Chapter – 1

Introduction
Depression is listed as the chief complaint by more than half of all people coming to outpatient clinics. According to recent reports, depression now rivals schizophrenia as the nation’s number one mental health problem. That fact makes depression numerically significant as well as important from human standpoint. Thus, the possibility of suicide frequently exists, in which case treatment results as a matter of life and death. Prompt intervention, emergency psychotherapy, therefore plays a crucial role in the care and treatment of the depressed people.

Depression has featured throughout history as perhaps the most pervasive of all psychopathology (cf. Boyd et al., 1982). If clinical depression was experienced as the “Epidemic of the 70s”, then it must be said that the epidemic appears to be growing. There is no evidence to indicate that the prevalence rates of depression are declining, and suicide appears to be on the increase especially among young adults. A disorder that will affect 5% to 10% of all adult males and 10% to 20% of all adult females demands the attention of mental health services and practitioners (Weissman & Paykel, 1974). Further, as society faces the continuing prospect of high unemployment and other difficulties one may suspect that depression will continue as major mental health problem for years to come.

Some of the apparent paradoxes of depression are highlighted by Beck: “The instinct for self-preservation, and the maternal instincts appear to vanish. Basic biological drives such as hunger and sexual drive are extinguished. Sleep, the easer of all woes, is thwarted. Social instincts such as attraction to other people, love, and affection evaporate the “pleasure principle”, and “reality principle”. The goals of maximizing pleasure and
minimizing pain are turned around. Not only is the capacity for enjoyment stifled but the victims of this odd malady appear to be driven to behave in ways that enhance their suffering” (Beck, 1974).

It has become customary to define depression in phenomenological terms rather than its meaning (Cholst, 1981; Depue & Monroe, 1978a; Spitzer, Sheehy, & Endicott, 1977; Blumenthal & Dielman, 1975). It makes sense to consider depression as disrupting a person’s thinking processes, emotional reactions, and day-by-day behaviours (Williams, 1984; Farby, 1980). Schuyler (1974) suggested that depression could mean a lifestyle, a temporary reaction to some important event, an enduring symptom or feeling state, or a more serious disturbance. Zung (Farby, 1980, p.590) proposed an operational definition of depression in a holistic sense and drew attention to the generalized disturbance or withdrawal of such functions as thought, feeling, experience, and emotion.

The depressive script as derived from empirical studies of depression related behaviour (Gotlib & Robinson, 1982) and the description of a major depressive episode (with psychomotor retardation) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980) clearly suggests that the persons in the depressed condition express pessimism (e.g., “Right now I am so far behind, I’ll never catch up”), apathy (e.g., “I have given up”), helplessness (e.g., “It does not seem to matter what I do, I just fall farther behind”), and sadness (e.g., “Being with other people makes me feel more alone”). Regarding their academic and relationship problems, they also limit eye contact and speak slowly in a low, monotonous tone, with an increased latency response. Deficits in energy (e.g., “I am really not up to it”) and interest in social activities (e.g., I have not felt like going out with friends or anyone”) are also acknowledged.

Diagnostic schemes, such as the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R, American Psychiatric Association, 1987) identify cardinal symptoms that include distinct patterns of daily behaviour (e.g. social isolation) and a list of psychological states (depressed mood, low energy, poor concentration, loss of interest in normal activities, feeling of fatigue, psychomotor agitation, and a sense of worthlessness) presumed to permeate much of a person's working hours.
Although there is an increasing recognition that pessimism may be expressed differently in childhood and adolescence than in adulthood (Carlson & Gaber, 1986; Rutter, 1986), these features of daily behaviour and psychological experience are included in most classifications of depression (McConville & Bruce, 1985). More recently Larson, Raffaelli, Richards, Ham, & Jewell (1990) found that depressed youth reported more negative effect and social emotions, lower psychological investment, lower energy, and greater variability in affect. These differences were weaker for 5th and 6th grades, suggesting that self-reported feeling states are a poor indicator of depression prior to adolescence.

It is assumed that development pathways that sequentially link these constructs exist in the course of normal and pathological development, although little is actually known on the rates and patterns of these transitions (cf. Formbonne, 1994). However, important methodological differences exist across studies according to the particular operationalization of depressive phenomenon that is used, and this jeopardizes the efforts to compare results across studies. These core symptoms represent a distillation of the observation on depression made by clinicians from the beginning of recorded history. Kraepelin’s description of what he called “melancholia simplex” neatly summarizes the nine diagnostic criteria of DSM-III-R in a precise, descriptive paragraph.

