the persistent depressed mood and little expectation of happiness or pleasure are predominant. In addition, the depressed mood of MDE is more persistent, whereas grief often "comes in waves." It's up to the clinician to make the judgment as to whether depression post loss is normal or not.

In addition to the elimination of the bereavement exclusion, new specifiers were added to the DSM-5, including "with anxious distress" (tension, restlessness, frequent worry). When depression is combined with anxious distress, prognosis is worsened and risk of suicide increases, complicating treatment. Other specifiers include "with melancholic features" (profound loss of interest or pleasure), psychotic features (thought insertion, depersonalization), catatonia (motionless for hours), and atypical features (sleeping more and eating more instead of less). Peripartum Onset is also a specifier, which is a new addition to the DSM-5 and reflects the problem of depression during pregnancy. Most postpartum depression is believed to begin during pregnancy, with CBT (cognitive behavioral therapy) and IPT (interpersonal therapy) found to be effective for the 3 to 5% of women who develop this problem. "With seasonal pattern" is also a specifier for MDD, replacing seasonal affective disorder. Finally, the "recurrent" specifier takes into account the increased risk of developing a future MDE once a client has experienced one in the past, allowing counselors to more effectively prevent future episodes.

We'll return to the case of James at the end of this chapter, and listen in as the counselor develops a case conceptualization using the T/C Model.

### **PERSISTENT DEPRESSIVE DISORDER (PDD)**

Persistent depressive disorder (PDD) is a chronic depressive spectrum disorder that replaces the

### The Case of Tom

*Tom, a man in his fifties, comes to see a counselor at the insistence of his wife.*

*Tom: "I think my wife has just had it with me. I just don't want to do anything anymore. I don't have the energy. Sometimes I don't even want to get out of bed."*

*Counselor: "How long have you felt this way?"*

*Tom: (sighing) "A long time, I guess. I've felt depressed on and off since college, and sometimes it got pretty bad . . ."*

*Counselor: "How bad? Bad enough to feel hopeless and think of killing yourself?"*

*Tom: (nodding) "A few times, yeah. But, it usually got a little better after a while and I sort of tried to just keep living with it."*

*Counselor: "And this time, isn't it?"*

*Tom: (shakes his head) "It's just starting to feel like this is the way things are—this is how I am. I don't think it's going to change. My dad was the same way, he went out on disability when he wasn't quite sixty, and he basically just drank himself to death after that."*

*Counselor: "I'm so sorry, that must have been very difficult for you."*

*Tom: "It was, I guess. My mom kept trying to get him to eat something, to stop drinking, to get up off the couch. He just never did."*

*Counselor: "Tom, are there any times during the day that you don't feel depressed?"*

*Tom: (shakes his head again) "Not really. It's all day, every day."*

*Counselor: "And how long have you felt this way?"*

*Tom: "It's hard to say, I think it sort of snuck up on me. My wife says it's been at least two years, maybe three. I don't think there's much hope of changing anything now. I don't blame her for thinking about leaving me."*

dysthymia category from the DSM-IV, and expands the symptom constellation to include the older diagnoses of both dysthymia and chronic major depression. The DSM-5 conceptualizes chronic depression differently, with both chronic major depressive disorder and the previous category of dysthymic disorder incorporated in this new category. The DSM-5 task force found no clinically meaningful differences between the two disorders; specifiers are now used to identify different pathways to the diagnosis. Symptoms must be present for two years, but the new disorder also

includes more severe symptoms that are chronic and may include major depressive episodes. Specifiers distinguish between the less severe symptoms that were typical of dysthymia, persistent MDEs (formerly referred to as "double depression"), and intermittent MDEs with or without current MDEs.

This disorder can be diagnosed when the mood disturbance continues for at least two years in adults or one year in children. Adults who are diagnosed with PDD have not been symptom free for more than a two-month period during

those two years. The essential feature of PDD is depressed mood for most of the day for most days, with two or more other symptoms, including poor appetite or overeating, sleeping too much or too little, low energy or feeling fatigued, low self-esteem, difficulty concentrating or making decisions, and feelings of hopelessness. As with MDD, there has never been a manic or hypomanic episode. There is often an early and insidious onset of PDD.

### **SUBSTANCE/MEDICATION INDUCED DEPRESSION**

Substance/Medication Induced Depression is also included in DSM-5. Medications, such as blood pressure and hypothyroidism treatments, and use of alcohol or drugs, can be associated with depression. Diagnosis of this disorder requires sufficient time for the counselor to disentangle the medication or substance use from the depression. For example, if the depression emerged prior to the client's alcohol use, a more appropriate diagnosis might be major depressive episode. If the client stops using alcohol and the depression symptoms disappear, again, this diagnosis would not be appropriate. This type of depression sometimes includes atypical symptoms, such as lack of feelings, worthlessness, or low self-esteem.

