CHAPTER - I

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In this section, first, the importance of studying depression and its prevalence will be presented, and then, the main prevailing theories of depression will be briefly reviewed, and finally, after considering the biopsychosocial approach, need and rational of the present study will be discussed.

1.1 Importance of studying depression

"For nearly 2500 years mood disorders have been described as the most common diseases of mankind, but only recently they command major public health interest. The World Health Organization has ranked depression fourth in a list of the most urgent problems worldwide" (Akiskal, 2000, p.1284). Moreover, by 2020, major depression is predicted to be second only to heart disease as cause of worldwide disability (Murray and Lopez, 1997).

Depressive disorder can have severe consequences in terms of suffering, disability and increased mortality, particularly if left untreated (Conti & Burton, 1994). They are prevalent in all cultural settings and present a major difficulty for the normal functioning of the patients' families (Sartorious, 2003; Sinha, 2002). The economic burden on family members and society is considerable (Pahlavian, Golmohamadi, Sadri & Zamanian, 2003; Patel, Rodrigues & Desouza, 2002).

In several studies conducted in Western countries, India and Iran, it was found that depression forms an important etiological factor in suicide (Bhandari, Upmanyu & Goyal, 2002; Kaviani, Rahimi & Naghavi, 2004; Pahlavian & Malaki, 2000). Hence, consistent with the cumulative studies, it should be noted that depressive disorders are a public health problem (Scott & Dickey, 2003). They occur frequently, and it is likely that their prevalence will grow in the years to come due to demographic change in most countries.
of the world that increase the number of people at high risk for depressive disorders (Satorious, 2003)

It is estimated that 8-18% of the general population will experience at least one clinically significant episode of depression during their life (Kessler, McGonagle, Swartz, Blazer & Nelson, 1993; Weisman et al., 1999) and that approximately twice as many women than men will be affected by this disorder (Blehar & Oven, 1995). Over 50% of depressed patients have been found to relapse within two years of recovery (Mueller et al., 1996; Scott & Dickey, 2003). This high rate of recurrence of depression suggests that there are individuals who are prone to experience depression repeatedly because of presence of a stable vulnerability factor or diathesis (Gotlib & Abramson, 1999). Research also suggest that as many as 18 per cent of all adults in the world may experience an episode of severe unipolar depression at some point of time in their lives (Commer, 1999). Women are over twice as likely to suffer an episode than men, largely for psychosocial reasons (Gilbert, 2000).

Analysis of 10 Indian studies on psychiatric morbidity, to estimate the median values for prevalence rates, for major affective disorders revealed it to be 31.2 per 1000 population. The urban morbidity rate was 2 per 1000 higher than rural rate (Madhav, 2001). Few studies in Iran showed that in recent years the rate of depression has been increasing because of psychosocial factors (Mohammadi et al., 2003; Noorbala, Bagheriyazdi, Yasamy & Mohammad, 2004). In an epidemiological study of psychiatric disorders in Tehran province, that have been recently reported, anxiety and mood disorders were the most prevalent psychiatric disorders with 6.83 % and 4.46% respectively (Mohammadi et al., 2003).

International data show what seems to be a modern epidemic of depression; each successive generation worldwide since the beginning of the twentieth century has lived with a higher risk than their parents of suffering a major depression. Although the likelihood of becoming depressed rises with age, the greatest increases are among young people. For those born after 1955 the likelihood that they will suffer a major depression at some point in life
is in many countries, three times or more greater than their grandparents. Among Americans born before 1905, the rate of those having a major depression over a lifetime was just 1 percent. Among those born in 1955, by age 24, about 6 percent had become depressed. For those born between 1945 and 1954, the chances of having had a major depression before age 34 are ten times greater than for those born between 1905 and 1914. For each generation the onset of person's first major depressive episode has tended to occur at an ever-earlier age (Goleman, 2000). These data from various societies are strong evidence for the role of socio-cultural factors in etiology of major depression. If this illness were based exclusively in a genetically inherited brain disease, the great increase in prevalence and the rapidly decreasing age of onset observed in societies around the world during the 20th century would not be found (Castillo, 1997).

These data also indicate that rapid changes in the socio-cultural environment are detrimentally affecting the mental health of persons in many societies. Modernization brings with it increasing individualism, the breakdown of traditional social support systems such as family and religious structures, and injects the influence of market-driven values into all aspects of life. It is most likely that these macro-level factors in the socio-cultural environment are largely responsible for the significant changes in age of onset and prevalence of major depression over the last several decades (Castillo, 1997).