“...the mood is dominated by a profound inward dejection, the patient is hopeless; he is indescribably unhappy, skeptical. Everything is disagreeable, he sees only the dark side of life; the world appears to him aimless, and he feels superfluous. Phobias may occur in simple melancholia, and the patient is tormented with guilt feelings. Energy is virtually absent, the patient has depressive concomitants such as decreased sexual interest, anorexia and weight loss, sleep disturbance with early morning awakening, and psychomotor retardation”, (Kraepelin, 1921).

In the case of DSM-IV, the presence of diminished mood or loss of interest or pleasure in all activities for at least two weeks together with a cluster of other symptoms form the somatic field and psychological domains, is necessary for a diagnosis of major depression to be made. Predictably, the
longstanding diagnostic confusion in the realm of mood disorders renders problematic any comparison between older and newer studies of its epidemiology. If psychiatry is to be considered science, its classification systems must be prepared to change as new discoveries are made. The fundamental challenge is to define exactly when depression crosses the line from being a normal experience into a pathological state.

In more recent times, the concept of depression has been broadened to include milder forms. Clinicians and researchers have debated whether the concept of depression refers to a single disease that varies from mild to severe along a continuum or whether it consists of a set of discrete subtypes that differ in phenomenology, pathophysiology, and ultimately etiology (Everitt, 1981; Kendell, 1976, 1968; Eysenck, 1970; Hamilton & White, 1959; & Lewis, 1938). This debate has yielded a number of different methods for subtyping depressive disorders, such as endogenous vs reactive, psychotic vs neurotic, and primary vs secondary (Nelson & Charney, 1980; Akiskal, Rosenthal, Kashgarian, Khani, & Puzantian, 1979; Bhrolchain, Brown, & Harris, 1979; Andreasen & Winokur, 1979a; Akiskal, Bitar, Puzantian, Rosenthal, & Walker, 1978; Winokur, Behar, Vanvalkenburg, Lowry, 1978; Lewis, 1971; McCcnaghy, Joffe & Murphy, 1967; Rosenthal & Klerman, 1966; Kiloh & Garside, 1963).

Inspite of considerable agreement on the phenomenology of the clinical syndrome of depression, a complete satisfactory explanation has yet to account for the mechanisms underlying the wide variations in symptomatology and course. The identification of psychosocial factors that may cause depression has proven to be an arduous task. The difficulty of demonstrating causal relationships in naturalistic research has been compound by an over-reliance on cross-sectional methodology. Cross-sectional research has been successful in demonstrating differences between depressed and non-depressed individuals; that is, it has identified abnormalities in the functioning of depressed individuals that are present during depressive episodes. Many of these abnormalities, such as dysfunctional cognitions, distressed relationships, anaclitic personality types, and deficits in social behaviors, have been implicated in the etiology of depression by theorists of various orientations (Abramson, Seligman, & Teasdale, 1978; Brown & Harris, 1978;
Beck, 1976; Hirschfeld, Klerman, Chodoff, Korchin, & Barrett, 1976; Lewinsohn, 1976). However, some of these problems in functioning may be symptoms, or concomitants of depression that appear with the onset of a depressive episode and disappear with remission.

The number of competing viewpoints and nosological systems (Wing, 1976; Rush, 1975; Becker, 1974; Klein, 1974; Akiskal & McKinney, 1973; Klerman, 1971; Beck, 1967) clearly mirrors the incomplete knowledge of etiological and contributory factors in the depressive disorders. Nevertheless, as Akiskal & McKinney's (1973) “pluralistic" view of depression suggests, most explanatory models, including psychological and biological models, provide a unique perspective that can contribute to a fuller understanding of these clinical syndromes. Furthermore, although recent reviews have discussed the relationships of individual psychosocial variables with depression or related psychological disorders (Coyne, Kahn, & Gotlib, 1987; Sweeney, Anderson, & Bailey, 1986; Cohen, & Wills, 1985; Akiskal, Hirschfeld, & Yerevanian, 1983), much less consideration has been given to how these variables might interrelate and to how their interactions might affect the development or maintenance of depression.

