

Handbook of Depression, 3rd ed

edited by Ian H. Gotlib, PhD, and Constance L. Hammen, PhD.
Guilford Press, New York, NY, 2014, 642 pages, \$85.00
(trade cloth).

This is the third edition of a book previously published in 2000 and 2009. The editors, recognized leaders in the field, have assembled a variety of experts to present a comprehensive and up-to-date overview of what is known about depression. Most of the work cited comes from the last 2 decades and includes references from 2014, the year of publication. Each chapter is free-standing and can be read independently and profitably on its own, thus entailing repetition of some of the material from one chapter to another.

Anyone spending time with the volume, part or all of its 597 pages of text, will come away enriched by a deeper appreciation of what is known scientifically about depression, and equally what is unknown, uncertain, and unsettled. There is very little theorizing or speculation, and this is acknowledged when it is done.

Although treatment is covered, this is very much a descriptive rather than prescriptive work. It documents the scientific basis of what is known about depression. For how-to instructions in actual therapy, one needs other sources. Obviously, with such a wealth of information, it is not possible to list, let alone summarize, the material in a short review. But it may be instructive and stimulating to quote or cite parts that made an impression on this reviewer.

In chapter 3 on methodological issues, the authors recall a reference in the first edition of the book to an old Oldsmobile television commercial as “not your father’s Oldsmobile.” They explain as follows:

Contemporary research on depression is no longer our father’s Oldsmobile. That car was cheaper and easy to service but not all that reliable. New cars are more expensive to buy and to operate and much more complicated and difficult to service. Yet the ride is better and more reliable, and we are more assured of getting to our destination. It is time to trade up (p 60).

In considering the course of depression, the writers touched on some issues created by the changes introduced in DSM-5 regarding the old categories of major depressive disorder and dysthymia (p 68).

For cases of comorbid depression and anxiety, the precipitant was most likely to be both a severe loss event and a severe danger event (p 92).

Omnibus analyses of 19 laboratory studies found that persons with MDD were characterized by reduced emotional reactivity to both positively and negatively valenced stimuli relative to healthy persons, with the reduction larger for positive stimuli (p 105).

Related to this are the constructs of “emotional inertia” and “psychological inflexibility” (p 106).

Pain and disability may be stronger risk factors for depression than is medical illness per se (p 123).

BD [bipolar disorder] is one of the most highly comorbid mental illnesses: More than 95% of adults meeting criteria for BD-I or -II . . . meet criteria for at least 1 more major mental health diagnosis (p 149).

Regarding genetic influences:

Existing findings are not sufficiently strong to suggest immediate translational applications into clinical practice (p 175).

REM suppression is neither a necessary nor a sufficient element of antidepressant therapy (p 193).

One particularly promising study found that training dysphoric individuals to be more concrete and less overgeneral in their thinking led to a significant reduction in depressive symptoms and rumination (p 266).

Rose (2002) extended research to include corumination [as a risk factor], an interpersonal ruminative process in which individuals within a dyad engage in non-solution-focused discussion of problems . . . and the negative feelings associated with them (p 285).

People with BD . . . have a higher incidence of childhood abuse than those with unipolar depression (p 320).

Across many cultural contexts, women are more likely to develop depression than men . . . exceptions to this pattern have been observed in some cultural groups, such as the Amish and Orthodox Jews (p 338).

With recent historical changes, neurasthenia is receding in China while depression-like presentations are becoming increasingly common (p 344).

Results of preventive interventions with adults are mixed (p 474).

Thus, currently, incidence of depression can be reduced by 22% on average and by as much as 38%–50% using the most potent methods (p 479).

No newer antidepressant has shown greater efficacy than the tricyclics (p 497).

A particularly promising and relatively novel therapy discussed in the book is behavioral activation (BA). It is a highly structured approach with assignments and self-reporting of symptom severity. The basic philosophy is “to encourage patients to act proactively instead of engaging in avoidance behaviors” (p 523). With studies showing results comparable or superior to cognitive therapy and other psychotherapies and requiring less training, BA may be easier to disseminate to a wide range of affected and vulnerable individuals (including non-Western populations), with such care being delivered by nonspecialist providers (p 523).

In the book’s closing comments, the editors note:

Unfortunately, some of the excitement of new developments and discoveries has been accompanied by a tendency toward reductionism that many would argue is not only erroneous but also misleading, if not destructive (p 593).

No single volume, even one of this size, can tell all about depression. One does not find here a discussion of the history of depression and its evolution over time. Nor is there significant discussion of analytic theory and therapy or of various traditional, religious, and native approaches. There are no clinical cases to illustrate the material. What is here is a thorough document of recent published studies of depression that can guide and inform the interested reader.

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