Depression; Diagnosis, Treatment, and Treatment Outcome

By Dr. Ken Morris

DEPRESSION; DIAGNOSIS, TREATMENT, AND TREATMENT OUTCOME

Prevalence of Disorder

Depression has been called America's number one health problem (Minirth & Meier, 1985), and is so common that a majority of Americans will suffer from its effects some time during their life (Department of Psychiatry, University of Pennsylvania, 1977). The DSM-IV (American Psychiatric Association, 1994) relates that Major Depression as a disorder is episodic by nature and that its prevalence occurs in up to one out of four women and one out of ten males (Shannon and Backus, 1973). The less severe diagnosis of dysthymia, is considered to be even more common (American Psychiatric Association, 1994). Depression is considered to be the leading cause of suicide, with fifteen percent of those found to be depressed being successful (Reese, 1970) and a 45% success rate among higher socio-economic groups (Shannon and Backus, 1973). As well, depression is most prevalent during the fourth and fifth decades of life (Shannon and Backus, 1973). Susceptibility to depression is usually event caused, but symptoms may continue long after the event (Arieti, 1982; Eaton and Peterson, 1969; Kolb, 1973). A study that reviewed several longitudinal studies of depression indicated that people born in subsequent decades beginning in 1905 and going through the year 1964 have had to endure increasing risk of depression (Weissman, Leckman, Merikangas, Gammon, & Prusoff, 1984). Because of this, the questions surrounding the diagnosis, causal structure, and cure of depression, are becoming increasingly important within our society.

Diagnosis of Depression

The symptomology of depression will vary in severity and in its overt expression between individuals. The DSM-IV (American Psychiatric Association, 1994) represents its

primary symptoms as either a depressed mood or a loss of interest or pleasure (American Psychiatric Association, 1994). Other authors have described depression as being a sad affect, painful thinking, various resulting physical symptoms, anxiety, and in a small percentage of people, delusional thinking (Minirth and Meirer, 1985; Sarason and Sarason, 1989; Shannon & Backus, 1973).

Determination as to what the extent or degree of a sad affect delineates between the "blues" and actual clinical depression is quite subjective (Sarason and Sarason, 1989). Psychiatrists are therefore at times not any more scientific in their diagnosis than simply asking the patient if they feel depressed or have depressive symptoms. And although this seems somewhat archaic in today's world of advanced technology, it does not reflect the total knowledge of what is known about depression, not only in regard to its symptoms of behaviors but its symptoms of physiology. It only indicates our ability to empirically test for the severity and effects of both the emotional and physiological symptoms. Therefore diagnosis, at this juncture, may simply result by a more intuitive approach than empirical one.

Some researchers in the helping professions, seem very sure of symptomologies which can be used to delineate depression. One author states that three elements of thinking are necessary to determine the difference between ordinary sadness and clinical depression (Rutter, 1986). The depressed person according to Rutter (1986) therefore will think of themselves as unworthy, or to blame for what has happened, helpless to change the situation, or will see a future with no hope of change. Another author (Minirith and Meier, 1985) states that the depressed person often cries or feels like crying, their eyes are cast down, they lose interest in their personal appearance, their forehead is wrinkled and the corners of their mouth droops. The

same author, in what at first seems to be a contradiction of terms, states that many depressed individuals have what is known as "smiling depression" and have therefore learned to smile through the depression (Minirith and Meier, 1985). Therefore, it may at times seem difficult, to determine the affect symptomologies in the final diagnosis of Major Depression. However, these symptoms should be used as indicators, and should be ultimately used as guides for the diagnosis and prognosis of an individual.

