Chapter 1
Causes of depression

This chapter begins by focusing on the epidemiology of depression. Epidemiological studies are discussed in relation to depression and the concept of depression as normal in relation to some life events. It also discusses when depression becomes abnormal in the sense that it impacts upon a person's ability to function and live normally within their environment. Gender issues will be introduced and the chapter will then review mild depression, major depression, seasonal affective disorder, postnatal depression and bipolar disorder. Different beliefs about the causes of depression including cultural beliefs, lay beliefs and sociological beliefs are also discussed. This chapter concludes by discussing the importance of cultural, lay and sociological beliefs about depression.

Epidemiology of depression

It is important to consider depression from a global perspective as it affects many people across the world. The World Health Organization (1997) has predicted that by 2010, depression will be the second most common cause of disability worldwide. In 1993, the Mental Health Foundation found that clinical depression affected up to 2.3 million people in the UK at any one time. The American Psychiatric Association (1994) reported that 3% of males and 7% of females in America suffered from depressive disorder and Rorsman et al. (1990) reported that in Sweden every second female and every fourth male were at risk of suffering from depression at some time in their lives. More recently, the Depression Alliance (2005) has stated that depression already affects at least one in five people in the UK. A key factor to consider is that many of these reports and findings are based upon the people who have been diagnosed with a depressive illness or disorder.

A report by Lundbeck, in 1995, found that three in four cases of depression were not recognized or treated. These facts demonstrate the need for improved knowledge and understanding when recognizing symptoms of depression. This
will help to ensure that patients are diagnosed and treated appropriately. Attitudes towards the illness are changing slowly as a result of the National Service Framework for Mental Health (2004) and improving education- and evidence-based approaches amongst doctors and other professionals.

Also, patients are demanding the best care and treatment as well as being part of the expert patient programmes. With the wealth of information available on the internet and in the media, patient expectations are forever increasing.

There is also more positive representation by the media when acknowledging celebrities who have suffered from mental illness. This includes sufferers from manic depression, depression, eating disorders and conditions associated with alcohol and drug abuse.

In Finland, back in 1994, Lehtinen and Joukamaa identified epidemiological studies which showed that depression was the most common mental disorder. They acknowledged that the occurrence of depression was associated with age, marital status, social class and social conditions, and that many people who suffered from depression did not get treatment. A worrying concern was that only about one-third of people suffering from depression were actually treated for their disorder in Finland.

Epidemiology must be considered from a local, national and international perspective when considering the implications of depression from a global perspective.

**Gender and depression**

The DH (2004) suggested that about one in five women and one in ten men get depression serious enough to require treatment. These facts also demonstrate that depression is more likely to occur in women than in men. Morris (1998) suggested that one in four women would suffer from clinical depression during their lifetime. This can potentially have major implications upon family life leading to individual, social and economic problems, resulting in a major public health problem.

There may be several reasons why women are more likely to be diagnosed with depression than men. It could be that women are more likely to report their symptoms and visit the doctor. Women are also more likely to see their general practitioner (GP) as they tend to be the main carer within the family who take children and other dependent relatives to the doctor.

Hormonal changes in women are also linked with depression, thus they may be more likely to visit their doctor. These visits often occur during pregnancy, after miscarriage, after childbirth or during changes in the menstrual cycle and the menopause (National Institute of Mental Health, 2000).

Murray and Lopez (1997) argue that depression amongst men should not be underestimated within British society as it is presently considered to be the fourth most important cause of disability worldwide. Men are more at risk of not being treated and are less likely to tell someone how they feel. This may
be one reason why doctors are less likely to suspect depression in men than in women.

The National Institute of Mental Health (2000) suggested that depression in men was not recognized as it was considered to be caused by overtime at work or drinking or drug taking.

This is a worrying perception and is probably one reason why men do not report their feelings and emotions to professionals. This leads to misconceptions about men’s health and can have serious implications resulting in men not being diagnosed with depression and not accessing the correct treatment. Some men may also perceive depression as a female illness and as a result feel less likely to obtain help.

