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# Major depression : diagnosis and intervention

Lindsay Linck  
*University of Northern Iowa*

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## **Abstract**

This paper will be an analysis of the psychological disorder of major depression. First, the classification of this disorder using the DSM-IV-TR will be reviewed. The areas of etiology, differential diagnosis, and treatment will then be considered. Following, a theory-specific approach to the disease including theoretical framework, diagnosis and treatment, and outcomes of using this approach, will be examined. Finally a personal reflection on the subject of major depression, and lessons learned from this project, will be discussed.

MAJOR DEPRESSION: DIAGNOSIS AND INTERVENTION

A Research Paper  
Submitted  
In Partial Fulfillment  
Of the Requirements for the Degree  
Master of Arts

Lindsay Linck

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Dr. Jan Bartlett, Advisor

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Dr. Vickie Robinson, Department Chair of Educational  
Leadership, Counseling, Postsecondary Counseling

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This paper will be an analysis of the psychological disorder of major depression. First, the classification of this disorder using the DSM-IV-TR will be reviewed. The areas of etiology, differential diagnosis, and treatment will then be considered. Following, a theory specific approach to the disease including theoretical framework, diagnosis and treatment, and outcomes of using this approach will be examined. Finally, a personal reflection of the subject of major depression and learning's gained from this project will be discussed.

## Major Depression

This paper will be an overview of the disorder of major depression and issues of treatment. First, the disorder will be defined and differential diagnosis will be considered. Next, different treatments will be considered including pharmacological, counseling therapy, electroconvulsive therapy, surgery, and exercise. Following, the behavioral and cognitive therapies will be discussed. Finally, a personal reflection and conclusion will be given.

### Etiology

#### *Classification*

The Diagnostic and Statistical Manual, the universal method practitioner's use in the clinical setting, classify the disorder of Major Depression as a mood disorder. Mood disorders are described by the DSM as the "presence or absence of mood episodes" (DSM). The disorders within this group vary greatly but include Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, Bipolar Disorder Not Otherwise Specified, and Mood Disorder Due to a General Medical Condition, Mood Disorder Not Otherwise Specified (DSM-IV-TR, 2000). The disorders of Dysthymic Disorder and Cyclothymic Disorder will be discussed in more detail as a differential diagnosis.

#### *Features of Disorder*

To understand Major Depression the diagnostic criteria used must first be discussed. According to the DSM-IV-TR, the episode features of Major Depression are:

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's preepisode status. The symptoms must persist for most of the day, nearly everyday for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort. (DSM-IV-TR, p. 349).

An individual must meet these criteria to receive a diagnosis of Major Depression.

The criteria set from the current manual is the most detailed and strict in its parameters of diagnosis.

Along with the episode features provided by the DSM, several subtypes within the disorder exist. The two to be discussed in this portion of the paper are Major Depression with vegetative symptoms and with reverse vegetative symptoms. Individuals experiencing vegetative symptoms may experience weight loss, insomnia, and/or appetite loss. The symptoms are of being in a hyper aroused state and can be accompanied by an anxiety disorder. Symptoms of reverse vegetative depression are weight gain, hypersomnia, and an increase in appetite. This disease presentation is more common in women than in men and about one third of all individuals with depression experience these symptoms. Research suggests this atypical presentation of Major Depression carries a stronger genetic link (Gotlib, I., Hammon, C., 2002).

### *Prevalence*

The issue of Major Depression is important not only for clinicians but also for the general public. The disorder of Major Depression is associated with both high mortality and morbidity. In addition it is one of the most costly disorders projected to be by 2020 the second only to heart disease as the cause of disability (Kendler, K., Neale, M., Sullivan, P., 2000). Community surveys report a prevalence of up to 20% in adults and 50% in adolescents and children (Gotlib, 2002). The numbers of reported cases of depression are considerably lower when the diagnostic criteria set by the DSM-IV-TR are used. Rates of depression in adults diagnosed by a clinician are approximately 2-4%, in children less than 1%, and in adolescents 6% (Gotlib,



2002). The discrepancy in the number of self-reported cases of depression and diagnosed depression are important for several reasons. First, many individuals could be experiencing a mild form of depression such as Minor Depressive Disorder, which is currently not a recognized diagnosis. Secondly, the number of individuals actually experiencing an episode of episodes of Major Depression might be higher but seeing a mental health professional not possible.

