ACA-PBs
American Counseling Association Practice Briefs
The Center for Counseling Practice, Policy, and Research
counseling.org/practice_briefs | 703-823-9800 x324

December 2013

Clinical Depression

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Description of Clinical Depression

Definition

- Clinical depression, also known as recurrent depression, major depressive disorder, or unipolar depression, is a disorder characterized by repeated episodes of depression without any history of independent episodes of mood elevation and increased energy (mania) (World Health Organization, 2010).
- An episode of depression is characterized by one or more of the following key symptoms lasting at least two weeks: persistent sadness or low mood, loss of interest or pleasure, and low energy or fatigue. Associated symptoms include sleep disturbances, poor concentration or indecisiveness, poor or increased appetite, agitation or slowing of movements, low self-confidence, guilt or self-blame and suicidal thoughts or acts.
- Episodes are mild, moderate, or severe depending upon number and severity of symptoms and degree of functional impairment. Mild episodes are characterized by two or three symptoms; client is distressed by these but is able to continue with most activities. For moderate episodes four or more of the symptoms are present; the client has difficulties in continuing with ordinary activities. Severe episodes with or without psychotic symptoms are characterized by several very distressing depressive symptoms and psychotic symptoms (World Health Organization, 2010).
- Typically mood and affect in clinical depression are minimally affected by circumstances and remain low throughout the day. Gradual improvements during the day are observed in some but the low mood tends to return the following morning. For others, mood elevations observed in response to positive environmental changes do not last and depressive feelings return soon thereafter (NICE, 2010).

Resources: American Counseling Association: Identifying and treating depression: Diversity and depression; Eyes Wide Open; Basic Facts About Clinical Depression; Depression in the Workplace; Major Depression and Dysthymic Disorder in Adolescents: The Critical Role of School Counselors; The Next Advancement in Counseling: The Bio-Psycho-Social Model. Healthline: Depression. NICE Guidelines: Depression in adults quality standard (QS8); Depression in children and young people: Identification and management in primary, community and secondary care (CG28); Mental Health America: Depression; National Institute of Mental Health (NIMH): Depression; Depression and College Students.

Prevalence

- Clinical depression affects about 6.7 percent of U.S. adults during a year. Prevalence is higher among women (8.1%) than men (4.6%). Depression affects 8.3 percent of youth between the ages of 12 to 17. Prevalence among girls (12.4%) is nearly 3 times that for boys (4.3%) (National Institute of Mental Health, 2013, a, b). Clinical depression is the leading cause of disability in the U.S. for ages 15-44 (National Institute of Mental Health, 2013, c; Vos et al., 2012; World Health Organization, 2008).

Resources: National Institute of Mental Health (NIMH): Statistics.

Clinical depression ranks third among the leading causes of disease burden worldwide, but it ranks first in middle- and high-income countries. Yet, many professionals have difficulties recognizing and diagnosing depression. When diagnosed, less than half of clients receive the appropriate diagnosis and fewer receive adequate treatment. Outcomes can be improved by using accepted assessment tools within a system of measurement-based care (Gelenber, 2010; Zalaquett & Stens, 2006).

IDENTIFICATION/ASSESSMENT STRATEGIES

Several tools are available for performing systematic and objective (a) screening, (b) diagnosis, and (c) monitoring treatment (Galenberg, 2010). Clinical suggestions: Use screening and diagnostic tools routinely to detect and diagnose depression; use patient-rated instruments to save time. Use treatment algorithms and collaborative care to manage depression effectively. Measure depressive symptoms, side effects of treatment, and suicide risk.

(a) Screening tools

Center for Epidemiologic Studies Depression scale (CES-D; Radloff, 1977)

The CES-D is a 20-item scale developed to measure symptoms of depression in community populations. The CES-D has 4 separate factors: Depressive affect, somatic symptoms, positive affect, and interpersonal relations. The CES-D has good internal consistency with alphas of .85 for the general population and .90 for a psychiatric population. Resources: The Center for Epidemiologic Studies Depression Scale (CESD).