In regard to the physiology of depression, although great strides have been made in understanding it, it is still somewhat misunderstood. To put it simply, depression at present is generally characterized by one of the three following possibilities, or the combination of the three: (1) the premature breakdown of norepinephrine (NE) by the enzymes monoamine oxidase (MAO) and catechol-O-methyltransferase (COMT) and reuptake by the presynaptic nerve terminal alpha 2 receptors; (2) the nonreceptivity of the norepinephrine (NE) with action potential by the postsynaptic nerve terminal alpha 1 receptors; and (3) the over-receptivity to the broken down norepinephrine (NE) and reuptake by the alpha 2 receptors in the presynaptic nerve terminal (McNeal & Cimbolic, 1986; Sarason & Sarason, 1989). Other findings involving other types of neurotransmitters have to do with the transference of serotonin (5HT) or acetylcholine (ACh), and have similar evidence that the breakdown and receptivity of these substances within the presynaptic and postsynaptic nerve terminals of the brain are involved in the emotional stability of an individual (Gershon and Shaw, 1961; Sarason and Sarason, 1989).

Biogenically based tests are as well found to be only partial indicators of depression and not empirical. One finding that produced excitement early on in empirical markers for depression was the Dexamethasone Suppression Test (DST) (APA Task Force, 1987; Carroll, 1985). This

test of injecting the steroid dexamethasone into the patient would normally suppress the level of cortisol in the blood for twenty-four hours in a normal person, however would not provide suppression of cortisol in a depressed person (Lingjaede, 1983; Sarason & Sarason, 1989). However, this was found not to be an empirical test for depression as non-suppression of cortisol was not found in all clinically depressed individuals (Sarason & Sarason, 1989). Another indicator of depression is a brain scanning technique called PT (positron emission tomography) and is non-evasive in nature (Sarason and Sarason, 1989). The PT, or sometimes called the PET scan, illustrates the decrease or increase of glucose metabolism found in the brain and indicates changes that would determine depression or mania (Carson, Butcher, & Coleman, 1988; Lingjaerde, 1983).

With regard to physiology, researchers seem still somewhat puzzled as to the actual biological key that would combat depression in the most natural way. Some suggest that depression may not be related to too much or too little neurotransmitter activity, but rather the regulation of the entire system (Siever and Davis, 1985). Others suggest that a change in the amino acid precursors to norepinephrine (NE) might effect depression (McNeal and Cimbolie, 1986). Still others have suggested, that in some cases, further regulation of glucose metabolism may have positive effects on depression (Minirth & Meier, 1985). Nevertheless, the jury is still out on a definitive explanation of the complex biochemical dysfunction of the neurotransmitter system with regard to depression.

Another element that can at times confuse the issue of depression is that of the person that suffers from grief. Minirth and Meier (1985) identify five stages of grief, which are: (1) denial; (2) anger turned outward; (3) anger turned inward; (4) genuine grief; and (5) resolution.

Although grief should not be construed as being the same as depression, if an individual does become trapped in, especially the third stage of grief, that of anger turned inward, depression can result.

Precursors to Depression

Theories that surround the predisposing causes of depression involve genetics, biochemical changes in physiology, environment, behavior patterns, and psychosocial stressors. Although some researchers may seem to emphasize one of these aspects over another as being predisposing to depression, most feel that the truth probably is found in a combination of these factors (Sarason & Sarason, 1989).

Although biochemical changes in physiology with respect to depression have already been addressed as to their diagnostic possibilities, the question may be asked, "What comes first the physiological changes or the psychological?" The answer to this can only be based in the individual's circumstance. However, where biogenic precursor illnesses seem to be absent, usually it is found that one's depression is one of psychological orientation (Minirith & Meier, 1985). Again, although primary psychological interventions may be indicated because of the psychological orientation of the illness, this does not mean that psychiatric interventions need not be employed (Eaton & Peterson, 1969). Medication should be viewed in these types of cases that are non-event oriented as therapy to be used in conjunction with psychological behavioral interventions, and in most cases are used temporarily as an agent of biogenic benefit, expeditiousness, and cost effectiveness (Minirith and Meier, 1985).