This highlights the importance of the role of GPs and other mental health professionals in taking time to listen and to discuss mental health needs with men. Mental health needs to be considered of equal importance as physical health. If health needs are addressed then primary prevention will be a key feature in future health care service provision.

What is depression?

The DH (2004) described depression as a form of mental ill health. It is an emotional state that causes its sufferers to experience negative feelings about their self-image. Burns and Hartmen (2004) stated that the person can become mentally sluggish, which causes apathy and lack of interest in life generally.

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The National Institute of Mental Health undertook research into depression in 2000 and suggested that there are a variety of causes of depression which include:

- Death of a loved one
- Relationship breakdown
- Financial worries
- Stressful events in a person’s life
- Difficult childhood experiences leading to depression in adulthood

Thus, depression can occur as a result of major life changes across the lifespan. These changes may cause feelings of inadequacy and stress. Young people may find it difficult to get a job; they may experience loss of a job and as a result of this have financial difficulties such as debt. Younger people may also experience relationship breakdown. Middle-aged people may experience a variety of loss.
Some examples include the death of parents, children leaving home, changes in financial status and moving house. An older person may lose their home, their lifelong partner, loss of income due to retirement or may experience moving into long-term care. Many of these life-changing events and experiences can potentially lead to stress and depression.

Depression is also linked to changes in the brain causing disturbances in thoughts, emotions, sleep, appetite and behaviour. The brain sends messages between the nerves using chemical neurotransmitters called noradrenaline and serotonin. Guyton and Hall (1996) suggest that depression occurs when these chemicals fail to function.

Within some families, genetic factors are also shown to cause depression where there is a family history of depression. However, for some individuals, there appears to be no known reason as to why depression occurs.

Recognizing the symptoms of depression

There are many common symptoms of depression. If a person experiences four or more of these symptoms for most of the day, nearly every day over a 2-week period, then help should be sought.

- Tiredness and lack of energy
- Persistent sadness
- Loss of self-confidence and loss of self-esteem
- Difficulty concentrating
- Not being able to enjoy things usually pleasurable or interesting
- Undue feelings of guilt or unworthiness
- Feelings of helplessness and hopelessness
- Sleeping problems, difficulties getting off to sleep or waking up much earlier than usual
- Avoiding other people, even your close friends
- Finding it hard to function at work/school/college
- Loss of appetite
- Loss of sex drive and/or sexual problems
- Physical aches and pains
- Thinking about suicide and death
- Self-harm

(Depression Alliance, 2003; National Institute of Clinical Excellence [NICE], 2004).

Depression as normal

It must be recognized that most people will experience some of these symptoms at different times in their life but may not necessarily be suffering from depression. Many of these symptoms are normal reactions to situations in the
short term. These would include normal grief reactions following death of a loved one, loss of a job or relationship breakdown. It is the inability to function normally for that individual which will determine if the depression requires intervention over a longer period of time. It is the number of symptoms experienced over a longer period of time that is a key indicator of depression. The cause of these symptoms is also an important factor to consider as there are different types of depression. Also, there are issues about compliance with treatment regimes which can affect the severity of the illness and also choice of treatment options.

**Different types of depression**

Thompson and Mathias (2000) suggest that depression is often categorized as a mood or affective disorder; however, there are a variety of types and varying degrees of depression.

The *ICD-10 Classification of Mental and Behavioural Disorders* (WHO, 1997) reviews the categories of mild, moderate and severe depression when diagnosing an initial depressive episode. Further depressive episodes are classified under categories of recurrent depressive disorder.

Scott (1988) suggested that chronic depression is defined when the symptoms occur for 2 or more years. Scott (1988) highlighted many factors which predicted the chronicity of major depression. It is more likely to affect females with neurotic personality traits who have high familial commitments. Other important factors to consider are the length of time the person has had the illness prior to getting treatment and the appropriateness of the treatment given.

**Major depression**

Major depression is also called clinical depression or unipolar depression. These symptoms are based upon the *ICD-10 Classification of Mental and Behavioural Disorders* (WHO, 1997).