Women are at a higher risk for developing depression with a prevalence rate of twice that of men (DSM-IV-TR, 2000). Several theories attempt to explain this phenomenon and range from hormonal factors to expression of emotions.

Major Depression rates are similar in different cultures and socioeconomic classes, with rates of approximately 17% of adults experiencing an episode at some point in their life (Comer, 2005). Although the prevalence of this disorder crosses cultural divides, there are differences in presentation. For example, Latinos might describe symptoms as nerves or headaches, Asians might complain of imbalance (DSM-IV-TR, 2000). These are important considerations for accurate diagnosis.

### *Lifetime Prevalence*

Depression is a disorder able to be categorized as either chronic or acute, ranging from a single episode to repeated episodes over a lifetime. According to the National Co-morbidity Study, 15.8% of individuals met criteria for lifetime Major Depression while 10% met criteria for lifetime Minor Depression (Gotlib, 2002). In contrast community based surveys estimate the prevalence of lifetime Major depression to be between 6% and 25%. Other studies show at least every one in six adults have experienced an episode of Major Depression and one in four experiencing

Minor Depression (Gotlib, 2002). It is important to note, the number or episodes being defined, as lifetime prevalence and severity of episodes were not given.

### *Biological vs. Environmental Cause*

Although depression is a devastating disease for individuals worldwide, the cause of depression is not clear. Two theories of causation dominate this debate and are endogenous and exogenous. Endogenous causes are those said to be inherent to the individual, in other words are biological causes. This is the theory with the most backing of research with monozyotic twins (identical) having a 65% correlation rate (Peters-Strickland, T., Sinicola, R., (2006). The other recognized cause is endogenous or environmental. These are things such as stress, grief, health issues, etc, which exist outside the individual. It is reported, 75% of individuals seeking treatment for Major Depression had recently experienced a negative life event. 17-31% had experienced a severe life stressor, such as a loss of a loved one prior to seeking treatment (de Kloet, R., van Os, J., van Praag, H., 2004). Most research concludes both environmental and biological factors contribute to the development of Major Depression.

### *Consequences of Major Depression*

As previously mentioned, depression is the second leading cause of disability worldwide and accounts for 33 billion dollars in lost productivity in the US alone (Gotlib, 2002). Employee's experiencing Major Depression is often unable to remain working and be productive, often using many sick days. This heavy burden is not

only felt in the workforce but in the arena of social services. Because of the inability of many individuals with Major Depression to work, they are often forced to use social services for themselves and their families (Gotlib, 2002). Clearly this disorder has a major impact on individuals as employee, a family member, and in cost of health care.

Another significant issue of Major Depression is the age of onset and implications for later life. Depression is largely diagnosed in the 20's, a time of transition and defining of roles for many individuals (Gotlib, 2002). Individuals in this stage of life are typically pursuing higher education, beginning careers, and/or starting a family. This is a time of individual definition and importance in life. Other transition stages such as having children, experiencing an empty nest, and retirement are times in which high rates of depression are found (Gotlib, 2002). To be diagnosed or even just experience Major Depression, can have devastating effects on these times of transition.

Finally, the most serious implication of Major Depression is the increased risk of suicide. The DSM-IV-TR states, "Suicide risk is especially high for individuals with psychotic features, a history of previous suicide attempts, a family history of completed suicides, or concurrent substance use" (DSM-IV-TR, p. 352). Of all psychiatric disorders, Major Depression carries the highest risk of suicide. Suicide rates in the United States have largely remained steady at approximately 11 to 12 per 100,000 (Blazer, D., 2005). These rates have not changed despite the use of medication for treatment, and have even increased in some population such as adolescents (Blazer, 2005).

