

Mental Health and Society week 7 Introduction to depression & mood disorders.

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Mood disorders are usually divided into unipolar disorders (depression) and bipolar disorders (manic depression) where periods of elation and depression alternate.

Definitions: Depression, according to DSMIV can involve:

i) A *major depressive episode*, where the depression is significantly disabling, lasts for two weeks or more, is characterised by at least five symptoms (see below) and is not caused by factors like drugs or alcohol. In addition a depressive episode may include delusions and hallucinations. A depressive episode may be described as single episode, recurrent, seasonal, catatonic (if there is excess motor activity or immobility) postpartum, or melancholic (early morning waking, no interest in pleasurable events, appetite loss, guilt). An untreated episode tends to last about 6 months. Half the people who have such an episode will have another within 2 years. People with recurrent depressive episodes have on average 7 in the course of a lifetime (Cancro, 1985).

In some cases of depression people may also experience delusions and hallucinations (Parker et al, 1997; Coryell et al, 1995; APA, 1994)

ii) *Dysthymic disorder*, where fewer symptoms are present. This lasts longer (2 years is specified) and periods of normal mood interrupt the depression. Sometimes dysthymic disorder leads on to a major depressive episode - this may be called 'double depression'.

Symptoms of depression can include:

i) *Emotional symptoms*: sad, dejected feelings, depressed mood, little pleasure. Sometimes also anxiety, anger or agitation. May lose interest in affection with friends and relatives, and feel angry towards them.

ii) *Motivational symptoms* 'Paralysis of will' (Beck, 1967). Lack of drive, initiative and spontaneity. Sufferers may become indifferent to life and wish to die, or believe they deserve to. Between 7 and 15 percent of depressed people commit suicide (Coryell & Winokur, 1992; Tsuang, 1978).

iii) *Behavioural symptoms*, May be less productive, spend more time alone, move and act slowly. Speech may be slow, quiet and monotonous. Posture may be hunched or bent and eye contact may be reduced.

iv) *Cognitive symptoms* include negative views of oneself, inadequate, undesirable, inferior, unattractive, repulsive. Usually a negative view of the future. May complain that their intellectual ability is deteriorating, may be confused and unable to remember things.

v) *Somatic symptoms*, e.g. headaches, indigestion, dizzy spells, tiredness, and disturbances of sleep. Some depressive problems may initially be diagnosed as medical problems (Simon & Katzelnick, 1995; Coyne et al, 1995)

A further typology is offered by Rutter (1986) who characterises depressed thoughts as follows: i) Feelings of unworthiness or self blame for what has happened. ii) Depressed people think they are unable to change the situation.

iii) Pessimism about the future (Rutter, 1986).

Reactive and endogenous depression

Reactive depression occurs in response to a traumatic event e.g. bereavement, losing job, home, failure, having heart attack or other health problem. Can also occur as part of e.g. Alzheimer's disease, withdrawal from e.g. alcohol, cocaine, amphetamines. In these cases depression is seen as a response to life stress or physical change and is not usually taken to indicate a mood disorder. *Endogenous depression* has no obvious precipitating cause.

Winston Churchill and the 'black dog'. People with depression distinguish between the 'black cloud' of depressive episodes and ordinary unhappiness, according to Hamilton (1982).

Mania & manic depression (Bipolar affective disorder).

Mania involves a flight of ideas, elevated mood, and increased psychomotor activity. Extreme so that normal social functioning is disrupted. May involve extreme and hostile overactivity. In addition hypomania is distinguished where people have some manic symptoms but social or job functioning is not disrupted. DSM distinguishes between *Bipolar disorder* - mania alternating with periods of depression; - *Bipolar II disorder* hypomania alternating with periods of depression; and *Cyclothymia* with hypomanic and mildly depressed episodes. Lithium the most popular treatment, relieves symptoms of about 2/3 of manic patients (Janicak and Boshes, 1987). Seasonal variations - depression in the winter and mania in the spring and summer so phototherapy - expose patient to light for 2-4 hours per day. Not known why it works (Wehr et al 1987). Some patients unwilling to continue treatment because of the pleasant cognitive and behavioural changes that come with elevated mood (Jamison et al, 1980).

