Lynn P. Rehm
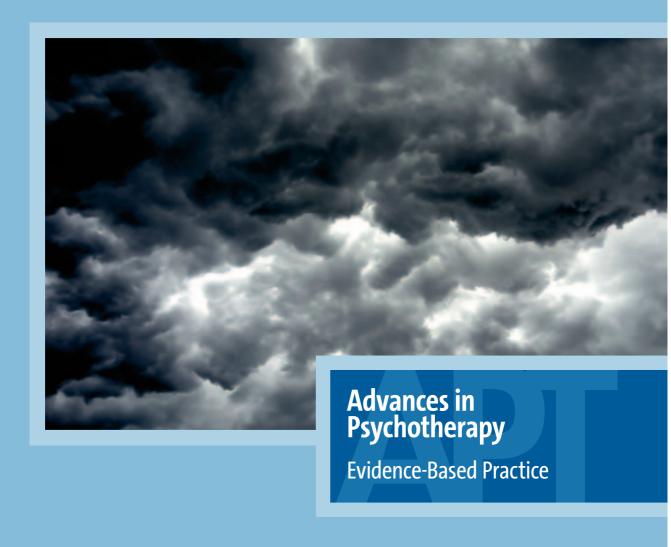
Depression

Advances in Psychotherapy
Evidence-Based Practice

HOGREFE

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.

Advances in Psychotherapy – Evidence-Based Practice

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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

Lynn P. Rehm
Santa Rosa, CA;
Professor Emeritus, Department of Psychology, University of Houston, TX

HOGREFE

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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

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

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

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.

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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.

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 Disorde**r. 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).

Diagnoses depend on the history of episodes

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) With Postpartum Onset. If the full criteria are not met by the current episode, it can be specified as In Partial Remission or In Full Remission along with any of 2 through 6 above.

The severity rating of episodes is a recognition that depression is dimensional within the categorical system of the *DSM*. Instruments for measuring severity will be covered later in this chapter. Although the *DSM* lists sets of criteria for deciding whether a person should receive a particular diagnosis or fit into a category, these criteria are polythetic in that not all criteria must be met by any individual and different individuals may meet the criteria with

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Table 2
Episode Specifiers

Severity Specifiers
    Mild
    Moderate
    Severe With Psychotic Features
    Severe Without Psychotic Features

Episode Specifiers
    Chronic
    With Catatonic Features
    With Melancholic Features
    With Postpartum Onset

Remission Specifiers
    In Partial Remission
    In Full Remission

different patterns of criterion symptoms. The system has also been referred to as prototypic (Cantor, Smith, French, & Mezzich, 1980), in that the full set of criteria define the prototype, i.e., the complete and full form of the disorder. A particular individual who has a minimal subset of these criteria is considered a sufficient match to the prototype. Natural language is prototypic. When we use the word "chair," the mental prototype has a seat, four legs, and a back, but we recognize many other objects as a sufficient match to call them a chair, such as a chair with fewer legs, or even a "bean bag chair." The boundaries are fuzzy. How wide does a chair have to be to become a couch? Psychiatric diagnoses are similarly fuzzy with marginal cases, overlaps, and indefinite boundaries.

Severe depression can have **Psychotic Features**, including delusions, hallucinations, and other positive and negative signs usually associated with **Schizophrenia**. Delusions during episodes of depression are most often "mood congruent," i.e., they are characterized by themes of guilt, punishment, disease, or decay with negative meaning for the patient. They may be bizarre or nonbizarre. Bizarre delusions are concerned with ideas that are not possible, e.g., the person is rotting away inside. Nonbizarre delusions can also occur, e.g., a woman may believe she is being poisoned because of her sinful behavior. Manic Episodes may also have psychotic features. Delusions are typically mood congruent and may be bizarre, e.g., a man may believe he has magical powers, or nonbizarre, e.g., a woman may be convinced she has wonderful ideas for a new TV show and must find a way to share her idea with a famous TV personality. The **Chronic** episode specifier is used when a depressive episode lasts for a minimum of 2 years with the criteria continuously met.