9-item Patient Health Questionnaire (PHQ-9; Spitzer, Kroenke, & Williams, 1999)

The PHQ- 9 is a self-report depression assessment tool, derived from the interview-based PRIME-MD. Completion of the instrument takes about 5 minutes. Useful for the diagnosis of major depression in primary care, with acceptable reliability, validity, sensitivity, and specificity (Richardson et al., 2010; Phelan et al., 2010). A shorter version, the PHQ-2, includes the first 2 items of the PHQ-9 and evaluates its presence during the last 2-weeks. (McGuire et al., 2013). Resources: Patient Health Questionnaire (PHQ) screeners; The MacArthur Initiative on Depression and Primary Care

The Hospital Anxiety and Depression Scale (HADS; Zigmond, A. S., & Snaith, R. P., 1983)

The HADS is a 14 questions self-rating scale. The scale measures anxiety and depression in both hospital and community settings. The one page scale can be completed in 2 to 5 minutes. The specificity for HADS-A is 0.78 and sensitivity is 0.9. For HADS-D specificity is 0.79 and sensitivity is 0.83 (Bjelland et al., 2002).
Resources: HADScale's Scoring Sheet.

Zung Self-Rating Depression Scale (Zung SDS; Zung, 1965)

The Zung SDS is a 20-item self-report screening questionnaire, covering affective, psychological and somatic symptoms of depression. Completion takes about 10 minutes. Alpha coefficient ranges from .79 to .88 (Thurver et al., 2002). Monitors changes in depression severity over time (World Health Organization, 2013). Resources: Zung Depression Scale; Zung Self-Rating Depression Scale.

(b) Diagnostic Instruments

The PHQ-9 and the Zung Depression Scale can be used for diagnosing as well as screening for clinical depression.

(c) Monitoring Instruments

Beck Depression Inventory (BDI; Beck et al., 1961)

The BDI –II is a 21-item self-report inventory measuring the severity of depression in adolescents and adults. The BDI-II is used as an indicator of the severity of depression, but not as a diagnostic tool. The internal scale reliability among older adults and among adults are alpha .86 and alpha .02, respectively. Completion time is about 10 minutes. Resources: Beck Depression Inventory®–II (BDI®–II).

Hamilton Depression Rating Scale (HDRS; Hamilton, M., 1960)

The HDRS has 17 original items; new versions include as many as 29. Completion of scale takes 20 minutes. Questions 18-21 may be recorded to give further information about the depression (e.g., diurnal variation or presence of paranoid symptoms), but are not part of the scale. The instrument has acceptable psychometric properties and is available in clinician- and patient-rated versions. Resources: Hamilton Depression Rating Scale.

Quick Inventory of Depressive Symptomatology (QIDS; Rush et al., 2003)
The QIDS is a 16 items instrument that measures similar symptoms as the IDQ. Test-retest reliability's Cronbach's alpha= 0.85 for self-rated scale. Resources: The QIDS.

Montgomery-Åsberg Depression Rating Scale (MADRS; Montgomery & Åsberg, 1979)
The MADRS is a 10 items instrument used to assess clients' mood, feelings of unease, sleep, appetite, ability to concentrate, initiative, emotional involvement, pessimism and zest for life. Higher scores indicate increased depression. The instrument is client or patient administered and completion takes about 20 minutes.
Resources: MADRS Scale.

Other Assessments: Clinically Useful Depression Outcome Scale (CUDOS) is useful to identify remission and assesses psychosocial impairment, and quality of life. Resources: CUDOS.

Adverse effects. The Frequency, Intensity, and Burden of Side Effects Rating (FIBSER) scale is useful to monitor side effects of depression treatment, as well as their interference with functioning. The scale does not address specific side effects; counselors need to ask about specific concerns. Resources: FIBSER.

Suicidality. Possible suicide and increased suicidal thoughts and behaviors in clients taking antidepressant medications are worldwide concerns. The Columbia Suicide Severity Rating Scale (C-SSRS) is useful to monitor suicidality. Resources: C-SSRS.