### Differential Diagnosis

Several other diagnoses exist, all closely related to Major Depression and worth consideration. First, is Dysthymic Disorder, which is characterized by episodes lasting at least 2 years, with depressive symptoms, occurring most days (DSM-IV-TR, 2000). As a clinician, this disorder is important because the presentation is often similar to that of depression. Difference in the diagnoses would be the length of occurrence and the severity of symptoms. Dysthymic Disorder is often described as the feeling of generally being down and individuals will often live with the disorder for longer periods of time before seeking treatment.

The second differential diagnosis for consideration is Minor Depressive Disorder. This disorder is characterized by duration of at least two weeks in which symptoms are similar to a Major Depressive episode, but less severe. At this time the Minor Depressive Disorder is not recognized as a diagnosable disorder, but is listed in the areas for further study.

Finally, depression has a high co-morbidity with substance use, with one researcher stating, “75% of respondents with lifetime MD also met criteria for at least one of the other DSM-III disorders assessed in that survey, while the comparable proportion of DSM-III-R co-morbidity in the NCS was 74%” (Gotlib, 2002). These are significant numbers when looking at an individual with Major Depression and possible substance use. A differential diagnosis if the patient does not meet criteria for a Major Depressive Episode, but is experiencing depressive symptoms in the intoxication or withdrawal stages, would be a Substance-Induced Mood Disorder. This disorder is characterized by a “a persistent disturbance in mood that is judged to

be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, other somatic treatment for depression or toxin exposure. Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication, or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood.” (DSM-IV-TR, p. 405).

## Treatment

### *Pharmacological Treatment*

Drug therapy emerged in the 1950's with the introduction of monoamine oxidase inhibitors (MAOI's), and tricyclics (Comer, 2005). This was a major breakthrough for practitioners and patients alike, giving hope for proven method of treating depression. MAOI's work with the neurotransmitter norepinephrine and interacts with emotional functions of the brain. MAO's are responsible for the breakdown of norepinephrine and by blocking them; the brain maintains higher levels of the neurotransmitter (Peters-Strickland, 2007). Side effects do exist with this class of antidepressant and one of the more cumbersome for patients is the strict diet, which must be maintained when taking these drugs.

Tricyclics are the oldest form of antidepressant and have recently made a comeback in popularity. TCA's "prevent the reuptake of neurotransmitter substance back into the presynaptic cell" (Peters-Strickland, p. 29, 2007). It is estimated up to 70% of patients treated with tricyclics show significant improvement in depressive symptoms (Comer, 2005). Side effects of this medication include; "sedation, weight

gain, difficulty urinating, dizziness, dry mouth, sexual dysfunction, orthostatic hypotension, and blurred vision” (Peters-Strickland, p. 29, 2007).

During the latter part of the 1980’s, a third class of antidepressants was developed, selective serotonin reuptake inhibitors (SSRI’s). The basic function of this drug can be described as the blocking of reuptake of serotonin, which is involved in mood regulation. Side effects of SSRI’s include; “headache, nausea, diarrhea, dry mouth, anorexia, weight gain, restlessness, insomnia, tremor, sweating, yawning, dizziness, inhibited sexual desire, and inhibited orgasm for some.” (Peters-Strickland, p. 30, 2007).

Considerations for treatment using drug therapy are first, the side effect previously mentioned. Often patients need to pursue several different courses of medication before finding one which is effective and possesses side effects the individual finds tolerable. There has also been show to be an increased risk of suicide ideation in 2 to 3% of adolescents taking SSRI’s. Another consideration is adherence to the treatment regimen of antidepressants. Adherence can be described as the amount of times the patient is appropriately taking the medication prescribed. One study showed only 51% of patients were taking their medication, and this number drops to 42% during the maintenance phase of treatment (Mc Innis, M., 2007). Factors weighing most heavily on patients taking their medication were; in addition, regular check-ups with a mental health practitioner, and the absence of substance use. Patients having more than one visit with a psychologist or psychiatrist were 5 times more consistent with adherence to treatment (Mc Innis, M., 2007).