The incidence and prevalence of depression

Incidence of depression Helgason (1979) study of Icelanders born between 1895 and 1897. 1 in 8 chance that Icelanders would develop an affective disorder before the age of 75. Holden (1986) estimates 6% of US population

experiences depression in any 6 month period. About 20% of depressed people receive treatment. Other estimates come from the National Co-Morbidity Survey (Kessler et al, 2005) where as many as 21% of their sample of over 9,000 Americans had suffered a mood disorder at some time in their lives.

One world-wide study on depression suggests that the incidence of depression is increasing (Weismann et al, 1992, Klerman, 1985; Klerman & Weismann, 1989). The risk of depression has increased with each generation since 1915. Efforts were made in these studies to ensure that the methods used to identify problems were comparable for each generation studied.

Although younger people are more at risk, opinion research (e.g. Newsweek, 1992) suggests that older people are more likely to feel bad about themselves when they can't pay bills, do something immoral, get divorced, be overweight, do something embarrassing, or receive criticism from someone they admire, compared to younger people.

Risk factors for depression can include *stressful life events* in the period leading up to the depressive episode. Paykel (e.g. 1982; 1983, Paykel and Cooper, 1992) has noted that depressed people have a greater number of these events in the year leading up to the disorder with a particular concentration in the few months before onset.

Gender Women are about twice as likely to have a major depression than men (Nolan Hoeksema, 1987). This is true of both treatment seeking rates and incidence rates. Maximum period of risk seems to be mid to late twenties. In the UK some researchers have found that if you are a woman having three young children at home, lacking a close confidant not being employed outside the home, losing one's mother before the age of 11 increase the likelihood of depression (Alloway and Bebbington, 1987; Brown, 1988; Brown et al, 1973).

Demographic factors and depression

Marital status and place of residence. According to Weismann et al (1991) if you are separated or divorced you are more likely to be depressed than married, widowed or never married people. Place of residence is associated with being depressed - 16% of nursing home residents in the US suffer a major depressive disorder, compared to 9.2% in prisons, 4.4% in mental health facilities and 2.7% in private households.

Leaf et al (1986) being separated or divorced is a risk factor, married people lower rates of depression.

Weismann (1987) identifies the pileup of stressful events, having a family history of depression, being a young child with a depressed parent as all increasing the likelihood of being diagnosed depressed.

Social class, gender and children

In the UK the social and demographic correlates of depression have been investigated most fully in the Camberwell Study (e.g. Brown and Harris, 1978, Brown et al, 1995). The study has now been taking place for over 20 years. This study highlights the importance of factors such as poverty and the loss of one's mother before the age of 11. In addition, they also identified the stress of child rearing, and the presence or absence of a close relationship with another adult. In addition they noted that working class women were more likely to experience severe negative events. Thus, the Brown and Harris research highlights the problems of material adversity a lack of direct economic power and not having access to the labour market. They also found some interactions, such that childless women from all socio-economic groups had similar rates of depression, whereas those with children were more likely to be depressed if they were from a lower SES. The link between poverty and depression is also promoted by Groh (2007). Finally, Brown et al (1995) argue that the crucial factor is a sense of entrapment or humiliation, rather than loss or threatened loss per se. In the US Mirowsky and his colleagues (Mirowsky, 1990; Ross and Mirowsky, 1988) a similar picture emerges. Amongst employed married women with children in their studies, they found that depression was related to the degree of responsibility for childcare. If childcare was shared between both partners then women were no more likely than the men to be depressed. Whereas the likelihood of depression increased with higher childcare responsibilities.

Alternative formulations of depression

The nature of the construct of depression reflects cultural values and ways of thinking about persons. The concept of depression individualises a social transaction (Wiener & Marcus, 1994, p 225) 'helplessness, powerlessness and worthlessness do not occur in social vacua'. Allwood (1995) notes how depression serves a number of social functions, in that it urges people to see life events as matters of the mind rather than public domain, encouraging internal self regulation, especially of women, and as a form of liberal humanist therapeutic theory it encourages a burdensome personal responsibility rather than a need for social change.