### **OTHER SPECIFIED AND UNSPECIFIED DEPRESSIVE DISORDERS**

Finally, the Depressive Disorders chapter of DSM-5 includes other specified and unspecified, which replaces the DSM-IV category of not otherwise specified (NOS), which was overused according to the DSM task force. If a client does not meet criteria for a MDE, for example, but is experiencing symptoms which are significant and serious, an OSDD (other specified depressive disorder) diagnosis can be used with the severe symptoms described.

### **COMORBIDITY**

When there are co-occurring disorders, treatment of depression can be more complicated. Other mental and physical disorders can be precipitating factors in developing depression, can be more likely because of depression, or can simply occur simultaneously. Anxiety disorders are the most common co-occurring problems, including posttraumatic stress disorder (PTSD), panic disorder, social phobia, generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD) (Devane, Chiao, Franklin, & Kruep, 2005; Regier, Rae, Narrow, Kessler, & Schatzberg, 1998). As previously mentioned, experiencing a traumatic event can be a risk factor for developing depression; individuals can also develop PTSD after experiencing a trauma. A National Institute of Mental Health (NIMH) study of people who had experienced a traumatic event found that over 40% who developed PTSD also suffered from depression four months post trauma (Shalev et al., 1998). Individuals with depression also commonly have issues with substance abuse (Conway, Compton, Stinson, & Grant, 2006). The pain of depression is difficult to bear, and those who do not get appropriate treatment may self-medicate with alcohol or other drugs.

Co-occurring medical conditions that are chronic or disabling also complicate the course of depression. Chronic illness, such as heart disease, diabetes, cancer, multiple sclerosis, fibromyalgia, human immunodeficiency virus (HIV), and Parkinson's disease are also risk factors for depression. The hopelessness that can come with a chronic diagnosis creates a predisposition for depression, and both diagnoses tend to worsen when they occur together (Cassano & Fava, 2002).

Substance abuse, panic disorder, obsessive compulsive disorder, anorexia, and bulimia nervosa also may be comorbid with MDD. In addition to mood and anxiety disorders, DMDD has high rates of comorbidity with autism spectrum disorders, and PMDD can co-occur with medical diagnoses, such as allergies, asthma, and migraines. Pathological gambling co-occurs with substance/medication-induced disorder. In

addition, certain personality disorders may be comorbid, including paranoid, histrionic, and antisocial personality disorder. Comorbid disorders common with PDD include anxiety disorders and substance use disorder. When the disorder is diagnosed before age 20, there is a higher risk of comorbid personality disorder or substance use disorder.

### CULTURAL CONSIDERATIONS AND POPULATION FACTORS

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Depression touches all groups of people, regardless of age, gender, ethnicity, or socioeconomic status. There are, however, differences in prevalence and symptom constellation in various groups of people.

Major depressive disorder is more prevalent in women than men. Females are 1.5 to 3 times more likely to be diagnosed with MDD than males, beginning in early adolescence (Cyranowski, Frank, Young, & Shear, 2000). Contributing factors include hormonal shifts with the menstrual cycle, ovulation, childbirth, and menopause, as well as cultural norms which may call for women to take on both work and home responsibilities, leading to role confusion and stress (Rubinow, Schmidt, & Roca, 1998). There is no specific diagnosis of what is commonly referred to as “Postpartum Depression”; however, a specifier of “with peripartum onset” can be used if the depressive episode occurs during pregnancy or after childbirth (Cuijpers, Brannmark, & Van Straten, 2008).

Women and men also experience different symptoms with depression. Women report more sadness, guilt, and feelings of worthlessness, while men have trouble sleeping, and experience fatigue, anger, and irritability (Cochran & Rabinowitz, 1998).

In contrast, DMDD is more common in males and school-age children, less in females and adolescents. Clients diagnosed with Substance/Medication Induced Depression are also more likely to be male than female, and more likely to be Black.

There are also age-related differences in the symptoms and prevalence of depression.

Children with depression may exhibit anxiety or irritability more than feelings of sadness. These can manifest as school refusal, clinginess, or behavioral difficulties (Walker & Roberts, 2001). By adolescence, depression can be connected to issues of identity, including sexual orientation, ethnic affiliation, and gender identity. Substance abuse and eating disorders commonly occur with adolescent depression, and suicide is a significant risk (Shaffer et al., 1996; Weissman et al., 1999).

Among older adults, depression can be caused or exacerbated by certain medical conditions or medications. For example, vascular depression occurs when blood vessels harden with age and become constricted. Loss is more frequent for the elderly, which can lead to either normal grieving or depression. The elderly may be unwilling to talk about being depressed, leading to misdiagnosis and lack of treatment. White men over the age of 85 have the highest suicide rate in the United States (Luoma, Martin, & Pearson, 2002).