1.2 Theories of depression and related issues.

Depression affects us in many different ways and symptoms are spread over different aspects of functioning (emotional, cognitive, behavioural, motivation and biological). Depression can arise for many different reasons. Biological and psychological processes often interact with environmental events. As Beck (1983) pointed "mental disorders, such as depression, should not be considered as either psychogenic or biochemical, reactive or endogenous. A more sophisticated way of looking at such
reactions is to recognize that the psychological and biochemical phenomena are simply different sides of the same coin" (p. 265). Although several theories, with substantial research support, have emerged to explain the origins of depression, still one cannot say with certainty what the cause of depression is or how it can best be treated. However, highly educated guesses can be made (Rosenhan & Seligman, 1995).

There are four main theories and therapies for depression. The biological model, psychodynamic model, interpersonal and environmental model and the cognitive-vulnerability stress model of depression. These theories overlap, and there is also a good deal of overlap in the therapies each recommends, but each tends to focus on an aspect of depression. In this section the above theories will be briefly presented.

(a) Biological aspects of depression

Proponents of this view have focused almost entirely on the brain (biogenic amines) that helps transmit impulses across the gaps (synapses) between nerve cells. Much of the current research interest focuses on the idea that depression reflects abnormalities in biogenic amine metabolism (Frude, 1998). They are divided into two groups with different chemical structures: catecholamines, which include norepinephrine, epinephrine, and dopamine, and Indolamines, which include serotonin and histamine. Low levels of these substances could account for many of the symptoms commonly associated with depression. Several researchers revealed that executive function of the cortex, which include problem solving and ability to concentrate are also clearly impaired and may be related to the findings of reduced activity in the left prefrontal cortex and overacting of the right frontal lobes (Bench, Frackowiak & Dolan, 1995).

In spite of above findings, researchers (Carson, Butcher & Mineka, 2000) believe that any simple theory such as the early monoamine theory of depression is not supported. Depression is not caused simply by isolated deficits in one or more neurotransmitter systems. Moreover, given the
heterogeneity of unipolar depression (e.g., dysthemic, unipolar depression
with or without melancholic and psychotic features), it is highly unlikely that
any single abnormality would be found in all patients.

(b) Psychosocial causal factors

Growing awareness of biological factors in the etiology of depressive
disorders does not, of course, imply that psychosocial factors are irrelevant.
Indeed evidence for important psychosocial causal factors in most mood
disorders is at least as strong as evidence for biological factors. Biological
and psychosocial approaches to understanding the mood disorders can be
made compatible because in many ways they are simply working at different
levels of analysis (Carson et al., 2000). There are three major psychosocial
theories of depression that have received much attention in psychological
studies. First is psychodynamic view, which emphasizes the unconscious
conflicts in association with grief and loss. Second, interpersonal and
environmental model that emphasize how depressed people. Lastly,
cognitive theories of depression, which consider the meaning or interpretation
that people, give to their experiences.

(i) Psychodynamic theories of depression

The first serious challenge to Kraepelin's biogenic theory of mood
disorder came from Freud and other psychoanalytic theorists, who argued
that depression was not a symptom of organic dysfunction but a massive
defense mounted by the ego against intra-psychic conflict (Alloy, Jacobson &
Acocella, 1999). Freud suggested the adult vulnerability to depression has its
roots in early childhood experiences, and most especially in early experiences
of real or imagined loss. Later psychodynamic theorists like Jacobson (1971)
and Bowlby (1973, 1980) emphasized even more than Freud did the
importance of quality of the mother-infant relationship in establishing a
vulnerability to depression.
Psychodynamic theory emphasizes the long-term predisposition to depression, rather than the losses that happen to cause it in the short term. These theorists have stressed three causes of depression: anger turned against the self, excessive dependence on others for self-esteem, and helplessness at achieving one’s goals (Arieti & Bemporad, 1978; Bibring, 1953; Fenichel, 1945).