Bonnie Burstow (1992) in 'Radical feminist therapy' identifies women's depression as a kind of protest 'depression paradoxically is often the strongest protest that people can muster in a dehumanising situation.' (p 63). Horsfall, (1998, p. 228) says that 'culture and gender relations structure vulnerabilities to extreme distress and disturbance which may be construed as psychiatric. Jacobs (1994) sees the bulk of psychopathology as resulting from deprivation and abusive backgrounds and argues that clinical and research literature has systematically ignored this in favour of biomedical notions of pathology. Gilbert (2000) sees depression as being to do with a loss of status or social rank. Scheff (2001)

sees it as being about shame. A number of commentators, including Pilgrim and Bentall (1999) speak of what they call 'the medicalisation of misery' – that sufferers and health professionals are apt to give a medical-sounding title to their distress more commonly nowadays than in the past.

Depression around the world

A good deal of research on depression (and other problems) is conducted from a European or American point of view, many researchers tend to see other culture's problems as masked versions of their own (Patel and Winston, 1994). Ndeti and Muhangi (1979) report that anxiety and depression were the commonest problems at a rural clinic in Kenya. Yet they say that 'none of the patients complained of subjective symptoms of either apprehension or fearfulness in the case of anxiety' (p.270). Likewise, there was a lack of 'sadness, guilt or nihilism in the case of depression' (p.270). Even 'direct enquiry about these feeling states also failed to elicit positive responses' (p.270). It would appear that the power of the language of Western diagnostic systems enabled even the absence of key features of anxiety and depression to be glossed over or ignored in the eagerness to find a diagnosis.

Some other evidence about the prevalence of depression comes from Kleinman, (1988) who claimed that depression was rare in India, Africa and other non western cultures. Kleinman believes that depression rates are elevated in response to the pressures of modernisation and industrialisation. In Taiwan, claims Kleinman, in two studies by Lin et al done 15 years apart in the late 1940s and the 1960s a significant increase in depression and anxiety disorders was noted. In China, says Kleinman, most of the research done from the 1950s onwards does not detect depression until after about 1980.

Some authors argue that people express their distress through more somatic symptoms in non western countries, for example by sleep disturbance, fatigue, weakness and weight loss (Manson & Good, 1993; Marsella, 1980)

Theories of the causes of depression

Psychodynamic models of depression

In the early years of the 20th century Freud (e.g. 1917) conceptualised depression as a reaction to a loss. The similarities between depression and grieving have been established recently too (Beutel et al, 1995; Stroebe et al, 1992). According to this model people respond to losses by regressing to the oral stage and introjecting the lost person or object. Whereas this passes in most cases some people become preoccupied with the sense of loss and become angry with their lost love object for deserting them. Because the love object has been introjected, the anger becomes anger at the self. Some later *object relations* thinkers in the same tradition that the threat of loss is also a significant factor (e.g. Kernberg, 1997) such that people who are insecure in their relationships with others will become depressed.

Research evidence suggests that there may be some relationship between early losses and depression later in life. Bowlby (1980; 1969) coined the term anaclitic depression for this phenomenon. A study of 1,250 medical patients by Barnes and Prosen (1985) indicated that those whose fathers had died in their childhood were at greater risk of developing depression. This finding is supported by other studies comparing people who have lost parents early in life with those who have not (Crook & Eliot, 1980). Childhood experience of parenting has been addressed retrospectively by e.g. Parker, (1992). People who report a childhood featuring 'affectionless control' are more likely to be depressed later (Parker et al, 1997). The view of the self in dreams has been investigated by Hauri et al (1974) and suggests that depressed people show higher levels of hostility and masochism.