The effectiveness of counseling for individuals diagnosed with a mood disorder has been demonstrated across a wide range of ages and diverse populations, including older adults, children and adolescents, low income clients, and individuals with disabilities (Kazdin, 2008; Kazdin et al., 2010). It is important to keep in mind, however, that certain underserved populations can benefit from specific adaptations to evidence-based treatments. For example, research suggests that racial/ethnic minorities, people with disabilities, those living in poverty, and members of the LGBT community may face specific challenges not addressed by current evidence-based treatment. Counselors should be sensitive to these challenges and pursue appropriate adaptations (Glickman, 2009; Livneh & Sherwood, 2001; Radnitz, 2000; Smith, 2005; Sue & Lam, 2002).

### ETIOLOGY AND RISK FACTORS

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Like most mental disorders, depression is not caused by a single precipitating factor. Rather, depression is multiply determined with various genetic, biological, chemical, social, psychological,



and environmental factors impacting the development of the disorder. A combination of risk factors and environmental stressors can bring about an episode. The causes of depression are not always immediately apparent, so the case conceptualization process is crucial.

## The Role of Experience

Sometimes the stressors which contribute to depression are acute and current; other times, there is a history of abuse or trauma that contribute to negative thought patterns and difficulties with identity and self-esteem. Significant transitions and major life stressors, such as the death of a loved one, the loss of a job, or relationship fractures like divorce or separation, can help bring about depression. Other more subtle factors that lead to a loss of self-identity or self-esteem may also contribute, like persistent bullying.

Normal developmental milestones, such as puberty, marriage, launching adult children, or retirement, may also serve to trigger depression when a particular event is personally distressing. Thoughts or situations that trigger a depressive episode may be new or reoccurring, or they may be past events that are re-traumatizing. Individuals who have experienced a traumatic event, such as a military battle, sexual assault, severe accident, or natural disaster, are more likely to experience a major depressive episode than people who have not experienced such trauma.

There are additional risk factors associated with specific depressive disorders. Seasonal changes and cultural norms for sexual behavior and gender roles can be risk factors for PMDD; a history of chronic irritability is a risk factor for DMDD; low income can be a risk factor for Substance/Medication Induced Depression; and parental loss or separation is a risk factor for PDD.

## Biological and Genetic Factors

Certain mood disorders tend to run in families, suggesting a genetic component (Tsuang & Faraone, 1990). Close family members of clients

with MDD have a risk two to four times higher than the general population of developing MDD, especially for early onset of depression symptoms. An imbalance in brain chemicals (neurotransmitters) has been found to be implicated in the development of depression, and there are differences in brain scans in people with depression on MRI scans (magnetic resonance imaging). Temperament risk factors associated with risk for developing a depressive disorder include neuroticism (negative affect).

## TREATMENT INTERVENTIONS

Left untreated, depression may last for months or years, and can worsen over time. However, depression is a treatable disorder; those who seek treatment often see significant improvement in symptoms. Individuals with depression who do not seek help suffer needlessly. When feelings and worries are not expressed, the isolation experienced can lead to worsening depression, which can last for long periods of time. Even individuals with severe depression can benefit from treatment.

Many research studies have demonstrated that counseling is effective for treating depression and relieving symptoms experienced by individuals who suffer from depression. Early treatment is beneficial—psychological treatments may prevent a person with milder depression from becoming more severely depressed. Further, although a past history of depression increases the risk of future episodes, there is evidence that ongoing counseling may lessen the chance of recurrence.

Several different approaches to counseling can help people recover from depression, specifically by identifying the behavioral, interpersonal, psychological, and situational factors that contribute to their symptoms and helping them deal more effectively with these influences.

## Counseling Interventions

There have been numerous empirical studies which have established that psychotherapy

is effective in treating depressive disorders (Cuijpers, Brannmark, & Van Straten, 2008; Cuijpers, van Straten, Warmerdam, & Smits, 2008; Elkin et al., 1989). Research demonstrates the efficacy of various modalities of treatment for mood disorders. Counseling approaches include cognitive behavioral treatment, reality therapy, client-centered counseling, and interpersonal therapy. Studies comparing the relative effectiveness of various types of psychotherapy show no significant differences in effectiveness (Castonguay & Beutler, 2006; Norcross, 2011). Compared to no treatment, the efficacy of counseling approaches across diverse conditions, including depression, are well established (Lambert & Archer, 2006; Shedler, 2010; Wampold, 2007). According to the research, most clients experiencing depression are able to return to normal functioning after a relatively brief course of counseling (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Stiles, Barkham, Connell, & Mellor-Clark, 2008; Wampold & Brown, 2005).