Catatonic Features are similar to the characteristics seen in **Schizophrenia, Catatonic Type**. Most frequently this condition is characterized by motoric immobility or stupor, extreme negativism and resistance to instructions, mutism, inappropriate posturing, and echolalia (repeating meaningless phrases or echoing back what others say) or echopraxia (mimicking others' gestures). Individuals in such a state may stay in uncomfortable positions that can be altered by others in what is known as "waxy flexibility," i.e., flexible like a wax statue. Alternatively, the person may show excessive agitated motor activity that is purposeless and not influenced by external stimuli (American Psychiatric Association, 2000).

Historically, a distinction was made between reactive or exogenous depressions and endogenous depressions. The basic idea behind this distinction is that some depressions occur as a response or reaction to loss or other environmental stress, whereas other depressions occur without a precipitating event and are thought to have an internal, endogenous origin. The former were assumed to be treatable by psychotherapy, whereas the latter, being of biological origin, were better treated by medication. However, this distinction was difficult to apply with any reliability. As clinicians learn more about individual patients over time, they are more likely to identify precipitating events to which the patients were reacting. Thus, low reliability has led to a decline in the use of the distinction. **With Melancholic Features** follows in this tradition, but without reference to etiology. Persons with these characteristics are still typically assumed to have a more biological form of depression, that is better treated with medication. The primary characteristic of melancholic depression is a

loss of pleasure in all or almost all activities, or a lack of reactivity to usually pleasurable stimuli. This characteristic is also referred to as *anhedonia*—the lack of the ability to experience pleasure. In addition, melancholic depression has three or more of the following characteristics: (1) a distinct quality of depressed mood (experienced as something different from ordinary sadness or grief); (2) depression that is regularly worse in the morning; (3) early morning awakening (a form of insomnia defined as waking at least 2 hours before one's usual time of waking); (4) marked psychomotor retardation or agitation; (5) significant anorexia or weight loss (without attempting to diet); and (6) excessive or inappropriate guilt (American Psychiatric Association, 2000). We will come back to Melancholic depression and the implications of the concept for treatment in a later chapter.

Typical depression involves loss of appetite and weight and difficulty sleeping. **With Atypical Features** implies increase in appetite, weight gain, and excessive sleeping. Technically, the criteria include first, mood reactivity (in contrast to the anhedonia of Melancholic depression), and second, two or more of the following: (1) significant weight gain or increase in appetite; (2) hypersomnia; (3) leaden paralysis (heavy, leaden feeling in arms or legs); and (4) a long-standing pattern of interpersonal rejection sensitivity that results in significant social or occupational impairment (American Psychiatric Association, 2000).

> Atypical depressions involve increase in appetite, weight, and sleep

With Postpartum Onset is diagnosed when the onset of the episode is within 4 weeks of giving birth. Postpartum depression was once generally thought to be a separate form of biologically caused depression. Today the etiology is seen as more complex, and postpartum depression is classified as a specific form of the disorder within the mood diagnoses.

> Postpartum depressions are now seen as a subset of Major Depressive Disorder

In addition to the episode specifiers above, the *DSM* lists three course specifiers: (1) **With/Without Interepisode Recovery**, i.e., whether full remission is obtained between episodes; (2) **Seasonal Pattern,** a regular association between the onset of episodes and time of the year; and (3) **Rapid Cycling**, whether the person with a Bipolar I or II diagnosis has four or more distinct mood episodes in a year, separated by full remission.

> Course Specifiers: With/Without Interepisode Recovery Seasonal Pattern Rapid Cycling

Seasonal Pattern may be seen in MDD, Bipolar I, or Bipolar II disorders. Typically it involves the regular onset of episodes of depression in the fall and remission or switch to mania in the spring. More rarely, manic episodes may have a spring onset and Fall Remission.