However, not all depressed people have undergone a loss, and only about 10% of people who have experienced a loss experience a major depressive episode (Paykel & Cooper, 1982). Equally some studies have not found a link between childhood loss and later depression, (Parker, 1982) and others have not found a link between hostility to self or others and depression (Klerman, 1984)

Biological aspects;

Heredity e.g. twin studies, kinship studies are taken to suggest heredity's role. E.g. Weismann et al (1984) younger a person is when s/he first experiences depression then the more likely relatives are to be diagnosed depressed.

Neurotransmitters have been implicated in depression, particularly the monoamine group, the most important of which are norepinephrine (noradrenaline) NE, Dopamine (DA) and the indoleamine serotonin (5HT).

Catecholamine theory of depression - that depression results from a decrease in NE and DA in the brain. Theory based on the effects of e.g. reserpine depletes NE and DA and causes depression in some patients. MAO inhibitors and tricyclic antidepressants increase the activity of catecholamines in the brain, prevent the breakdown of NE by MAO, or by blocking the uptake of amines and allowing the neurotransmitters to continue to work.

Indolamine theory of depression - serotonin. Traskmann et al (1981) decreased level of serotonin metabolite 5-HIAA in people who'd made suicide attempts, suggesting that depression is associated with low levels of serotonin.

Similar theory about acetylcholine (ACh) - increased brain ACh levels were associated with depression and decreased levels with mania (Gershon and Shaw, 1961).

Neurotransmitter regulation failure theory. Siever and Davis (1985) neurotransmitter activity may be highly variable and may be inappropriate to the situation experienced.

Treatments based on biological theories include antidepressant drugs, tricyclics and MAO inhibitors which increase NE availability, or SSRIs which increase serotonin availability. Tricyclics slow down the reabsorption of NE by transmitter neurone and MAO inhibitors inhibit the enzyme which breaks it up. SSRI's or 'second generation antidepressant' drugs such as fluoxetine and paroxetine which increase the availability of serotonin by inhibiting its reuptake by the secreting cell. Lithium compounds are used in treating bipolar mood disorders, which may alter the balance of body fluids by replacing calcium, magnesium, potassium, sodium, or may slow down the release or increase the absorption of NE.

Attributional models of depression.

Attributional models of depression are based on the causes people assign to things. Depressed people tend to blame themselves when things go wrong and luck when things go right. Nondepressed the opposite. Depressed people feel helpless to control their lives and their environment. Seligman (e.g. 1974) and learned helplessness. The helplessness people feel depends on how they interpret the situation. Depression more likely when people attribute negative qualities to themselves as a result of having experienced situations in which they felt themselves to be helpless (Abramson et al, 1978). 3 dimensions to the feeling of helplessness. i) Whether the person sees the problem as internal or external ii) whether the situation is seen as global or specific - totally helpless or just helpless in this situation. iii) Whether the situation is viewed as stable - persistent (chronic) or unstable - transitory (acute). Research indicates that depression can be produced by either stable or global attributions. Internal attributions can produce depression when they are connected with stable and global components (Robins 1988). However, attributional style is not consistent for all people in all situations. Indications are that attributional style is implicated only in a subgroup of depressed people. *Accuracy* - There's an assumption in psychology that positive self appraisal, internal locus of control etc. is good. But most nondepressed people have: i) Unrealistically positive views of themselves. ii) Exaggerated perceptions of how much control they have over events. iii) Unrealistic optimism about the future. (Taylor & Brown, 1988). People overestimate their degree of control over events that are largely determined by chance, overestimate their role in making a desired outcome happen (Miller & Ross, 1975). Depressed individuals are less vulnerable to the illusion of control (Greenberg & Alloy, 1989).