Counseling is effective for adults, as well as in special populations, such as older adults (Cuijpers, van Straten, & Smit, 2006) and women with postpartum depression (Lumley, Austin, & Mitchell, 2004). Psychotherapy is also an effective treatment for children and adolescents with depression (Kazdin et al., 2010; Weisz, McCarty, & Valeri, 2006). Older adults with depression can benefit from problem solving and supportive therapy (Alexopoulos et al., 2011; Areán et al., 2010) as well as from reminiscence and life review (Bohlmeijer, Smit, & Cuijpers, 2003).

Psychological and pharmacological treatments for depression show comparable effects (Robinson, Berman, & Neimeyer, 1990), and combined treatment is more effective than treatment with medication alone (Arnow & Constantino, 2003; Friedman et al., 2004; Pampanolla, Bollini, Tibaldi, Kupelnick, & Munizza, 2004).

### **Cognitive Behavioral Interventions**

Cognitive behavioral therapy (CBT) has been shown to be effective for the treatment of

depression (Churchill et al., 2001; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Pace & Dixon, 1993; Wampold, Minami, Baskin, & Tierney, 2002).

Based on the work of Aaron Beck and colleagues (Beck, Rush, Shaw & Emery, 1979), cognitive models of depression emphasize our cognitive schemas, or core beliefs. These underlying assumptions about self and others develop out of early experiences. Depressed individuals often develop negative beliefs about themselves and others, which lead people to interpret life events through a negative filter, distorting reality to fit their schemas. Cognitive treatment is based on the idea that when people experience stressful life events, negative ways of thinking which they have developed over the life course can be activated, along with negative automatic thoughts. The self-defeating thoughts create a negative filter which the person uses to view themselves and others, which leads to depression, which in turn reinforces the negative ways of thinking, producing a vicious cycle. Cognitive therapy challenges these negative automatic thoughts and beliefs, teaching the client to engage in reality testing and eventually replacing the dysfunctional and irrational thoughts with more functional and rational ones. The client can then challenge these negative beliefs in the future, reducing symptoms of depression.

Counselors working from a cognitive or cognitive behavioral orientation help clients become aware of negative and distorted patterns of thinking and behavior that contribute to feelings of hopelessness, helplessness, and self-blame. When clients revise their habitual ways of thinking, a more realistic view of self and others develops, resulting in more positive interactions and relationships. A counselor working from a CBT perspective helps the client identify the life problems that contribute to their depression, and helps them understand which aspects of those problems they may be able to solve or improve. Perhaps the client was depressed in the past and found some coping strategies that worked, at least partially. Identifying past successes and the parts of contributing factors which are solvable

creates a sense of hope, allowing clients to set realistic goals for the future and move toward them. As treatment progresses, the client may also develop new skills for preventing future depressive episodes, strengthening support networks, and crafting new routines for physical and emotional self-care.

Let's revisit the counselor we introduced at the beginning of this chapter as work with James continues using a CBT approach.

*Counselor:* "You said before that you don't bother answering the phone when your friends call."

*James:* "Right."

*Counselor:* "It seems like you usually assume that they're only calling because they're obligated, not because they want to spend time with you."

*James:* (nods)

*Counselor:* "I'm a little confused about that, because I remember you saying that a few of your close friends planned a surprise party for your birthday several months ago. That takes a lot of effort—do you think it was only out of obligation?"

*James:* "I don't know, maybe."

*Counselor:* "So they didn't have fun at the party, or seem like they wanted to be there."

*James:* (shrugs) "No, they . . . I guess they did have fun that night."

*Counselor:* "So, it seems as if you have a negative filter on when you think about your friends, and assume that they don't like you when it seems like they probably do."

*James:* "I never thought about it like that. I don't know."

*Counselor:* "We all develop habitual ways of thinking about ourselves and about other people, out of our past experiences. Can you think of some reasons you might assume the worst about your friends?"

*James:* "Well, I haven't had a lot of close friends—we moved around a lot when I

*was a kid, and I was always the new kid, you know? It was hard to make friends, and I got teased a lot. Bullied, I guess."*

*Counselor:* "That must have been really hard. How did you deal with it?"

*James:* "I just kinda gave up on having friends, kept to myself."

*Counselor:* "Do you think that's contributing to your depression?"

*James:* "Yeah. I feel worse when I stay in my room and don't talk to anyone, but at least I'm not getting hurt."

*Counselor:* "It's understandable that you might worry about the friends you have now, but it seems like that negative filter isn't realistic for you now. Your friends do seem to care."

*James:* "I guess I could give them the benefit of the doubt more often."

*Counselor:* "What would that change, do you think?"

*James:* (with a slight smile) "Well, I might answer the phone more often when they called."

*Counselor:* "And then you might end up not being on your own so much. I wonder if that might make life seem a little less hopeless."

*James:* "And make it a little easier to get out of bed in the morning."