INTERVENTION STRATEGIES

Effective Psychotherapies for Clinical Depression
Psychosocial interventions for clinical depression strongly supported by randomized control trials and other sources of evidence:

Cognitive-based therapies (CT)
Cognitive therapy (CT) is a time limited, collaborative therapy (Beck, 1967). The goals of CT are to change thoughts, improve skills, and modify emotional states that contribute to mental disorders. Cognitive therapy can be applied in multiple ways using techniques from Beck's (Beck, 1967) cognitive therapy model, Ellis's (Ellis, 1973; Ellis & Grieger, 1986) rational emotive behavioral therapy model, or Meichenbaum's (1977) cognitive behavioral modification program, all of whom are major contributors to the field of Cognitive Behavioral Therapy (CBT). CBT treatment for clinical depression is efficacious and specific (Hollow & Ponniah, 2010; Zalaquett & Stens, 2006). Resources: Beck Institute; Academy of Cognitive Therapy; The Association for Behavioral and Cognitive Therapies; GoodTherapy.org

Interpersonal Psychotherapy (IPT)
Interpersonal psychotherapy (IPT) for depression focuses on interpersonal roles and conflicts (Kennedy & Tanenbaum, 2000). IPT includes three phases of treatment addressing two of four main problem areas: grief, interpersonal disputes, role transition, and interpersonal deficits. Short-term IPT usually involves up to 20 weekly hour-long sessions. IPT treatment for clinical depression is efficacious and specific (Hollow & Ponniah, 2010; Zalaquett & Stens, 2006). Resources: International Society for Interpersonal Psychotherapy; Interpersonal Therapy for depression; Interpersonal Psychotherapy: An overview:

Behavior Therapy (BT)
Behavioral interventions include contextual approaches based on functional analyses (contingency management and behavioral activation), social skills training, self-control therapy, problem-solving therapy, and behavioral marital therapy. Common therapeutic strategies include self-monitoring, self-reinforcement, graded task assignments, activity scheduling, and targeted improvements in social skills through assertiveness training, modeling, and role-playing. Relaxation training is used to cope with anxiety or insomnia. BT treatment for clinical depression is efficacious and specific (Hollow & Ponniah, 2010; Zalaquett & Stens, 2006). Resources: Behavior Therapy vs.

Cognitive Therapy For Depression: Here We Go Again.

Brief Dynamic Therapy (BDT)
BDT explores unconscious processes, process lifetime developmental issues, and facilitates client insight and life changes. Main goal is to increase insight into the unconscious processes by leading clients to repeat past experiences and to institute corrective experiences through the interaction with their therapists (Nordhus & Nielsen, 1999); transference and countertransference are important (Gatz et al., 1998). BDT treatment for clinical depression is possible efficacious (Hollow & Ponniah, 2010). Resources: Brief Dynamic Therapy; Short-Term Psychodynamic Therapy for Depression:

Emotionally focused therapy (EFT)
Emotionally focused therapy (EFT) is a short-term (8-20 sessions) structured therapeutic approach to working with individuals, couples and families. It is based in attachment theory but includes elements of experiential, person-centered, constructivist, and systems theory. EFT treatment for clinical depression is possible efficacious (Hollow & Ponniah, 2010). Resources: The International Centre for Excellence in Emotionally Focused Therapy (ICEEFT); FAQ's - Emotion Focused Therapy.

Newer psychological interventions are as efficacious as medication in the treatment of clinical depression (Hollon & Ponniah, 2010).

Other therapeutic options
Antidepressant medication, repetitive transcranial magnetic stimulation (rTMS), vagus nerve stimulation (VNS), deep brain stimulation (DBS), and electroconvulsive therapy (ECT).

Additional Resources
The Macarthur Initiative on Depression and Primary Care: Depression Management Tool Kit. The Center for the Study of Traumatic Stress: Courage to Care – Depression in Primary Care.

The Importance of Cultural Constructs
A culturally-sensitive therapeutic approach is of essence. There are recognized cross-cultural variations in presenting symptoms of depression. For example, guilt, self-blame, amount of suicidal ideation, and somatization vary across different U.S. cultural groups. Considerable variability between countries in the management of clinical depression led to the development of the International Consensus Statement on Major Depressive Disorder. Experts adapted Japan's treatment algorithm and offered specific recommendations for screening, diagnosing, and treating depression. Resources: International Consensus Statement on Major Depressive Disorder.

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