DSM IV Diagnosis

The DSM-IV serves as our guide to identifying general behavior symptoms of depression (American Psychiatric Association, 1994). The DSM-IV formally identifies the following symptoms as part of the diagnosis of Major Depression: (1) depressed mood; (2) markedly diminished interest or pleasure in all or almost all activities of the day or an apathetic attitude most of the time; (3) significant weight loss or weight gain (e.g., more than 5% of body weight in a month); (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or guilt; (8) diminished ability to think or concentrate or indecisiveness; (9) and recurrent thoughts of death or suicidal ideation. It should be noted that only five of these nine symptoms need be present for a diagnosis of depression, with at least one of them being a depressed mood or loss of interest or pleasure. Other lacking symptomologies are as well identified by the DSM-IV (American Psychiatric Association, 1994). These are: (1) an organic factor that did not initiate or cause the condition to continue and which may result in a differing diagnosis; (2) The depression is not as a result of the normal grieving process precipitated by a death or other loss; (3) if delusional symptoms are present, they are not exhibited apart from the symptoms of depression itself (American Psychiatric Association, 1994).

Other dysfunctional types of behavior also result in depression. There are three primary areas of deficit that may produce emotional pain which will result in depression. These areas involve lack of self-worth, lack of intimacy with others, and lack of spiritual intimacy (Minirth & Meier, 1985). Parents who are overly strict, or a rejecting mother and a passive or absent father will produce children with low self-esteem (Minirth & Meirer, 1985). Dr. Harry Stack Sullivan

states that loneliness or lack of intimacy, although it is not synonymous with depression, can predispose one to depression (Minirth & Meirer, 1885). Many doctors such as Dr. William P. Wilson, professor of psychiatry at Duke University and Dr. Armand Nicholi, professor of psychiatry at Harvard are convinced that deep within man is a spiritual vacuum, an inner emptiness that can only be filled by a Higher Power. Therefore lack of intimacy with one's Higher Power may ultimately produce depression (Minirth & Meirer, 1985). These areas of behavior are therefore pivotal in producing healthy mental wellness.

TREATMENT

Out of the various different treatment modalities come three primary treatments and one that synergizes the three. The first is the medical modeled psychiatric approach that deals with the biogenic side of depression. The second approach is the long-standing cognitive-behavioral approach of Beck (1979). And thirdly is the interpersonal therapy of Klerman and Weissman (1984). The fourth treatment possibility combines the above three treatments into an eclectic model of treatment.

The purely psychiatric approach primarily treats depression as an illness of physical chemical imbalance. It will therefore employ medications such as the various antidepressants (tricyclics, tetracyclics, SSRI's, and MAO inhibitors), and at times may use amphetamines, lithium, tranquilizers, various vitamins, thyroid preparation, estrogen, (Audio-Digest Foundation, 1975). Other medical interventions, which are rarely if ever used today for depression, and some of which are quite controversial, are electro-convulsive therapy, insulin coma therapy, sleep therapy, and psychosurgery (Audio-Digest Foundation, 1977). The most commonly used and

most effective medical therapy is the various antidepressants (Hollon & Beck, 1978; Mindham, 1982; Noel, Davis, & DeLeon- Jones, 1985).

The cognitive-behavioral approach used by Beck (1979) is a relatively brief approach that focuses on the here-and-now problem that is believed to be cognitive in nature. It will consist of a highly structured and systematic attempt to re-educate the patient with regard to their aberrant cognitions (Carson, Butcher, & Coleman, 1988). Though Beck's approach to depression is very impressive and is competitively compared with drug treatment, it is especially effective in regard to the long-term follow-up of depression (Blackburn, Bishop, Glen, Whalley & Christie, 1981; DeRubeis, 1983; Murphy, Simons, Wetzel & Lustman, 1984; Rush, Beck, Kovacs, & Hollon, 1977; Rush, Beck, Kovacs, Weissenburger & Hollon, 1982; Simons, Murphy, Levine, & Wetzel, 1986).

