Depression I

Assessment and Models

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Learning Outcomes

- Outline symptoms of depression
- Explain methods used to assess depression
- Describe the main psychological models of depression

James is a 31 year old engineer who lives with his girlfriend and four year old daughter. He was made redundant six months ago and has become increasingly depressed over the past three months, having been unable to find a new job. James has little confidence and said he feels useless as his job interviews have not been successful. He has become irritable and money worries have led to arguments with his girlfriend, not only about money but also about looking after their daughter. James has difficulty sleeping and has a reduced appetite, resulting in a noticeable loss of weight. He has little energy, has lost interest in activities he used to enjoy and feels that his friends don't want to socialise with him. Sometimes he spends several hours in front of the television, but can't get interested in programmes he used to like, and most of the time he doesn't pay attention. Household chores became impossible, leading to further arguments with his girlfriend.

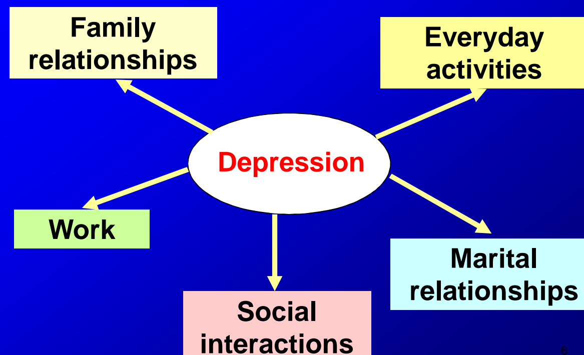
Depression

- Clinical depression 'common cold of psychiatry' (Seligman, 1975)
- Depressed mood – experience of unhappiness or distress
- Depressive syndrome – cluster of symptoms, impact on everyday life

Symptoms of depression

Emotional/affective	Cognitive
Behavioural	Physical/somatic

Consequences of depression



Prevalence

- 5% clinical level in population *(Williams, 1997)*
- Lifetime prevalence 17% *(Blazer et al, 1994)*
- 3% treated by GPs
- Women more prone than men
  - 10-25%women, 5-12% men *(APA, 2000)*
- Severe depression life threatening
  - 15% commit suicide
  - 40% attempt suicide

Duration of depression

- Most episodes recover within 4-6 mths
- Majority vanish whether treated or not
- Recurrence common
- Duration *(Williams, 1997)*

25% < 1mth

50% < 3 mths

15%-39% continue to 1 year

22% remain depressed 2 years later

- Relapse: 20% 2mths, 30% 6mths, 40% in first year, 50% by second year

Classifications of depression

DSM-IV and ICD-10

1) Unipolar and bipolar

2) Major depressive episode and dysthymic disorders

Aetiology

- Genetic
- Biological
- Socio-cultural factors

- Psychological models
  - Psychodynamic
  - Behavioural
  - Cognitive

Aetiology *(Carr & McNulty, 2006)*

Risk factors
Childhood adversity, loss of parent in childhood, personality traits, attributional style

Maintaining factors
Environmental stress, low activity, low +ve social interaction and relationships

Protective factors
At least 1 +ve early relationship with adult in childhood, high intelligence, social support, problem solving, functional coping strategies

Assessment

Assessment of depression

Types of investigation

1. Diagnostic
2. Measures from which to monitor change with treatment
3. Determine suitability of patient for treatment (e.g. CBT)

Also assess suicide risk

DSM-IV Major Depression

5 or more symptoms for at least 2 weeks, include depressed mood or loss of interest/pleasure:

- Depressed mood most of the day nearly every day
- Loss of interest or pleasure
- Significant weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Diminished ability to think or concentration
- Recurrent thoughts of death or suicidal ideation

Types of Assessment

- Interviews
- Self-report measures
- Observational methods
- Functional analysis

Diagnostic Assessment

- Interview
  - DSM (e.g. SCID) or ICD criteria
  - Present State Examination (Wing et al, 1974)
  - Hamilton Rating Scale (completed after interview)
- Questionnaire
  - GHQ-28
  - Wakefield Depression Inventory
  - Beck Depression Inventory

Provide cut-off for clinical depression

Structured Interviews

- **Structured Clinical Interview for DSM-IV (SCID)**
  - Semistructured interview - open-ended interview and systematic series of questions (‘probes’)
  - 60 – 90 minutes
- **Hamilton Rating Scale for Depression (HRSD)**
  - 17 item measure of severity
  - Completed following clinical interview

SCID – example ‘probe’

In the last month has there been a period of time when you felt depressed or down most of the day nearly every day? (What was that like?)