In general, like most psychodynamic theories, these assumptions are not fully open to empirical validation. While “anger in” still figures importantly in traditional psychoanalytic discussions of depression, modern theorists have expanded and revised this early position. For example, many investigators believe that negative and maladaptive reciprocal interaction patterns have more roles in depression than parental loss and anger turned-inward (Alloy et al., 1999a). Recent research has focused especially on a parenting pattern called – affectionless control – that is, too much protectiveness combined with too little real care. This pattern may leave children feeling chronically helpless and over dependent. As adults, when they encounter stress, they are more vulnerable to depression because they feel helpless (Rapee, 1997).

(ii) Interpersonal and environmental models

The social environment has long been thought to play an integral role in depression. Environmental factors are important, both in creating underlying diatheses for depression such as rejection – sensitive or depressive ways of viewing the self and the world, and in triggering episodes of major depression (Lewinsohn, Allen, Seely & Gotlib, 1999).

Many of the social models of depression emphasize circular causal patterns (Coyne, 1984; Joiner, 2000). Social relationships are held to play an important role in determining the onset of depressive episode, and depression is seen to have a major impact on social interaction (Teichman & Teichman, 1990). The interpersonal approach (Klerman, Weissman & Rounsaville, 1984; Weissman, Markowitz & Klerman, 2000) maintains that depression
reflects past, ongoing or long-term problems between the person and significant others, and emphasizes the role of interpersonal stress both in the development and in the maintenance of depression.

Behavioral theoreticians (Ferster, 1973; Lewinsohn, 1974) argue that depression could be equated with a state of extinction from positive reinforcement. Depressed people are often seen as lacking the social skills necessary to obtain reinforcement from their social environment, which results in a low rate of response-contingent positive reinforcement (Lewinsohn & Gotlib, 1995).

According to interpersonal theories of depression, depressed individuals play a role in creating the negative social environments that cause or maintain their mood disorders. As researchers (Davila, Hammen, Burge, Paley & Daley, 1995; Monroe & Simmons, 1991) have reported in recent years attention is paid to the fact that the stress-depression relationship is not unidirectional. Depressed persons shape their environments and the consequences of their depression and behaviors may serve to generate stressful conditions and events, which in turn cause additional symptomatology.

Despite support for the interpersonal model, there is reason to believe that the relationship between depression and interpersonal rejection may be moderated by other factors. For example, depression is associated with poor interpersonal problem solving and use of more non-adjustmental coping strategies, which in turn leads to further symptoms of depression (Summerfeldt & Endler, 1996; Watson, Clark & Harkness, 1994).

(iii) Cognitive vulnerability-stress models of depression

Among cognitive theories of depression, both Beck's theory and attributional theories of depression are very renowned. According to these theories, the meaning or interpretation that people give to their experiences
importantly influences whether they will become depressed and whether they will suffer repeated, severe, or long-duration episodes of depression.

(a) Beck theory of depression

The most important contemporary theory that regards thought processes as causative factors in depression is that of Beck (1967, 1987). According to this theory, maladaptive self-schema (structure for screening, coding, and evaluating impinging stimuli) containing dysfunctional attitudes involving themes of loss, inadequacy, failure and worthlessness constitute the cognitive vulnerability for depression. Such dysfunctional attitudes often involve the theme that one's happiness and worth depend on being perfect or other people's approval (Abramson et al., 2002). When these hypothesized depressogenic self-schema are activated by the occurrence of stress, together with cognitive biases or distortions, maintain what Beck called the negative triad: far-reaching negative views of the self, the world and future (Davison & Neal, 2001).

Beck (1987) also postulated that the negative cognitive triad once activated, along with depressogenic self-schemata which fuels it tends to be maintained by a variety of cognitive biases or distortions like dichotomous or all or none reasoning, selective abstraction, arbitrary inference and overgeneralization. In the absence of activation by negative events, however, the depressogenic self-schema remain latent, less accessible to awareness, and do not directly lead to negative automatic thoughts or depressive mood and symptoms (Haaga, Dyck & Ernst, 1991). Beck (1987) has hypothesized that this model applies to only some forms of depression, particularly non-endogenous, unipolar depression.

Although several researches support most features of the descriptive aspects of Beck's theory (Hammen, 1997; Segal & Ingram, 1994), there have been some roadblocks in the demonstration of depressogenic cognitions as vulnerability factors for depression. For example, few studies actually tested the causal propositions in the form of the diathesis-stress model and relatively
little actual supportive evidence was found (Hammen, 2001). Despite
uncertainties, Beck's theory has the advantage of being testable and it has
engendered considerable research on the treatment of depression (Davison &
Neal, 2001).