Meta-analyses have indicated the effectiveness of cognitive therapy as compared to pharmacotherapy or wait-list (no treatment) control conditions for depressive disorders (Dobson, 1989; Elkin et al., 1989; Gloaguen, Cottraux, Chucherat, & Blackburn, 1998; Miller & Berman, 1983; Pace & Dixon, 1993; Robinson, Berman, & Neimeyer, 1990). Cognitive therapy has been shown to prevent recurrent episodes of depression more effectively than antidepressant medication alone (Vittengl, Clark, Dunn, & Jarrett, 2007). While there were no differences in effectiveness for CBT compared to other counseling treatments, or compared to medication alone, recent studies did find that combined CBT and pharmacotherapy was significantly more effective than medication alone (Cuijpers et al., 2013; Cuijpers, Dekker,

Hollon, & Andersson, 2009). There were also long term effects of CBT for depression, with lower relapse rates at one-year and two-year follow-ups compared to individuals who received medication alone (Vittengl, Clark, Dunn, & Jarrett, 2007; Dobson et al., 2008).

## Interpersonal Therapy

Interpersonal Therapy (IPT) is also an empirically supported treatment for depression. IPT focuses on the relationship between the client and counselor, reworking past problematic relationships and crafting a more positive healthy identity. Problematic relationships contribute to depression; as relationships improve with IPT, depression symptoms lessen.

## Family Systems

Family systems counseling explores the ways that family history and family relationships sustain the client's depression, and aims to discover ways in which family members can support client progress. Family systems approaches to treating depression focus on families as interconnected and interdependent networks; therefore, in order to help the individual, it is necessary to work with the family system.

Developed by Murray Bowen, Family Systems holds that individuals cannot be understood or treated in isolation, since in a family system each member must adapt to the others (Bowen, 1978). For example, if one family member struggles with alcoholism, the rest of the system adapts. One person may cope with denial, another may act out, and a third may become depressed or avoid the problem by withdrawing or leaving the family. Treatment explores roles within the family, as well as the rules adopted for interaction and the boundaries set between members. When these are problematic, each individual in the family is adversely impacted. Family therapy breaks down the system's inherent resistance to change and helps family members develop healthier roles, rules, and boundaries.

The counselor working with James from a family systems perspective would focus on James' past and current relationship with his parents and family to examine what impact the family system has on his depression.

*Counselor:* "Can you tell me more about your family? Is there a history of depression in your family?"

*James:* "I guess maybe there is. My dad was always sort of up and down. Maybe more down than up. And my mom, she was definitely depressed after my dad left. Hardly came out of her room at all for a long time, years maybe."

*Counselor:* "It must have felt like losing both your parents then . . ."

*James:* (tearful) "It did, it really did."

*Counselor:* "You said your parents divorced when you were a child—how old were you?"

*James:* "I was ten. I still remember the yelling and screaming; and then my dad left."

*Counselor:* "That must have been devastating for a 10-year-old."

*James:* "It was. My dad promised to stay in touch, said we'd have all kinds of adventures on the weekends—fishing and going to the races and stuff. But, he pretty much disappeared after they got divorced."

*Counselor:* "You never saw him much after he left?"

*James:* "Every now and then. Sometimes he'd make plans and then never show up. I think he just felt obligated to see me sometimes, but he didn't want to—he wanted to move on, start a new life; and he did."

*Counselor:* "That's a really difficult loss for a child, and hard to understand."

*James:* "Well, I had to pull myself together. My mom needed me."

*Counselor:* "She needed you?"

*James:* "She fell apart. I had to be the man of the house, you know? She always said,

*men are supposed to be there, to take care of women. I tried to take care of my little brother—and to take care of her, too. But, she never did get better; started drinking. I guess I failed at that too.”*

*Counselor: “You were just a kid. Do you think your mother blames you for her drinking?”*

*James: “I think she blames me for everything. Maybe she’s right, maybe I was such a rotten kid that my father had to go. No wonder he didn’t come back.”*

The counselor working with James from a family systems perspective will want to explore further James’ experience of his parents’ divorce and his troubled relationship with both of them today, and how these experiences are contributing to his depression.

## Brief Treatments

Brief counseling approaches, including brief versions of CBT and Problem Solving Therapy have also been effective in remediating depression, although a recent meta-analysis found larger effect sizes for treatment of longer duration (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010).

## Other Counseling Approaches

As discussed previously, counselors incorporate many different theories of counseling into their work with clients. While CBT and IPT are empirically supported treatments, counselors also use other theoretical approaches to help clients experiencing depression. Person centered counseling also helps clients understand their issues and relationships through the therapeutic relationship. Reality therapy helps clients identify which problems are in their control and which are not, and then set realistic goals for the future and change. Psychoanalytic approaches examine the ways that the client’s past is impacting their present symptoms and helps clients develop insight into these influences, with the goal of moving forward.