IF YES: How long did it last? (At least 2 weeks?)

During this time…did you lose or gain any weight? (How much?) (Were you trying to lose weight?)

HRSD - example

1.Depressed mood
0 Absent
1 Gloomy attitude, pessimism, hopelessness
2 Occasional weeping
3 Frequent weeping
4 Patient reports highlight these feeling states in spontaneous verbal and non-verbal communication

Self-report measures

- Screening tool
- Subclinical symptoms
- Wide selection
- Auxiliary to diagnosis
- Monitor progress
- Outcome measures
- Useful when large number of patients

Beck Depression Inventory II (BDI-II)

- Revised from BDI to be more reflective of DSM-IV criteria
- 21 items – each consists of 4 statements (score 0-3)
- How you have been feeling in past 2 weeks
- Cognitive and somatic items

BDI-II example

I do not feel sad

I feel sad

I am sad all the time

I am so sad or unhappy that I can’t stand it

WDI - example

I still enjoy the things I used to

Yes, definitely
Yes, sometimes
No, not much,
No, not at all

Functional Analysis

- Identify environmental factors that may be related to onset and maintenance of depression
- e.g. social withdrawal, lethargy, crying
- Interview patient and significant others
- Observation
- Daily monitoring (patient record)
- Use to hypothesise and formulate treatment

Monitoring Progress

- Number of symptoms
- Frequency of symptoms
- Severity of symptoms

e.g. Hamilton Rating Scale, Beck Depression Inventory, Zung Self Rating Depression Scale

- Change – Montgomery Asberg Scale

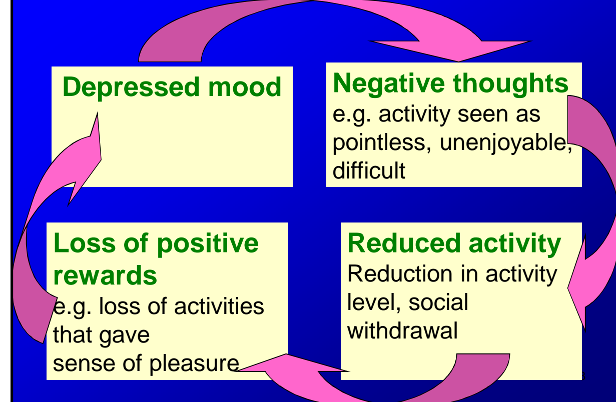
Assessment for treatment

- Identifying the problem
- Is mood proportionate to circumstances?
- Is the patient in a treatable condition?
- Potential difficulties and obstacles to treatment
- Assessing specific aspects of the problem

Assessment and formulation

- Assess risk of self-harm
- Interview (diagnostic criteria)
- Questionnaires/rating scales
- Identify precipitating, maintaining and protective factors
- Potential treatment goals and possible plans for reaching these

Maintenance factors



Models of depression

Psychodynamic models

Range of theories (e.g. Freud, 1917)

- Emphasis on unconscious factors
- How early development can create vulnerability to depression
- Depression is emotional expression of state of powerlessness to self to live up to strongly held wishes
- Repressed hostility

Psychodynamic models

- Real or imagined loss of valued or loved 'object'
- Loss in early childhood is diathesis to depression in adulthood if confronted with significant loss/disappointment
- Loss - between mourning and depression (Freud, 1917)
- Criticisms and more recent ideas

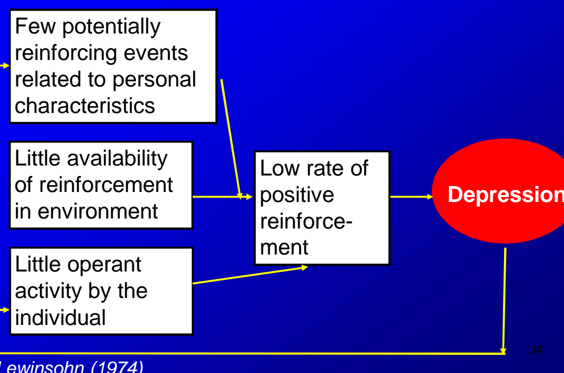
Psychodynamic model

1. Person experiences disappointment (e.g. loved one)
2. Cannot abandon loved one so affection transferred to someone else
3. Identifies with and internalises representation of lost object
4. Loved one now part of self/ego which is attacked (repressed hostility)