Thus, the word 'depression' encompasses a huge array of psychological experiences, a heterogeneity found both in the lay and in the professional literature (Formbonne, 1994). From a practical point of view, three levels of definition may be used (Kazdin, 1990; Angold, 1988). Depressed mood or affect refers to a state of dysphoria that occurs frequently in the course of normal development. Depressed mood is part of a broader set of negative feelings (Watson & Clark, 1984), but a lack of positive affect and a loss of emotional involvement with other people, objects or activities constitute specific features that distinguish depressed mood from normal feelings of sadness of more demoralization and from other negative affects such as anxiety. Depressive syndrome refers to a constellation of observable symptoms (of which depressed mood is only one component) such as tearfulness, irritability, death thoughts, loss of appetite, disturbances of sleep, lack of energy, etc. that tend to cluster together. At the individual level, a depressive syndrome is recognized when the behavioural characteristics reach a given threshold that signals a significant deviation from the normal.
Depressive disorders correspond to psychiatric diagnosis of depression as defined in ICD-10 (WHO, 1988) or DSM-III-R (APA, 1987). The present study, however, is concerned with the presence of psychological correlates of depression among nurses in clinical areas.

The classification and measurement of depression has attracted interest and controversy for many years. The great emphasis that has been given to measurement in psychiatry has often been a distraction, but accurate measurement and clarity about diagnostic issues is an essential prerequisite of any scientific process.

Classification has a purpose and is intended to help doctors with their work (Kendell, 1975). There are three main functions: (i) communication; (ii) guiding treatment on prognosis; and (iii) informing research. Classifications have to be useful to survive in clinical practice, and will persist if they are used, even if they find little favour in the scientific journals. If these functions of classification are to be 'effectively' fulfilled, psychiatric diagnoses need to be reliable. Though the reliability of diagnosis tends to be largely a concern of the research community, one should not forget that clinicians also need to be able to make diagnoses with sufficient reliability in order to communicate with each other, their patients, and to apply the results of research studies to their clinical work. In parallel with the discussion of reliability is that concerning the 'validity' of diagnostic categories. This expression is best thought of as utility in the absence of 'gold standard' measures. If diagnoses aid communication, treatment decisions and prognostic predictions then they are useful and in that sense 'valid'.

There is now an international consensus over the diagnostic categories of depression and it is reassuring that both the major diagnostic manuals, DSM-IV-TR and ICD-10, have the same diagnostic criteria for unipolar depression. Of particular note is that the criteria for major depressive disorder can be met even if a person complains of loss of interest rather than low mood. The criteria also allow for hypersomnia and increased appetite as well as the more conventional syndrome in which there is less sleep and poor appetite. Our current classification retains the opportunity to code the somatic syndrome of depression: early morning wakening, weight loss, diurnal variation, retardation or agitation, and loss of libido.
There has been a trend to give less emphasis to the somatic syndrome of depression over recent years. In the past, these 'biological' symptoms were thought to reflect an illness more endogenous and less linked to adverse events in the environment in contrast to neurotic depression. Biological symptoms were also thought to indicate likely response to antidepressant medication. However, both of these statements have been challenged. There is evidence that life events are as common before depression with somatic symptoms as before depression without somatic symptoms (Brown, 1979). The link between a depressive episode and environmental adversity seems more important for the first episode of depression and subsequent episodes seems less linked to adverse events. The antidepressants have also been successfully used in depressed patients without the somatic syndrome (Geddes, 2000).

The change in the perceived utility of the somatic syndrome has led to more emphasis on thinking of depression along a continuum of severity (Lewinsohn, 2000; Paykel, 1992). This is in tune with a long tradition within medical epidemiology that argues that almost all medical conditions in the community are most accurately viewed along a continuum (Rose & Barker, 1978). For clinicians, categories are useful in order to guide decision making, but in the real world most illnesses including depression do not exist in simple categories but along continua. Kendell's (1968) classic study illustrated the continuum between the neurotic and endogenous forms of depression. Likewise, community surveys illustrate that the key symptoms of depression are common in the community and exist across the whole range of severity (Jenkins, et al., 1997).