The interpersonal therapy approach of Klerman and Weissman is relatively new, however preliminary results seem promising (Rounsaville, Weissman, & Prusoff, 1985). Interpersonal therapy attempts to deal with matters relative to role conflicts, grief, and deficient interpersonal relationships from a cognitive-behavioral modality (Klerman, Weissman, Rounsaville & Chevron, 1984). Both Beck's treatment and the interpersonal approach of Klerman and Weissman have received strong support from studies done by the National Institute of Mental Health (Sarason & Sarason, 1989).

The final approach is a synergy of the three previously discussed therapies and would thus be called an eclectic mode of therapy. Although it may employ medication as needed, long term effects and maintenance are based in the cognitive behavioral side of therapy. It would primarily focus on the three basic needs of man, that of: (1) self worth; (2) intimacy with others;

and spiritual intimacy (Minirth & Meirer, 1985). It will also address inappropriate anger stemming from selfishness, perfectionistic demands, and suspiciousness of other's motives, that are generally a result of lack of forgiveness (Minirth & Meier, 1985). Additionally, would deal with ridding oneself of various irrational thoughts that result in anxiety or depression.

CLIENT AND THERAPIST TRAITS AND TREATMENT OUTCOMES

Variables that effect treatment outcomes have long been a subject of great discussion among researchers and mental health professionals. These variables should be considered and rearranged in light of their effect on clients, our treatment milieu, and the client's traits and possibly their diagnosis.

Some client attributes which have been studied have involved social class, personality, diagnosis, age, sex, intelligence, degree of disturbance, ego strength, client expectations, client-therapy interaction, client attractiveness, and others (Bergin and Garfield, 1978). In looking at studies where a great deal of work was done to reduce the intrusion of outside variables such as the comparison of heterogeneous groups and heterogeneous therapy for what was considered a homogenous diagnosis, some conclusions where made with regard to a number of client and therapist attributes. Following are some statements that are a synopsis of a great number of researchers findings, much of which where spawned out of meta-analysis situations. With regard to social class it was found in a number of studies that lower social classes were significantly less likely to complete therapy (Berrigan and Garfield, 1981; Pilkonis, Imber Lewis, & Rubinsky, 1984). However others (Lorion, 1973) reported that socioeconomic status was unrelated to treatment outcome. Intelligence likewise produced similar results, in that it was found that there was a positive relationship between education and the length of therapy (Hollingshead &

Redlich, 1958; Garfield, 1986b). Although these findings where not always duplicated in other studies. With regard to the sex of the client and premature termination of therapy, most studies showed no significant differences between a client's sex and its relationship with premature termination (Affeck & Garfield, 1961; Berrigan & Garfield, 1981; Craig & Huffine, 1976; Frank, Gliedman, Imber, Nash, & Stone, 1957; Garfield & Affleck, 1959; Gratjahn, 1972; Heisler, Beck, Fraps, & McReynolds, 1982; Koran & Costell, 1973; Koss, 1980; Rodolfa, Rapaport, & Lee, 1983; Weighill et al., 1983). The age of a client, in most studies, did not appear to have any significance with regard to continuation in therapy (Affleck & Garfield, 1961; Berrigan & Garfield, 1981; Cartwright, 1955; Frank et. al., 1957; Garfield & Affleck, 1959; Heisler et. al., 1982; Rosenthal & Frank, 1958; Rubinstein & Lorr, 1956), although some felt as though older clients were less desirable because their treatment outcome was not as positive (Matarazzo, 1972).

With regard to the diagnosis of a client and their continuation in therapy, a number of findings were drawn, however not all have been duplicated. For the most part, in appraisals of a number of studies by Garfield (1986b), diagnosis had no clear relationship with continuation in therapy. Craig and Huffine (1976) however reported that those with a psychosis or personality disorder tended to stay in therapy longer than did those diagnosed with a simple neurosis or transient disorder. Bergin and Garfield (1978) report that groups that have undergone therapy for specifically targeted syndromes have shown a correlation to premature dropout.