(b) The helplessness and hopelessness theories of depression

In a cognitive-learning model of depression, Seligman (1975) has
suggested that depression may be understood as analogous to the
phenomenon of learned helplessness. According to this theory people are
likely to give up trying to exert an influence on the physical and social
environment when they find that important aspects of their lives are
uncontrollable. And when people feel helpless, they are likely to be drained of
motivation and to become depressed.

Although the learned helplessness model provides an explanation of
exogenous depression, it does not provide an explanation for all the clinical
features associated with this condition. In particular, it fails to account for the
chronicity of depressive disorders, for the marked individual differences in
vulnerability and for the major loss of self-esteem, which is often a prominent
feature of the condition (Abramson, Seligman & Teasdale, 1978).

In response to various shortcomings of the original learned helplessness formulation, Seligman collaborated with a number of colleagues
to provide an extended version of the model. This employs a number of
concepts, from field of social cognition, especially those associated with
"attribution theory". The revised learned hopelessness model emphasizes the
way in which people perceive and interpret unfavourable events (Abramson et
al., 1978). In particular, they proposed that when people (probably unlike
animals) are exposed to uncontrollable negative events, they ask themselves,
why? The kinds of attributions that people make about uncontrollable events
are in turn, central to whether they become depressed. They proposed three
critical dimensions on which attributions are made: (1) internal/external, (2)
global-specific, and (3) stable/unstable. Individuals with a tendency to make
internal, global and stable causal attributions for negative events are theoretically at greater risk for depression (Sweeney, Anderson & Bailey, 1989).

Although the 1978 reformulated helplessness theory of depression represented an important advancement over the original model, and provided the impetus for a great number of empirical studies, it suffered from two major shortcomings: (a) it did not present an explicitly articulated theory of depression; (b) it did not incorporate insights from descriptive psychiatry concerning the heterogeneity of depression (Gotlib & Abramson, 1999).

Consequently, Abramson, Metalsky and Alloy (1989) revised the reformulated helplessness theory and developed the hopelessness theory of depression. Although many elements of the earlier theories were similar, these investigators proposed that having a pessimistic attributional style in conjunction with one or more negative life events was not sufficient to produce depression unless one first experienced a state of hopelessness (Carson et al., 2000). This theory was developed to describe and explain one hypothesized subtype of depression – hopelessness depression – and to specify a chain of distal and proximal causes of its symptoms. Research is currently testing this theory.

Ultimately, as Hammen (2001) pointed out, “the cognitive models have fallen short in empirically substantiating several key assumptions: that cognitive vulnerabilities exist prior to depression experiences, that negative cognitions play a causal role in onset or first depression as well as recurrences, and that if they are causal rather than merely concomitants or consequences of depression, their contribution is necessary, substantial and specific to depression” (p. 240).
1.3 Bio-psychosocial approach and rational of the present study

While significant advances have been made over the last 30 years in the understanding of major affective disorders, the role of psychosocial and clinical variables in the prediction of depressive disorders is still controversial (Ezquiaga et al., 2004). Because, there is not an integrated etiological model for depression. During recent years, for comprehensive understanding of abnormal behaviour, bio-psychosocial approach is considered more appropriate by researchers, because of its emphasis on interacting role of biological, psychological and socio-cultural factors (Abramson et al., 2002; Gilbert, 1995, 2002; Kendler, Gardner & Prescott, 2002; Li, 2003; Smith, Kendal & Keefe, 2002). If we think of depression as involving changes in many different domains of functioning then we can see how there can be interactions between them. This is the essence of bio-psychosocial approach (Gilbert, 1995). What this means is that we need to consider depression as a complex web of interactions.

This model has added greatly to the understanding and treatment of abnormal functioning (Comer, 1999). Bio-psychosocial model clearly denote that the researcher and practitioner in order to better comprehend abnormal behaviour and illness especially depression appropriately must understand the psychological and socio-cultural factors that contribute to them (Garber & Flynn, 2001; Gotlib & Hammen, 1992; O'Brien & Houston, 2000; Segrin & Abramson, 1994). Research in the past two decades has focused on various psychosocial factors that play an important role in the etiology and maintenance of depression (Sharma, 2001). Growing literature has documented the pervasive difficulties in psychosocial functioning exhibited by depressed persons (Barnet & Gotlib, 1988; Gotlib & Hammen, 1992). These problems occur in multiple spheres, including cognitions, self-perceptions, interpersonal behaviours, stressors, coping skills and physical health (Lewinsohn, Gotlib & Seely, 1997).