Most patients with depression are treated in primary care or its equivalent (Regier, 1978; Shephered, 1966), and it is important to be aware that in primary care the whole range of depressive syndromes will be seen. Primary care physicians will see a large number of people in a 'grey' area where treatment decisions are difficult to make. One of the major challenges of research in this area is to help primary care physicians rapidly assess the severity of depression and link this with decisions about pharmacological and psychological treatment. There is increasing concern within primary care that patients with very mild depressive symptoms or problems of living are being
medicalised and treated with antidepressants. Making the diagnosis of depression is at the heart of this controversy and in the context of primary care regarding depression along a continuum of severity seems particularly important.

**DISABILITY AND DEPRESSION**

Several studies have shown a close association between depression and disability in both Western and non-industrialised countries (Ormel, 1994; Broadhead, 1990). The association persists after statistical adjustment for the presence of physical illness and across time. Wells et al. (1989) studied more than 11,000 patients with different chronic diseases to find that the level of disability among patients with depressive symptoms, whether or not meeting diagnostic criteria for depression, was comparable or greater than that associated with the most frequent physical chronic diseases such as diabetes and hypertension.

**Table 1.1 : Global burden of disease (GBD) measured in disability adjusted life years (DALYs) lost in illness (cf., Murray, 1997)**

<table>
<thead>
<tr>
<th>Illness</th>
<th>% of DALYs lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Problems</td>
<td>8.1</td>
</tr>
<tr>
<td>Maternal/perinatal</td>
<td>9.5</td>
</tr>
<tr>
<td>Respiratory</td>
<td>9</td>
</tr>
<tr>
<td>Cancer</td>
<td>5.8</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>4.4</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td>3.2</td>
</tr>
<tr>
<td>Malaria</td>
<td>2.6</td>
</tr>
<tr>
<td>Other Communicable</td>
<td>5.3</td>
</tr>
<tr>
<td>Other Non Communicable diseases</td>
<td>18</td>
</tr>
<tr>
<td>Behaviour related illness</td>
<td>34</td>
</tr>
</tbody>
</table>

**Table 1.2 : The Global burden of disease in 2020 (cf., Murray, 1997)**

<table>
<thead>
<tr>
<th>Illness</th>
<th>% of DALYs lost to illness</th>
</tr>
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<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>5.9</td>
</tr>
<tr>
<td>Unipolar depression</td>
<td>5.7</td>
</tr>
<tr>
<td>Road traffic accidents</td>
<td>5.0</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>4.4%</td>
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</table>
Common mental disorders have also been linked to important indirect costs due to either diminished productivity or absence from work. Broadhead et al. (1990) found that people with depression had 4.8 times higher risk than people without symptoms of having had sickness leave. More recently, an American study found that for every 100 workers, 6 days of work are lost for sickness leave and 31 days are lost for diminished productivity every month due to poor mental health (Kesslar, 1997).

The World Bank Report and associated publications (Murray 1997a; Murray 1997b; Murray 1997c) have provided the first estimates that have allowed comparison between depression, other psychiatric disorders and physical illness leading to death. The report estimated that neuropsychiatric disorders led to 8% of the global burden of disease (GBD) measured in disability adjusted life years (DALYs) lost to illness (Table 1.1). For adults aged 15-44 years, psychiatric disorders are estimated to account for 12% of the GBD; if 'self-inflicted, unintentional injuries' are added, the proportion reaches 15.1% for women and 16.1% for men. In fact, mental disorders are projected to increase to 15% of the global disease burden and major depression is expected to become second only to ischaemic heart disease in terms of disease burden by the year 2020 (Murray 1997), (Table 1.2).

Psychiatric disorder has received little priority in the non-industrialised world. Demographic transition and improved measures to combat infectious diseases are leading to a change in the pattern of disease in many poor countries. In Chile, for example, life expectancy is now over 70 years and, alongside many other areas of the world, the burden of disease is largely produced by non-communicable diseases, familiar to those in the West. These changes will contribute to the growing importance of depression and other psychiatric disorders in world health (Feachem, 1992).

These figures, with all their caveats, have profound implications for public health and epidemiological research. Depression in particular, is as big a potential public health issue as ischaemic heart disease (IHD). For IHD, the major risk factors of high cholesterol, smoking, and hypertension are well known and preventive strategies are proposed in relation to all these factors. In contrast, little is known about the aetiology of depression and, in particular, there is little evidence for strategies that would lead to primary prevention of
depression. Therefore, from the perspective of public health, depression must be a major priority for research (Murry, 1997).