### *Counseling*

Modes of therapy most used in the treatment of depression are cognitive, psychodynamic, and behavioral. Of these therapies, only the cognitive method has been shown to have efficacy (Comer, 2005). Both the cognitive and behavioral theories will be discussed further during the analysis of these models of psychology. Counseling involves a client and therapist talking in a confidential setting about issues and feelings surrounding the depression. Processing depressive symptoms, environmental triggers, and providing interventions can ease distress caused by the disease. Three-stages almost universally exist in therapy and are creating a therapeutic alliance, helping the client gain deeper understanding of the issue, and intervention application (Patterson, L., Reynolds, E., 2005). The most effective treatment of Major Depression has been found to be a combination of pharmacological and counseling treatment (Peters-Strickland, 2006).

### *Exercise*

Exercise as a treatment for Major Depression is not a widely studied, but a growing body of research is supporting the benefits of using exercise as an intervention in the counseling process. Physical activity has been shown to “decrease aggression, confusion, depression, phobias, tension, Type A behavior, and alcohol abuse” (Fletcher, p. 429). This intervention has also been shown to be as effective in mild to moderate depression as pharmacological treatment. The benefits of exercise positively affect the individual sense of self-worth and self esteem. It has been hypothesized that individuals and/or clients who begin the process of physical self care show transference in becoming more vested in mental self care (Baird, 1999).

In treating depressed individuals, exercise has shown to alleviate depression symptoms based on the Beck Depression Inventory (Hardman, 2003). In treating clients with depression, it has been found the most improved condition resulted from clients that were treated through counseling and exercise prescription making this a very effective intervention for clients with depression (Baird, 1999).

### *Alternative Therapies*

Several therapies exist on the outskirts of what is medically recognized, but should not be diminished in their possible effectiveness. First, multiple herbal remedies have been shown to improve symptoms of depression. St. Johns Wart has been shown to decrease symptoms of mild to moderate depression but can interfere with other pharmacological treatment. Ginkgo biloba has also demonstrated benefits for the depressed individual by improving memory and concentration (Peters-Strikland, 2006).

A second, and more controversial therapy is electroconvulsive therapy. Little is known about how or why this works, but for many patients it has been the only way relief has been obtained. Patients are anesthetized so they are unable to move during the procedure. Electricity is then administered through electrodes, causing seizure in the patient. Although this procedure is now relatively safe, some risks are still involved including memory loss and brain damage (Peters-Strikland, 2006).

## Behavioral Therapy

### *Theory Overview*

B.F. Skinner is acknowledged to be the father of behavioral therapy. Skinner did not believe thoughts and emotions were relevant to our actions, but instead we are



programmed to perform certain behaviors and therefore can be most effectively treated in this manner. Behavioral therapy can be divided into 4 stages of its development: classical conditioning, operant conditioning, social learning theory, and cognitive behavioral therapy (Cory, 2005). Classical conditioning is the most basic being our responses such as salivating or startling. This was best illustrated with Pavlov's dog becoming conditioned to respond to a bell by salivating. Operant conditioning occurs when behaviors are reinforced by consequences such as driving on the correct side of the road, if you do not you might be in a car accident or at the least anger others.

The next phase of development in this theory occurred when Albert Bandura and Richard Walters created the social learning model. This model can be described as "behavior is influenced by stimulus events, by external reinforcement, and by cognitive motivational processes" (Cory, p.230, 2005). This theory more broadly encompassed other theoretical perspectives and was also credited with the idea of self-efficacy or individuals ability to bring about change.

The final phase of behavioral theory development was the merging of behavior and cognitive process in the approach to treatment. It is largely recognized the cognitive process involved in the behavior also needs to be understood to bring about measurable change. The process of cognitive therapy will be discussed at greater length following behavioral treatments for Major Depression.

### *Behavioral Treatment for Major Depression*

Behavioralists believe maladaptive behaviors are to blame for individual's development of Major Depression; therefore, treatment involves correcting behaviors

(de Kloet, 2004). Some of the basic assumptions of behavioral theory necessary to understand in the context of treating depression are; first, this theory is based on a scientific model and efficacy of treatment is empirically evaluated. This means treatment of is provided systematically and without personal bias on the therapist part. Second, therapy would only deal with the current problems, with no regard for past episodes or issues. A client seeking therapy for Major Depression might find this to be difficult particularly if the perceived cause of the depression is a traumatic life event (Cory, 2005).