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Mental health and society week 7 Models of depression and therapies for depression

1) Behavioural models: Depression as a lack of reinforcement

Associated with the work of Lewinsohn (e.g. Lewinsohn et al, 1984; Lewinsohn & Arconad, 1981) who suggests that depression can be caused by a reduction in positive rewarding experiences. As they become more depressed they have fewer sources of reward and thus enter a vicious circle of depression. Even in family settings, depressed people may receive fewer reinforcing comments from family members than nondepressed people (Libet and Lewinsohn, 1973; Lewinsohn & Schaffer, 1971). Depressed people report fewer reinforcing events when asked to keep a 'pleasant events schedule' diary (Lewinsohn et al, 1979). Moreover, depressed people report more negative events in the field of health, finances, professional and academic activities, social activities (Lewinsohn, 1975)

The role of social reinforcement: Evidence for the vicious circle idea of depression comes from findings such as Boyce et al (1993) where depressed people had greater difficulty than nondepressed people with self disclosure, worried about separation from loved ones, feared rejection and misread social situations. In addition Coyne (1976) found that people who had a phone conversation with a depressed person felt worse than usual. In a study by Gottlib and Robinson (1982) people interacting with a depressed person became less verbal, less supportive and less cheerful. This evidence is *correlational* rather than *causal*.

Implications for therapy: As a result of this theory and evidence Lewinsohn and his colleagues have tried a number of therapies with depressed people, These may involve

1) *Reintroducing pleasurable events:* This begins with the client completing schedules of pleasant events and selecting a set of these which the client is then encouraged to engage in each week by means of a 'contract'. There is some evidence that this does indeed lead to greater participation in the activities and an improved mood (Teri and Lewinsohn, 1986; Lewinsohn & Graf, 1973).

2) *Reinforcing non-depressed behaviour,* such as talking, going to work, and ignoring depressed behaviours like complaining, crying and self-deprecation. People's family members can be enlisted in this (Lieberman & Raskin, 1971)

3) *Teaching social skills:* Depressed people are liable to act despondently in social settings, so other people are likely to keep their distance. Depressed people can be taught to exercise effective social skills. This is often done by means of role play, where clients practice eye contact, tone of voice, facial expression, posture and other interactive skills. This seems to improve clients' interactive skills (Hersen et al, 1984; King et al, 1974)

On their own these therapeutic techniques do not necessarily result in improvement, but combining several of them can be effective, especially with mild or moderate depression (Lewinsohn et al, 1982; 1984; 1990). Lewinsohn's therapy has developed to include classes, textbooks, homework assignments. The programme typically lasts eight weeks and Lewinsohn reports improvements in 80% of clients.

Cognitive models: Depression as a kind of distorted thinking

This is associated with the work of Aaron Beck (e.g. 1967; 1991) who sees depression as involving negative thoughts. These he breaks down into:

1) **Maladaptive attitudes:** Originates in childhood, and is based on the way children learn to perceive themselves as a consequence of how others perceive them. Children may come to believe that their worth as a person is tied to every task they perform. Thus, life's failures and setbacks may come to take a heavy toll. The negative attitudes become a kind of schema against which the child evaluates all experiences (Beck et al (1992)

2) **The cognitive triad:** This involves people making negative interpretations of i) their experiences - often interpreted as burdens, ii) themselves - as deficient, undesirable or worthless, and iii) their futures - as bleak and full of hardships, frustrations and failures.

3) **Errors in thinking:** These were broken up further by Beck into i) Arbitrary inference - negative conclusions based on little evidence. ii) Selective abstraction - focusing on failures in an otherwise satisfactory situation. iii) Overgeneralization - forming a generally negative view of oneself from a single failure. iv) Magnification and minimisation - underestimating the significance of positive experiences and overestimating the importance of negatives ones. v) Personalisation - seeing oneself as the cause of problems.

4) **Automatic thoughts:** many of these aspects of thinking become habitual, so that the depressed person is constantly giving themselves reminders of their failures.

5) The totality of depressing thoughts can form a **feedback system** or vicious circle. Experiencing the symptoms will be self confirming.

Research and therapy on the cognitive model

Beck's model has stimulated a great deal of research and therapy since his development of it in the early 1960s. E.g. Garber et al (1993) found that depressed people regularly experience negative automatic thoughts. Reading statements to oneself which resemble automatic thoughts makes one increasingly depressed (Strickland et al, 1975). People who were inclined to ruminate about their mood were more inclined to experience depression for longer

periods (Nolen-Hoeksema et al, 1993). In another study by Rush et al (1986) the researchers studied 15 depressed women who were interviewed after their depressive symptoms had started to decline. Those who still had maladaptive attitudes were more likely to have a relapse within six months.