Some of the newer DSM-5 diagnoses do not yet have empirically supported treatments identified. For example, in the case of DMDD there is no identified empirically supported treatment recommendation as yet, but CBT is suggested along with parent training and parent support workshops. Suggested treatments for PMDD also include dietary changes (increased carbohydrates in the week before), as well as CBT and medications.

Most counseling approaches also help the client identify and strengthen support networks, promote physical health, and improve coping skills. These changes are effective in remediating the current episode of depression, as well as preventing future episodes (Daley, 2008).

## Medications

Several classes of medication have also been found to be effective in treating mood disorders, either alone or (ideally) in combination with counseling. An NIMH funded study of adolescents found that a combination of medication and psychotherapy was most effective in remediating depression (March et al., 2004).

Pharmacologic treatment of depression impacts certain chemicals in the brain. When brain chemicals are out of balance, depression may result. Some of the earliest medications used to treat depression were the monoamine oxidase inhibitors (MAOIs), which are particularly effective with some of the less common symptoms of depression, such as a greater need for sleep or food, sometimes known as “atypical depression.” MAOIs can also help with co-occurring anxiety. However, a life threatening interaction with food and drink containing tyramine and medications, such as birth control pills, aspirin, herbal supplements, and cold and allergy medications can occur with MAOIs, which necessitates close monitoring.

Tricyclics (including Imipramine and Nortriptyline) are also an older treatment for depression. These medications were effective, but had serious side effects in some clients, including heart problems, dizziness, dry mouth, and weight gain, and overdoses of Tricyclics can be life threatening.

More recently, selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) have shown effectiveness in treating depression. These medications (including the brand names Prozac, Zoloft, Lexapro, Paxil, Celexa, and Effexor) regulate the amount of specific neurotransmitters available in the brain, such as serotonin, dopamine, and norepinephrine with fewer side effects than earlier generations of medication. Bupropion (brand name Wellbutrin) is a newer medication which impacts the neurotransmitter dopamine, also with fewer side effects. Nevertheless, most medications for depression do have some side effects, including headaches, stomach upset, sleep problems, agitation, and sexual difficulties. The tricyclics can cause dry mouth, constipation, blurred vision, and problems emptying the bladder. SSRIs interact with MAOIs to cause problems with blood pressure, heart function, and seizures, so these two medications should not be taken simultaneously. See Figure 4.1 for a list of common medications used for depression as well as common side effects.

In addition, the herbal remedy St. John's wort is also used for mild to moderate depression, both in the United States and Europe. However, some studies found that St. John's wort is not effective for treatment of major depression (Hypericum Depression Trial Study Group, 2002) and can lessen the effectiveness of birth control pills and certain heart and seizure medications.

While it is not commonly used today, electroconvulsive therapy (ECT) is also used for severe depression which does not respond to medication or counseling. Clients who receive ECT are under mild anesthesia and the treatment is brief. However, side effects can include memory loss, confusion, and disorientation, most of which are short-term (Lisanby, 2007).

When clients are prescribed medication, counselors work closely with the prescribing practitioner to monitor side effects and to help clients cope with their uncertainties about taking medication. Counselors can emphasize to clients the need to take an antidepressant for 4 to

6 weeks before the full effect will be experienced, preventing clients from feeling hopeless or giving up on treatment too quickly. In addition, counselors are instrumental in helping clients continue their medication regimen even after they start to feel better, making relapse less likely. Discontinuing an antidepressant suddenly can result in withdrawal symptoms or worsening depression or anxiety. Counselors also support clients as they work with a physician to find the medication that's best for them; some clients have to try several medications before this is accomplished, which can be a frustrating and frightening experience.

While research shows that the benefits of medication for depression outweigh the risks, nevertheless counselors should be aware that there is an increased risk of suicidal ideation or suicide attempts in some children and adolescents who are prescribed antidepressants (Bridge et al., 2007). In the United States, the Food and Drug Administration includes a "black box" warning on antidepressants for children and young adults up to age 24. The risk is greatest when clients begin a medication, so counselors should monitor clients during this time and work closely with the prescribing physician.

Now that we've examined the research and diagnostic categories for depressive disorders, let's return to the case of James and follow along as the counselor develops a case conceptualization.

### CASE CONCEPTUALIZATION FOR DEPRESSION USING THE T/C MODEL

Like most disorders, depression has biological, psychological, and environmental risk factors which contribute to the etiology of the disorder. It is important to pay attention to all these domains when developing a case conceptualization.