In addition to these major mood disorders, the *DSM* also identifies **Dysthymia** under the depressive disorders and **Cyclothymia** under the bipolar disorders. These are lesser, but more chronic versions of depression and bipolar disorder. Dysthymia requires a duration of two years during which the person has depressed mood "most of the day, more days than not" (APA, p. 380), but only two of a list of six symptoms. Cyclothymia also requires a duration of 2 years, during which the person must have had numerous periods of hypomanic and depressed symptoms that never meet criteria for either episode. Dysthymia has specifiers of **Early Onset** (before age 21) or **Late Onset** (after age 21), and **With Atypical Features** (defined the same as with Major Depression). Early Onset Dysthymia may be continuous from childhood, and thus bears some resemblance to a personality disorder. Psychological approaches to treatment reflect this similarity and will be addressed in a later chapter.

> Dysthymia and Clyclothymia are chronic milder versions of unipolar and bipolar disorders

The *DSM* also has an appendix entitled "Criteria sets and axes provided for further study." As implied, these categories have been suggested by various authorities, but have not been formally adopted by the *DSM* committees pending further research using the proposed criteria to establish their validity. These include **Depressive Personality Disorder** heavily based on psychological symptoms such as gloom, negative self-esteem, and pessimism, in contrast to the more biologically based symptoms sets of Dysthymia and Major Depressive Disorder. **Minor Depressive Disorder**, on the other hand, uses the same nine-symptom set, but requires a minimum of only two (but less than five) symptoms (i.e., less than Major Depressive Disorder). **Recurrent Brief Depressive Disorder** requires that criteria for a Major Depressive Episode are met, except for the 2 week duration criterion. The person must have at least one of these episodes per month for a year. **Mixed Anxiety-Depressive Disorder**, as the name implies, involves a symptom list that includes both anxiety and depression symptoms without meeting criteria for either type of specific diagnosis.

The *DSM* is based on a categorical view of psychiatric disorders. Thus, issues of severity are dealt with in part with severity specifiers, but also by creating separate categories for fewer symptoms or for shorter duration than are required for the primary diagnoses. For example, Dysthymia and Minor Depressive Disorder have fewer symptoms and Recurrent Brief Depressive Disorder is defined by brief duration. A more psychological perspective might see depression as dimensional in terms of severity and perhaps duration as well. The *DSM* categorical view leads to such oddities as the concept of "double depression," a term used to describe a person who has first met criterion for Dysthymia and then qualifies for a Major Depressive Disorder. Under the *DSM* categorical system, the person can be given both diagnoses, thus "double depression." Another oddity occurs when symptoms of two disorders overlap and the overlap is given a separate category name, as in Mixed Anxiety-Depressive Disorder. Another example in the *DSM* is **Schizoaffective Disorder**, which is diagnosed when a Major Depressive Episode occurs while symptoms of Schizophrenia are met.

Depression overlaps with anxiety and schizophrenic diagnoses

The World Health Organization publishes the *International Statistical Classification of Diseases*, now in its tenth revision, commonly referred to as the *ICD-10* (World Health Organization, 1992). Its purpose is to support the classification and tabulation of morbidity and mortality data from around the world. In the United States, the National Center for Health Statistics produces a "Clinical Modification," known as the *ICD-10-CM*, for the purpose of classifying and tabulating incidence and prevalence of diseases and disorders in the US. Effort is made to coordinate the *ICD-10-CM* system with US diagnostic codes, such as those in the *DSM*. With regard to the mood disorders, slightly different terms are applied and diagnoses are grouped somewhat differently, but for the most part diagnoses are similar. The major categories in the *ICD-10-CM* are identified in Table 3. Within the first four categories are subtypes based largely on severity. **Persistent Mood Disorders** include Dysthymia and Cyclothymia. The *ICD-10* system is an important alternative system to the *DSM* and is used in many places in the world instead of the *DSM*.