Cognitive Therapy for depressed individuals may involve:

1) Increasing activities and elevating mood. This is a common feature with behavioural therapies (see above). The therapist may help the client prepare a schedule of activities for the coming week. As therapy proceeds, the weekly schedule becomes more demanding and more active.

2) Examining and invalidating automatic thoughts. This may involve 'homework' of recognising and recording negative thoughts. These can then be reviewed in the subsequent therapy session. The therapist can question the validity of the thoughts. This is sometimes referred to as collaborative empiricism, where the client and therapist try to get at the reality behind the thoughts and conclude that they are groundless.

3) Identifying distorted thinking and negative biases. As clients begin to detect the fallacies in their automatic thoughts therapists can help them identify other illogical features in their thinking. That is, people might be engaging in 'dichotomous thinking' where e.g. anything less than perfection is an abject failure. With self blaming clients therapists might use 'retribution techniques' to guide their clients to identify other possible causes of problems.

4) Altering primary attitudes. This might involve questioning the primary attitudes that got the client depressed in the first place. By encouraging clients to test their attitudes the therapist can encourage further change in a positive direction.

Evaluating the effectiveness of cognitive therapy.

There are a number of studies which show that cognitive therapy can be successful compared with a placebo group (Hollon & Beck, 1994; Pace and Dixon, 1993; Hollon et al, 1993). Moreover, clients who do respond to this therapy tend to show steadily more positive feelings about themselves.

Cognitive and cognitive behavioural therapies have proved popular with therapists yet there are some questions of a broader philosophical and political kind left unanswered. Many philosophers (e.g. Derrida, 1973) are suspicious of the idea that we necessarily have an inner self conscious core that we can discover by ourselves or with the help of others. Whereas the likes of Beck can identify features of these 'cognitions' no one is really sure what they are (Parker et al, 1995). There is some scepticism of the idea that what happens in the individual's head frames what happens in the social world. There is also the implied optimism of the therapeutic view - negative thoughts are almost by definition *wrong* ones.

Moreover as Smail (1993) argues, understanding and itemising the distress does not necessarily lead to a change in the conditions that brought it about. Although the cognitive approach makes use of the idea of attitudes and beliefs it does not generally analyse how they might have come about in the first place. This is because when cognitive therapists talk about them they are usually cut off from the environmental context that makes them intelligible.

Much cognitive therapy and research thus falls under the heading of philosophical nominalism, the idea that the individual exists before society, and society was created subsequently as a result of a social contract between individuals. Thus, we have the origins, says Emerick (1996) of this disparate collection of individuals seeking self centred personal assistance. It is this view that has pervaded the literature on depression.

What happens to clients whose distress can't be brought under control by keeping diaries or challenging their cognition

Befriending, listening and depression

Harris et al (1999) describe an intervention with depressed women who were recruited through a postal questionnaire. Out of 4000 people who were screened a total of 104 were found who had depressive symptoms, were not seeing another therapist and were interested in being in a befriending scheme. Half of them were given befrienders. Of those given befrienders 65% got better, compared with a 'spontaneous remission' rate of 39% in the control group. Similar results have been reported in studies of elderly people being visited by a community nurse (Blanchard et al, 1995) where 55% of depressed elderly clients who were visited regularly improved compared with 20% of those who did not receive visits.

Listening visits in pregnancy were advocated by Clement (1995) as a way of reducing the incidence of postnatal depression - these visits can be undertaken prior to the birth, during pregnancy. Postnatal depression is relatively widespread, affecting between 12% and 15% of those who have babies (Cox et al, 1982, Kumar and Robson, 1984; Watson et al, 1984). However, it does seem to respond to 'listening visits. In a study by Holden et al (1989) a series of 8 listening visits were made to postnatally depressed women. After 6 months only 31% of those who were visited were still depressed, compared to 62% of those who were not.

The effectiveness of the befriending and listening strategies seems to be comparable to antidepressant treatment, according to Harris et al (1999)

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