Behavioural model

- Inadequate or insufficient positive reinforcement from environment
- Lewinsohn (1974): lack of response-contingent positive social reinforcement
- Depression is overgeneralised response (e.g. loss of interest in activities) to circumscribed stimulus (e.g. loss of job)

Behavioural model of depression



Lewinsohn (1974)

Low positive reinforcement

Factors that may lead to this:

1) Deficits in behavioural repertoire or skills
2) Lack of potential reinforcers in environment
3) Decreased capacity to enjoy +ve experiences, or increased sensitivity to –ve experiences

Learned helplessness

Seligman (1975)

- Originated from animal studies
  - Symptoms of lack of motivation, passivity, disrupted learning
- Learning that one's physical or social environment is beyond one's personal control ⟶ depression

Learned helplessness/hopelessness

Abramson et al (1978)

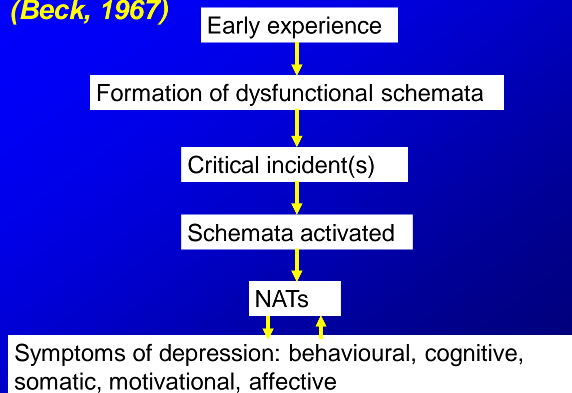
- Depression (or hopelessness) result of key attributional process in response to both +ve and –ve events:
  - Internal/external
  - Stable/unstable
  - Global/specific
- Internal, stable + global attributions = prone to depression (maladaptive attributional style)

Cognitive model (Beck, 1967, 1976)

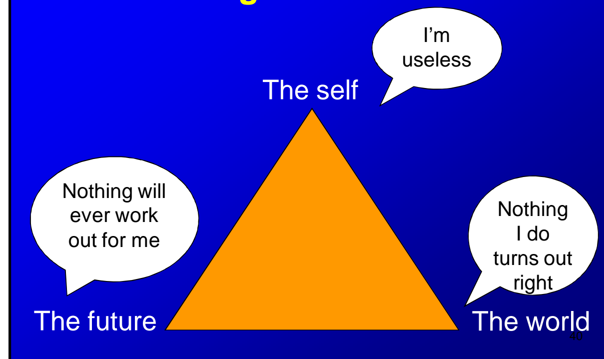
- Schema (beliefs, assumptions) based on early experience
- Negative events establish negative/dysfunctional schemata
- Critical incidents trigger negative schemata – governs information processing
- Activation of schema leads to **negative automatic thoughts (NATs)**

Cognitive model of depression

(Beck, 1967)



Depressive cognitions: cognitive triad



Cognitive biases (faulty information processing)

- Arbitrary inference *"My friend didn't answer the phone, they must be avoiding me"*
- Selective abstraction
- Overgeneralisation *"Everything I do goes wrong"*
- Personalisation *"They always pick on me"*

Cognitive biases (cont.)

- Magnification and minimisation *"He said he likes me but probably doesn't mean it"*
- Dichotomous thinking *"If I don't succeed at X then I am an absolute failure"*

Negative self schema

- Self schema = organised beliefs and propositions about the self
- Guides selection, interpretation and recall of information
- Beck: depression prone person has negative self schema – only takes in confirmatory negative information

Summary of Beck's model

- Depressed mood results from negative thoughts and negatively biased perception
- Depressed people show negative distortions in interpretation of experience
- When depressed, negative schemata activated and govern information processing
- Cognitive triad, cognitive biases, negative self-schemas

Summary: test yourself

Can you

- Outline the symptoms of depression?
- Explain the methods used to assess depression?
- Describe the main psychological models of depression

Next week…

- Link between models and treatments
- Psychological treatments for depression
- Evidence for effectiveness of treatments

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