Although considerable gains over the past decade have been made with respect to understanding the nature of psychosocial deficits in depressive
individuals, a number of important issues remain unresolved (Lewinsohn et al., 1997). For example, while psychosocial factors have been shown to play an important role in mild and non-clinical depression, their predictive power for severe and recurrent depression is a matter of controversy (Ezquiaga et al., 2004; Paykel, Cooper, Ramana & Hayhurst, 1996). Furthermore, in several investigations in which depressed individuals were compared explicitly with non-depressed controls, researchers have failed to demonstrate specificity of psychosocial dysfunction to depression (Barnet & Gotlib, 1988; Brewin, 1988; Follete & Jacobson, 1987; Luten, Ralph & Mineka, 1997). Thus, the identification of psychosocial factors that may cause depression has proven to be an arduous task. Beyond studies of variables related to depression, as Lewinsohn, Hoberman and Rosenbaum (1988) have observed, it looks an additional step appears necessary to provide greater clarity about the risk factors, and etiology of depression.

Lewinsohn et al., (1988) further observed that several writers have argued for a theoretical synthesis of various findings concerning depression in contrast to the more simple "single-sentence" theoretical position of most major theories. These writers and researchers (Akiskal, 2000; Billings & Moos, 1982; Gilbert, 1995; Lewinsohn et al., 1988) have advocated the importance of a perspective that regards depression as a multi-determined clinical phenomenon in which a number of antecedent conditions may be neither necessary nor sufficient, but rather, contributory in nature. The presence of any of these contributory factors increases the probability of the onset of a depression episode. Accumulation of these factors in an individual would have an additive effect and greatly increases the likelihood of the occurrence of the depressive episode.

Another issue is about the applicability of findings across cultures. The past majority of studies of psychosocial factors about depression have been conducted on subjects having an independent cultural orientation like Western countries. To what extent are the main findings and theories involving psychosocial factors can be applied to people with other orientation (interdependent cultural orientation) is not clear. According to Triandis (1996),
contemporary psychology is based on research conducted in the Western hemisphere (Europe, North America and Australia) even though 70% of the world's population lives in non-Western regions. He concluded, "if psychology is to become a universal discipline it will need both theories and data from the majority of humans".

Considering the above developments and contradictory reports, in the present study, the role of four effective psychological and social factors related to depression will be examined in two clinical samples from two different countries with interdependent (collectivistic) cultural orientation (India and Iran). The main purpose of the current study is to refine, replicate, and extend the body of knowledge about the nature of depression. The results of this study will have important implications for both the theoretical understanding of the depressogenic process and for more practical issues of clinical practice.

Variables included in this study were attributional style, sense of personal control, stress coping strategies and social support. These factors were selected for inclusion in the present study for four reasons: First, all four of these variables have been the focus of extensive research especially in Western countries (Aldwine, 2000; Davison & Neal, 2001; Shapiro et. al., 1996). Second, belief about the self, attributional style, coping strategies, sense of personal control and social support reflect key component of an individual's view of the world and his or her ability to function successfully, and thus should be especially potent in shaping reaction to stressful events (Baron & Byrne, 2004; Dalgrad, Bjork & Tambs, 1995; Zeidner & Endler, 1996). Third, cultures differ in their world views (Plotnik, 2002; Triandis, 1996), and influence explanatory style, sense of control, stress coping strategies, the extent of social support available and the self-sense. Fourth, the most researches on these variables were conducted in non-clinical samples (college-student populations). There are only few studies, which are conducted on clinical depression, that is, sample drawn from a psychiatric center with a clinician making a diagnosis of depression based on DSM or ICD. Accumulating evidence indicated that selecting subjects solely on the
basis of self-report measures does not yield a group of people who can serve as a good analogue for those with clinical depression (Davison & Neal, 2001). Most adults who have been designed as depressed on the basis of self-report measures are not clinically depressed (Santor & Coyne, 2001). In the next chapter researches about the relationship between these four psychosocial variables and depression will be reviewed.