The ICD-10 is a diagnostic system published by the World Health Organization

ICD diagnoses are somewhat different than DSM diagnoses

At the time of this writing, the revision processes are underway for both the *DSM-V*, due in 2014, and the ICD-11, due in 2012. A number of changes

Table 3
Major Categories of Disorders in the *ICD-10-CM*

Manic Episode

Bipolar Affective Disorder

Depressive Episode

Recurrent Depressive Disorder

Persistent Mood (affective) Disorders (Dysthymia and Cyclothymia)

Other Mood (affective) Disorders

are expected. An initial goal of basing the *DSM* more heavily on biological markers was determined to be premature (Frances, 2009). The *DSM* groups are planning on adding dimensional components to diagnoses, paying more attention to developmental and cultural issues, and coordinating diagnoses with the ICD system. The ICD is expected to pay greater attention to daily functioning and quality of life (Kupfer, Regier, & Kuhl, 2008).

Both the DSM and ICD are being revised

The various diagnoses described above are relevant to assessment and treatment of depression. However, depression as emotion per se is also relevant to understanding the phenomena of depression. There is a long research tradition of studying the relationships among the emotional connotations of words. The classic work was done by Charles Osgood (1962) using the technique of the semantic differential in which affective words are rated on a series of bipolar dimensions. Osgood established that connotation could be accounted for by the three primary dimensions of evaluation (good–bad), potency (strong–weak), and activity (active–passive).

Since Osgood's work, a number of different models have been developed to account for the basic dimensions of emotion. Prominent among these is Russell's (1980) two-dimensional circumplex model that arranges emotions around a circle like colors in a color wheel. The horizontal and vertical axes of Russell's model are pleasure–displeasure (happy–sad) and arousal (tense–relaxed). Depression is located at the extreme end of the horizontal displeasure dimension and at a virtual neutral point on the arousal dimension.

Basic conceptions of emotion inform our understanding of depression

A similar circumplex was described by Watson and Tellegen (1985). The Watson and Tellegen model can be construed as a 45-degree rotation of Russell's model, but it adds the intriguing element of suggesting that the primary horizontal and vertical axes of the circumplex are positive and negative affect as separate and independent dimensions rather that opposite poles of a single dimension. In this model, depression is represented by high negative affect and a relative absence of positive affect. On the basis of this model, the authors (Watson, Clark, & Tellegen, 1988) developed an instrument for assessing positive and negative affect, the Positive Affect Negative Affect Scale (PANAS), which will be reviewed later in the chapter. Clark and Watson (1991) presented a model of anxiety and depression that added a third dimension. In this case, the dimensions are identified as general distress (negative affect), anhedonia (lack of positive affect), and physiological hyperarousal, which is akin to Osgood's potency. These models help define the emotion of depression and are relevant to understanding the mechanisms by which psychotherapy of depression works.

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

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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*

Disorder are approximately equal for men and women. The gender ratios for depression are not limited to the United States. In reviews of the available data, Myrna Weissman and colleagues (Weissman et al., 1996; Weissman & Klerman, 1977) cite data from studies outside the US that document that 1.5 to 2.0 times as many women as men become depressed. Boys and girls score about equally on depression inventories. It is not until adolescence that the scores and rates of depression diverge (Twenge & Nolen-Hoeksema, 2002).

A number of different explanations have been offered for the higher rates of depression in women, including endocrine and hormone hypotheses. Cyranowski and colleagues (Cyranowski, Frank, Young, & Shear, 2000) suggest that pubertal hormones increase affiliative needs in adolescent girls, thereby intensifying socialization stress. Family studies suggest that depression has a heritable component. Several studies, however, have found that depression in women and substance abuse in men (especially alcoholism), run in the same families (Winokur & Clayton, 1967). This suggests a similar underlying genetic component, but men may be discouraged from expressing depression and may medicate their depression with alcohol. Hammen and Peters (1977) demonstrated that both male and female raters were less positive toward a fictitious "fellow student" who had symptoms of depression when that person was given a male name. They concluded that men meet with negative reactions when they display depression and thus learn alternative ways to deal with their negative feelings. Depression is not only more acceptable in women, it may be that women are encouraged by meeting others expectations of depression. One study of family perceptions among adult family members found that women are more likely to be reported as depressed by a member of the family, even when they themselves do not report depression (Brommelhoff, Conway, Merikangas, & Levy, 2004). Family members were also more likely to attribute the depression of women to internal causes, whereas they attributed external causes equally between men and women. This gender bias may lead to women being more susceptible to depression because they are confirming others' impressions of them and others may reinforce these confirmations.