CORRELATES OF DEPRESSION

Depressive symptoms are frequent in physically ill adults, occurring in 22-23% of all medical in-patients (Levenson et al., 1987) and in 6-28% of medical out-patients (Broadhead et al., 1989). Between 20 and 58% of depressed in-patients have physical illness (Keitner et al., 1991), and findings from the medical outcomes study show that 68% of depressed out-patients have at least one of eight chronic diseases (Wells et al., 1989).

It is common to observe depressive symptoms following various types of endocrine dysfunction that include hyperthyroidism, hypothyroidism, autoimmune thyroiditis, hyperparathyroidism, hyperinsulinism and adrenal cortical hyperplasia. Associations have been reported between depression and other physical conditions including stroke, hypertension, upper respiratory infection or chronic lung disease, cardiovascular disease, diabetes, and cancer (Stern & Bachman, 1991; Wells et al., 1989).

These associations have not been conclusively established. For example, Murrell (1983) found no difference in the prevalence of depression between those with and without diabetes and Zonderman et al. (1989) could not replicate an association between depression and cancer.

The somatic condition that has been found to co-occur consistently with depression is migraine headache. The results of several systematic studies show a strong association between migraine and depression among patients undergoing treatment for migraine (Jarman et al., 1990), patients in treatment for depression (Marchesi et al., 1989) and subjects from the general population (Breslau et al., 1991).

Moldin, Scheftner, Rice, Nelson, Knesevich, & Akiskal (1993) examined association between depressive disorder and physical illness. The association between major depressive disorder (MDD) and self-reported histories of specific physical illness was investigated in 320 controls of 968 first-degree relatives and 254 spouses of probands in the NIMH collaborative depression study. The Affective Disorders and Schizophrenia – Lifetime Version was used to assign Research Diagnostic Criteria (RDC) for diagnoses
and a structured self-report instrument was used to assess lifetime medical history. Lifetime MDD was diagnosed in 914 subjects, 402 of whom had been hospitalized or received somatic treatment (treated MDD). Strong associations were observed between MDD (either treated or untreated) and both frequent/severe headaches and migraine headaches. To report migraine there was a marked gender effect, such as the relative odds for a woman with treated MDD were over 5.1. Other associations were found between MDD and skin infections, respiratory illness, ulcer, hypertension and diabetes. The authors remarked that this is the largest non-patient sample using standardized assessment of mental disorders by direct interview in which associations between specific physical illness and MDD have been demonstrated.

Beekman, Kriegsman, Deeg, & Tilburg (1995) examined the association of physical health and depressive symptoms. In this study the relation between four aspects of physical health and depressive symptom’s levels were studied in a community-based sample of older inhabitants of a small town in the Netherland (n=224). Results indicated that depression is sufficiently different from physical health to be distinguished from it, and that it is sufficiently related to physical health to be relevant for further study. The more subjective measures of physical health used in this study (pain and subjective health) appeared to have a much stronger relation with depression than the more objective health measures (chronic diseases and functional limitations). Physical health and aspects of the social environment such as marital status appeared to have independent effects on mood. In this study these effects were moderated by age and sex. In women and the young-old (55-64) none of the associations between physical health and depression were significant. In men and the young-old (75+) all associations were highly significant.

A number of studies have also shown that ongoing depression is associated with social support, negative cognitions and social adversity. Depressed individuals have greater difficulties in interpersonal interaction (Brugha, 1995; Upmanyu, Upmanyu, & Dhingra, 1992; Coyne, 1976; Weissman & Paykel, 1974), less gratifying social contacts (Costello, 1982; Roy, 1978) and a weak social support system (Andrews et al. 1978). They
also manifested a variety of negative cognitive patterns (Umanyu & Reen, 1991; Teasdale, 1988; Lewinsohn et al., 1981; Seligman et al., 1979; Beck, 1967). However, only prospective studies can establish whether these characteristics precede a depressive episode and whether they can be used to predict a new onset (Lewinsohn et al., 1988). Although the role of stressors in provoking depressive episodes is well documented (Billings et al., 1983; Paykel, 1978). Such events cannot usually be used for predictive purposes since they are usually too closely linked in time with the onset itself, usually occurring in the prior few weeks. In brief, it is imperative to note that the role of negative cognition, stressful life events and social support is well documented in the literature.

Keeping in view the discussion in the preceding paragraphs, the present study was designed to study the psychological correlates of depression among nurses.