In the physiological/biological domain, the client's description of any issues with eating, sleeping, or level of activity are relevant. Both lack of appetite or wanting to eat all the time can be associated with depression; similarly, feeling

**Figure 4.1** Antidepressant Medications and Side Effects

<i>Antidepressants</i>	<i>Brand Medications</i>	<i>Common Side Effects</i>
<b>SSRIs</b> —work by increasing the amount of serotonin, a neurotransmitter found in the brain	Prozac®, Zoloft®, Lexapro®, Paxil®, Celexa®, Luvox®, Sarafem®	Dizziness, headaches, nausea right after ingestion, insomnia, jitteriness, sexual problems, including low sex drive or inability to have an orgasm are common, but reversible
<b>Tricyclics</b> —work by increasing the available amount of serotonin and/or norepinephrine in the brain	Tofranil®, Anafranil®, Adapin®, Aventyl®, Elavil®, Endep®, Pamelor®, Sinequan®, Zonalon®	Dry mouth, blurred vision, increased fatigue, weight gain, muscle twitching, constipation, bladder problems, dizziness, increased heart rate, sexual problems
<b>MAOIs</b> —increase the amount of norepinephrine and serotonin in the brain	Emsam®, Eldepryl®, Nardil®, Marplan®, Parnate®, Zelapar®	Must avoid certain foods and medications to avoid dangerous interactions. Side effects may include headaches, heart racing, chest pain, neck stiffness, nausea and vomiting
<b>Bupropion</b> —may increase the amounts of the neurotransmitters norepinephrine and dopamine in the brain	Aplenzin®, Budeprion®, Buproban®, Forfivo®, Wellbutrin®	Weight loss, decreased appetite, restlessness, insomnia, anxiety, constipation, dry mouth, diarrhea, dizziness, seizures
<b>SNRIs</b> —increase the levels of the neurotransmitters serotonin and norepinephrine in the brain	Cymbalta®, Effexor®, Fetzima®, Khedezla®, Pristiq®	Drowsiness, blurred vision, lightheadedness, strange dreams, constipation, fever/chills, headaches, increased or decreased appetite, tremors, dry mouth, nausea

too tired and discouraged to get out of bed, or having difficulty falling asleep or staying asleep may be indicators of depression. Other behaviors which may be of concern are social isolation and difficulty concentrating. Clients may describe their lives as without pleasure, and may be unable to enjoy much of anything. In addition, keep in mind that depression can manifest in somatic symptoms, such as chronic pain, headaches, or stomach pain.

There are also psychological and cognitive factors that play a role in developing or sustaining depression. What is the client's explanatory

style? How do they view the world and others (safe and trustworthy, or dangerous and unpredictable)? Do they tend to see themselves and others through a negative filter, increasing vulnerability to depression? Because the explanatory styles of clients with depression tend to be unrealistically negative, it is essential to thoroughly assess the client's existing strengths and abilities so that their automatic thoughts can be challenged. In addition, having an understanding of the resources and supports the client has in place or can cultivate will help the client recover from depression and maintain that recovery.

Excessive guilt and low self-esteem also put a client at risk for depression. These may have been learned in childhood and never questioned. Clients with depression may be hopeless, or think about suicide to end the pain they're experiencing. Asking about suicidal thoughts and intent is a critical part of the case conceptualization process when working with a client who is depressed.

Environmental factors to assess include experiences of loss, both recently or in the past, current stressors, and relationship conflict. In addition, consider whether the client's episodes of depression occur at a particular time of year, or whether depression for female clients is tied to the menstrual cycle or childbirth.

Let's see how a case conceptualization using the T/C Model is developed for the client we met at the beginning of this chapter: James.

## THE CASE OF JAMES

### Example of T/C Case Conceptualization Model Outline

(\* Areas that require more information)

**Presenting Problem:** Depression, isolation, problems with eating, sleeping, and concentration

#### Internal Personality Constructs and Behavior:

*Self-efficacy:* feels hopeless, doubts efficacy in relationships and at work

*Self-esteem:* low, feels paralyzed by depression and hopelessness

*Attitudes/Values/Beliefs:* sense of responsibility, belief that men are supposed to take care of women

*Attachment Style:*

*Biology/Physiology/Hereditry:* male, 30, headaches, medical history\*, family history of depression\*, mother's history of alcohol use\*, temperament (negative affect)

*Affect:* depressed, hopeless

*Cognition:* belief that people only spend time with him because they're obligated; belief that he is responsible for parents' divorce

*Hot Thoughts:* "My friends don't really want to hang out with me anyway, they just feel obligated. Everyone would be better off if I wasn't even alive."