The next construct of therapy is the expectations for clients to be actively involved in the therapeutic process. Clients who are experiencing a depressive episode might find this to be very difficult. Depression can cause retardation in speech and diminished communication skills (Gotlib, 2002). In a setting where the client is expected to be very active in participation, this might be difficult. The client is also expected to be self-monitoring and willing to do homework assignments. A depressed patient often has an inability to function in even the most basic capacities, asking to record behaviors or complete homework assignments could unreasonable (Cory, 2005).

Some aspects of behavioral therapy, which could be seen as highly beneficial to a client experiencing Major Depression, would be first the emphasis on self-control. Behavioral theorist believe clients should be empowered to help themselves meaning the therapist provides tools for them to take outside of the therapy setting and apply to their lives. The emphasis of therapy is on practical application to the client's life. Interventions are also catered to the client's culture and lifestyle. The

client is also an active member of therapy in the sense they are informed of all aspects of therapy and are involved in the creation of goals and interventions (Cory, 2005).

### *Behavioral Intervention*

Several behavioral interventions are seen to be effective for the treatment of Major Depression. Problem solving therapy or skills training is seen to be a highly effective form of treatment for depression and the often co-occurring conditions (Gotlib, 2002). Skills training for an individual with Major Depression could possibly give clients the ability to generate different coping mechanisms as opposed to falling into the behaviors, which facilitate the depression. For example, if a individual disposed to depression recognizes the anniversary of a loved ones death is a trigger to become more reclusive and eventually depressed, through therapy they could adapt different behaviors.

Another behavioral intervention applicable to depression is relaxation training. This method teaches individuals to cope with stress or anxiety producing situations with systematic relaxation of the mind and body. This therapy can easily be taught and learned by therapist and client. It is also particularly effective in treating clients presenting with anxiety and depression. Relaxation training can be administered through several methods, but does simply simply having the client close their eyes and concentrate on taking deep breaths learn most often. The therapist then guides them through a muscle relaxation, as the client is also encouraged to clear the mind.

Finally reviewing the application of behavioral therapy to Major Depression, according to Gotlib, "behavioral therapy is considerably easier to apply and lends

itself more readily to dissemination than either cognitive therapy or more traditional psychotherapeutic approaches” (Gotlib, p.396, 2002). With this reference in mind, cognitive therapy will now be discussed.

## Cognitive Therapy

### *Theory Overview*

Cognitive therapies recognized father is Aaron T. Beck. Beck developed this theory out of frustration with the psychoanalytic views of therapy and as a result the most influential research on depression was done. Beck believed the negative cognitions resulted in depression and if these negative thoughts and beliefs could be treated, the individual would be relieved of symptoms.

Some of the basic principals found in cognitive therapy are first, “erroneous beliefs and maladaptive information processing can lead to emotional distress and problems in behavioral adaptation” (Brown, J., Joiner, T., Kistner, J., p. 134, 2006). Although cognitive therapy operates form a different causation model, several similarities exist including, relationship between client and therapist being collaborative, distress is caused by maladaptive cognitive processes, changing thoughts will change behaviors, and therapy is highly structured and time efficient (Cory, 2005).

Cognitive therapist also believe clients can best be helped by creating an educational setting and focusing on thoughts and behaviors, not emotions. The ABC theory is at the core of cognitive therapy and uses the following equation; activating event correlates with personal belief creating emotional response. Therapist in the cognitive school believes if the personal beliefs can be changed, the individual will

have a more adaptive emotional response (Corey, 2005). For example, a client comes to therapy saying they are going to fail because they did not pass a test and are feeling depressed. A cognitive therapist would dispute the notion the individual was a failure because of one test, hopefully alleviating the feelings of depression.