A number of other findings with respect to a clients continuation in therapy and treatment outcome were also found with respect to race, client expectations, client-counselor interaction, and ego strength. In some studies, race seemed to play a part in treatment length and outcome,

however generally it is felt that if the counselor is matched with same-race clients or the counselor is sensitive to ethnicity then little differences in length of treatment or outcome are seen (e.g., Hall & Malony, 1983; Leong, 1986; Ridley, 1984; Sue, 1990; Turner & Armstrong, 1981). With regard to client expectations, generally it was found that if the clients expectations are congruent with the counselor then an adequate treatment length and a positive treatment outcome are more likely (Bergin and Garfield, 1978). Client counselor interaction studies seem to have determined that if the therapist's empathy for the client is good, they have positive feelings toward the client, and they believe in the client's ability to form a positive therapeutic relationship, then a positive outcome is more likely (Bergin and Garfield, 1978; Rosenzweig & Folman, 1974). The ego-strength of the client also showed some promise with regard to positive treatment outcome Kernber et. al., 1972). Studies compared with therapists and clients that were compared as having either an internal or an external locus of control. Internal locus of control therapists were viewed as being more directive in their treatment approach, whereas the external locus therapist was more non-directive. The studies found that positive client outcome was related to them having a therapist that was opposite in their locus of control than they were (Abramowitz, Abramowitz, Roback, & Jackson, 1974; Bergin & Garfield, 1978;Stein & Beall, 1971).

With respect to therapist traits and treatment outcome, several situations were found to have some benefit. Female therapists where generally found to gain symptomatic improvement with female clients than their male counterparts in treatment (Jones, Krupnick, and Kerig, 1987; Orlinsky & Howard, 1980; Jones & Zoppel, 1982). However these findings where not replicated in a study by Jones and Zoppel (1982) when they allowed the clients to rate their outcome rather

than the therapist. Studies that involved the age of the therapist and successful treatment outcomes seemed to be skewed with mis-matches in therapist educational background and experience, as a result this area presently offer no conclusive findings (Bergin and Garfield, 1978). Other counselor traits that have seemingly produced positive conclusive correlations with treatment outcomes were therapist dogmatism (Tracey, 1985), therapist abstract and complex cognitive processing styles vs. a concrete and nondiscriminating style (Holloway & Wampold (1986), therapist maturity in emotional adjustment (Lambert & Bergin, 1983), therapist/client congruousness to client's value systems (Worthington, 1988), religious oriented therapy (Propst, 1980), therapist self-disclosure (Jourard, 1971), and therapist to client accurate empathy, respect, and therapeutic genuiness (Rogers, 1957; Patterson, 1983).

The above client and therapist traits that relate to treatment outcome and treatment continuation should be considered to be free from any diagnostic criteria. Although some diagnosis may have characteristics that might cause optimum client and therapist traits to change, I would consider the diagnosis of depression, unless coupled with other treatment difficulties, to allow the previously mentioned characteristics to remain fairly constant. In light of this, when treating an individual and choices are available that allow for more optimal traits to be implemented they should then be used.

Conclusion

Depression is without a doubt a disorder of the mind, the body, and the spirit of man. It also has the power to totally debilitate an individual from accomplishing his or her life goals. In realizing the scope of depression, one may be taken from a temporary sadness or grief caused by a small loss, to a major depression that manifests itself with hallucinatory delusions. Because of

the multi-faceted nature of depression, it is believed that a multi-faceted approach to treatment must be employed. It should use the best available techniques from the medical field and the cognitive-behavioral treatment modality, and should synergize them as needed into an eclectic model of therapy. Since depression is a disease of hopelessness, treatment must be hope laden. It is therefore felt that some sort of source beyond man, a Higher Power if you will, must therefore be a part of treatment in that it is the only avenue of gaining a lasting hope and in realizing that there is some meaning to one's life.

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