*Behavior:* isolating, missing work, visibly distraught in session, can't even answer the phone

*Symptomology:* headaches, fatigue, difficulty sleeping, trouble concentrating, appetite changes

*Coping Skills and Strengths*

*Readiness for Change:* contemplation stage—ambivalent about change, but willing to consider, hopeless

*Life Roles:* career\*, family\*

#### Environment:

*Relationships:* conflicted relationship with both parents\*, past negative experiences with friends, was bullied\*, difficult to trust

*Culture:* family background\*

*Family Norms and Values:* Belief that men are supposed to take care of women

*Societal Influences:*

#### Timeline:

*Past Influences:* bullied, parents' divorce, father's abandonment, mother's drinking

*Present Influences:* work stress, depressed mood, difficulty sleeping, eating, and concentrating, conflicted relationship with mother,\* relationship with father\*

*Future Goals:* closer friendships, able to go to work, increased confidence at work

**Question:** What else would you want to ask, to complete this case conceptualization?

## COUNSELING KEYSTONES

- Depressive disorders are characterized by a sad, empty, or irritable mood, as well as cognitive and physiological changes.



- Depression can cause physical suffering, such as headaches, stomach upset, or chronic pain, as well as emotional pain, and some depressed individuals may consider or attempt suicide.
- Disruptive mood dysregulation disorder was added in DSM-5 as a disorder which must be diagnosed in childhood. The core feature is chronic severe persistent irritability, marked by temper outbursts (usually in response to frustration).
- Premenstrual dysphoric disorder was also added in DSM-5, and is characterized by significant affective symptoms (mood swings, irritability, depression, anxiety) in the week prior to the menstrual cycle, which quickly disappear after the cycle.
- Major depressive disorder is defined in DSM-5 by a depressed mood or a loss of interest or pleasure, with four other symptoms, including sleep difficulties, fatigue, difficulty concentrating, and thoughts of suicide.
- Persistent depressive disorder is a chronic depressive spectrum disorder (with symptoms lasting two years) which replaces the dysthymia category in DSM IV, and expands the symptom constellation to include the older diagnoses of both dysthymia and chronic major depression.
- Anxiety disorders are the most common co-occurring problems, including posttraumatic stress disorder (PTSD), panic disorder, social phobia, generalized anxiety disorder, and obsessive-compulsive disorder (OCD).
- Depression is not caused by a single precipitating factor. Rather, depression is multiply determined with various genetic, biological, chemical, social, psychological, and environmental factors impacting the development of the disorder.
- Certain mood disorders tend to run in families, suggesting a genetic component.
- Many research studies have demonstrated that counseling approaches (including cognitive behavioral and interpersonal therapies) are effective for treating depression and relieving symptoms experienced by individuals who suffer from depression.
- Several classes of medication have also been found to be effective in treating mood disorders, either alone or (ideally) in combination with counseling. An NIMH funded study of adolescents found that a combination of medication and psychotherapy was most effective in remediating depression.

## EXERCISES

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### EXERCISE 4.1 What Words Do People Use to Describe Depression?

**CLASS EXERCISE:** Small group work followed by large group discussion.

**Question 1:** What are some typical words or phrases that clients might use to describe their depression?

**Question 2:** Are there certain words or phrases that seem to point to more severity? Which ones?

**Question 3:** What follow-up questions can counselors ask to get at the underlying thoughts that are associated with these descriptions?

### EXERCISE 4.2 How Do You Classify Your Experience of Sadness?

**CLASS EXERCISE:** Individual work followed by large group discussion.

**Question 1:** How would you describe your experience when you are having a bad day?

**Question 2:** Categorize your symptoms using the T/C Model, with specific focus on environment, cognition, and behaviors.

**Question 3:** What do you typically do to “feel better”?

### EXERCISE 4.3 Dig Deeper Using the Case of Genevieve Described at the Start of This Chapter

**CLASS EXERCISE:** Small group discussion followed by large group discussion.

**Question 1:** What questions would you ask next following this dialogue?

**Question 2:** What else would you want to know?

**Question 3:** How would you help Genevieve gain a better understanding of her depression?

### **EXERCISE 4.4 Case Conceptualization Practice Using the Case of Tom Described Earlier**

**CLASS EXERCISE:** Small group discussion followed by large group discussion.

**Question 1:** What is your case conceptualization of this case so far?

**Question 2:** What else would you want to know?

**Question 3:** What would be three possible goals for Tom in counseling?

### **Go FURTHER**

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*Depression: Causes and Treatment* by Aaron T. Beck and Brad A. Alford (2009) University of Pennsylvania Press

*Mind Over Mood: Change How You Feel by Changing the Way You Think* by Dennis Greenberger and Christine Padesky (1995) Guilford Press

*Mindfulness-Based Cognitive Therapy for Depression* by Zindel V. Segal, J. Mark G. Williams, John D. Teasdale, and Jon Kabat-Zinn (2012) The Guilford Press

*Treatment Plans and Interventions for Depression and Anxiety Disorders* by Robert L. Leahy, Stephen J. F. Holland, and Lata K. McGinn (2011) The Guilford Press

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