### *Cognitive Therapy Treatment of Major Depression*

The most widely used assessment of depression is the Beck Depression Inventory II, which examines the existence of depression and the severity of the disorder (Patterson, L., 2005). The inventory includes 21 symptoms and attitudes of depressed individuals: “sadness, pessimism, sense of failure, dissatisfaction, guilt, sense of punishment, self-dislike, self-accusations, suicidal ideation, crying spells, irritability, social withdrawal, indecision, distorted body image, work inhibition, sleep disturbance, tendency to become fatigued, loss of appetite, weight loss, somatic preoccupations, and loss of libido” (Cory, p. 290, 2005). This assessment is useful in not only understanding the clients depression but is universally recognized as an accurate assessment tool.

After assessing the presence of depression in a client the following might be a way in which therapy would proceed. First the therapist would begin disputing irrational beliefs. This often involves questioning the client about what they are thinking and putting it in a context of rationality. During this process the client is also thought to enact this process on his or her own, outside the therapy setting. With this, a therapist would likely give the client homework focusing on putting themselves into situations in which irrational thoughts are present, and disputing these thoughts on their own.

A cognitive therapist dealing with a client suffering from Major Depression would also challenge the self-talk a client exhibits. For example, a client who says they will never be loved and will always be alone would be asked by the therapist to give examples of why they feel this way and what experience they have leading them to believe this is the case.

A final Beck approach to therapy, which often works well treating clients with depression, is the use of humor. Clients have created a world of depression in which laughter is none-existent. One study even found individuals suffering from Major Depression were less able to recognize humor or even happy or joyful faces (Oquendo, M., Parsey, R., 2007). Using humor could have great transference to the client's life outside of therapy in the experiencing of happiness (Corey, 2005).

### *Cognitive Interventions*

The first intervention to be discussed is the use of imagery to relieve symptoms of depression. Clients are asked to imagine themselves reacting the way in which they normally would to a situation typically producing depressive feelings. They would then be asked to imagine what the worse case scenario could be in this situation and talk through a more positive outcome. An intervention similar to this is the use of role-play in the therapy setting. The therapist can play many roles such as the negative emotion, a positive emotion, or even another person view to be part of the issue. The client and therapist then recreate verbal or mental dialogue with less implication to the depressive symptoms.

A therapist would also deal with the overgeneralization often used by individuals with Major Depression. Client will often talk in terms, which are very

broad such as, “I have difficulty understanding math and therefore will never pass a math class. A therapist might also look at the client’s tendency to maximize or minimize situations. For example, a minimizing behavior could be the client saying their spouse only loved them because they have children.

Finally, a therapist might work on the personalization many depressive clients feel. Clients often take everything personally when in fact often times the situation or reaction from another person has nothing to do with them. The therapist might ask how the client knows the reaction or behavior is directed at them and what basis they have for these thoughts (Corey, 2005).

As mentioned cognitive therapy is the most widely used treatment for the disorder of Major Depression. Outcome studies of clients who have sought help through this therapy have been higher than any other. The use of cognitive therapy and pharmacological treatment has been the most effective in alleviating the symptoms of Major Depression.

### Personal Reflection

Through the research and writing of this paper, the disorder of Major Depression has become an issue in the field of psychology I now recognize to be of great importance as a future clinician. First the scope of other areas affected by this disorder is astounding. From the research, I would find it difficult to believe as a therapist, depression would not be a prevalent disorder in practice.



It is also important for anyone planning to practice in the field to recognize the implications this disorder has on managed care and social services. The amount of money being used not only for client seeking therapy, but also in the realm of disability and social services is immense. This will be an issue, I feel, most therapist will need to address be it through the amount of time allocated for treatment, or the type of treatment provided.

Finally, the greatest issue I feel from writing this paper, a therapist needs to understand are the biological workings of a depressed individual and using medication in the therapeutic setting. The understanding of the brain and biological causes of depression is becoming greater everyday. It will soon be necessary for therapist to understand what medications the client is taking and how to appropriately manage therapy in conjunction with pharmacology.

#### Conclusion

This paper has been a very brief look at the disorder of Major Depression. The areas of epidemiology, diagnosis and assessment were first discussed. Next, an overview of treatment was given. Finally, the application of the behavioral and cognitive therapies was discussed. The disease of Major Depression is a complex one and difficult to address in a just these pages. The hope of this paper is it leaves the reader with an accurate concept of the disorder and knowledge of treatment.



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