Radloff (1975) reviewed demographic correlates of depression and reported that, among men, *married and divorced men are the least depressed and widowed men are the most depressed*. Among women, *married and divorced women exhibit a higher incidence of depression with never-married the least depressed*. Women are more depressed than men if working, whereas men are more depressed if unemployed. Being young, poor, and having limited education are all correlates of depression, but when controlled for, they do not account for the differences in rates of depression between men and women. When marital and job satisfaction are controlled for, working wives are less depressed than wives who are not working, though still more depressed than working husbands. Radloff interprets these data in terms of a job outside of the home being an outlet for self expression for women. She concludes by drawing on a learned helplessness model of depression, suggesting that women have more constraints on their lives and are more prone to feeling helpless to control outcomes. Greater vulnerability due to a more helpless explanatory style in female children has also been suggested by Nolen-Hoeksema, Girgus, and Seligman (1991).

Sociotropic persons are more susceptible to interpersonal losses, and autonomous persons are more susceptible to achievement-related losses

Aaron Beck (1983) introduced the concept of **sociotropy–autonomy** to explain individual differences in the ways people are vulnerable to depression. A sociotropic individual is focused on interpersonal relationships and bases his or her self-esteem on the good opinion of others. The autonomous person is focused on achievement and goal attainment and finds self-worth in success in these endeavors. Sociotropes are susceptible to depression when interpersonal relationships are disrupted or lost. Autonomous individuals are more susceptible to depression when they encounter a failure or other blows to their achievement goals. Although the concepts are often discussed as if these are two opposite types of people, the scale developed to measure sociotropy–autonomy views them as separate dimensions, such that a person could be high or low on both (Bieling, Beck, & Brown, 2000). Relevant to the difference in depression between men and women is the common finding that women more frequently score high on sociotropy whereas men more frequently score high on autonomy. Women may be more vulnerable than men because of the higher likelihood of interpersonal stresses in our society.

On a similar note, Sidney Blatt and his colleagues (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982) drew on a psychodynamic tradition and proposed a distinction between dependent and self-critical experiences of depression. The dependent dimension of depression, once called *anaclitic depression*, is characterized by feelings of helplessness, weakness, and fears of abandonment. Self-critical depression, earlier termed *introjective*, is characterized by feelings of competition, worthlessness, guilt, and constant self-evaluation. Blatt later added a third dimension of efficacy characterized by goal-oriented striving and valuing of accomplishment. Dependent tendencies are similar to sociotropy, whereas Blatt's latter two dimensions are similar to autonomy. This group (Zuroff, Quinlan, & Blatt, 1990) has developed a Depressive Experiences Questionnaire to measure the three dimensions. As with other measures of depression, women tend to score higher on dependency and thus may be more vulnerable to depression based on stresses related to dependent relationships.

Women are more likely to respond to loss with a ruminative coping style

Another answer to the question of why women might have a greater risk for depression is offered by Susan Nolen-Hoeksema (Nolen-Hoeksema, 1987; Nolen-Hoeksema, Larson, & Grayson, 1999) in terms of different coping styles between men and women. In response to an event that brings on sad feelings, women are more likely to respond passively and to ruminate about the event and its causes and implications. They are more likely to discuss their sadness with others and try to find the reasons behind their mood. Men are more likely to respond actively by thinking about something else or distracting themselves with some other activity. While a ruminative coping style is a continuous dimension, such that both women and men may ruminate and both may distract to varying degrees, women score higher on rumination and men score higher on distraction. *Rumination prolongs and amplifies the negative feelings whereas distraction cuts them short*. Rumination also allows time to associate events and reactions to similar events in the past and to develop pessimistic, depressive explanations for personal events. Rumination is seen as interacting with other chronic strains and a low sense of mastery to produce depression.

There is clearly some overlap among these explanations. The sociotropic person may be more dependent on others, fear abandonment, feel helpless, and