**Typical symptoms**

- Depressed mood
- Loss of interest and enjoyment
- Reduced energy

**Common symptoms**

- Reduced concentration and attention
- Reduced self-esteem and self-confidence
- Ideas of guilt and unworthiness
- Bleak and pessimistic view of the future
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- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Diminished appetite

The severity is based upon the number of symptoms and the effect this has upon the individual’s daily living. These symptoms will have been experienced for a period of at least 2 weeks.

**Dysthymia**

Dysthymia is a more chronic but milder depressive order than major depression. It is more prevalent in women than in men and also is more likely to occur in the older person.

**Common symptoms**

- Depressed mood for most of the day for at least 2 years
- Presence of at least two of the following:
  - Poor appetite
  - Insomnia
  - Low energy or fatigue
  - Poor concentration and difficulty in making decisions
  - Feelings of hopelessness
- Absence of mania

These symptoms affect the ability to function socially and occupationally. These symptoms are taken from the *DSM IV* criteria. The criteria is a well-used classification system within the UK which views mental disorders as comprising specific symptoms.

**Manic depression or bipolar disorder**

Manic depression is also known as bipolar disorder where a person has high- and low-mood swings. Bipolar disorder or manic depression causes major depressive episodes and is shown when the person displays extreme alternations in mood between mania and deep depression.

Bland (1997) estimated that about 1% of the population will experience bipolar disorder and that it is during the late teens or early adulthood that symptoms appear. The National Institute of Mental Health Genetics Workgroup (1998) identified that there is a genetic link and that research with twins demonstrates
that where one twin has been diagnosed with bipolar disorder the other twin is highly likely to develop the disorder.

Stressful life events can also trigger the disorder in people who are predisposed to manic depression. This is important as if it is established that lack of support, physical illness or stressful life events can cause increased episodes of the illness, then measures can be undertaken to provide support and help to prevent relapse. Manic depression affects women and men equally and there does not appear to be any gender-specific association with the condition. The person with bipolar disorder may suffer from extreme mood swings from mania to depression. Many sufferers of the disorder will experience varying types of mood swings; however, some sufferers will experience one or the other as an extreme.

Mental symptoms of depression experienced by people with manic depression include the following:

- Feeling unhappy
- Loss of interest
- Loss of enjoyment
- Tiredness
- Loss of self-confidence
- Irritability
- Tiredness and agitation
- Feeling hopeless and inadequate
- Thoughts of suicide
- Lack of confidence
- Inability to make simple decisions

Physical symptoms of manic depression experienced include the following:

- Early waking
- Loss of appetite
- Loss of weight
- Constipation
- Reduction in libido

The person feels unable to continue functioning with their daily routine and also finds it difficult to maintain contact with other people. Because of these feelings, it is extremely difficult for individuals to maintain employment and as a result relationships often break down. If left untreated or undiagnosed, depression can lead to suicide.

**Mania**

Mania is the opposite of depression. It also affects an individual’s ability to function with daily living and can potentially affect employment and relationships. Mania can cause individuals to lose contact with reality and take risks and make
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decisions that are harmful or dangerous. Some people have spent all their savings or purchased an abundance of items.

Symptoms experienced during mania are as follows:

- Lack of insight into a condition
- Rapid speech and thoughts
- Irritation with others
- Elation and excitability
- Inability to sleep
- Unwillingness to sleep
- Hearing voices that no one else can hear
- Feelings of high importance
- Recklessness, particularly with money
- Bizarre behaviour
- Flight of ideas
- Lowered inhibitions regarding sexual behaviour
- Making unrealistic plans

Initially, the person suffering from this manic episode experiences feelings of well-being and may not listen to family, friends or carers who will have noticed this rapid change in their mood and behaviour.

This can initially cause conflict in these relationships during the manic phase. After the manic episode, the sufferer may feel a sense of guilt and embarrassment which can then lead into the depressive state of the illness. It is important to recognize warning signs of the illness so that the person can seek appropriate help before the mood and behaviour get out of hand. Helping a depressed relative or friend and knowing where to seek help is very important. Important considerations are nutrition and hygiene needs and also accessing medical help.

Seasonal affective disorder

Magnusson and Boivin (2003) suggest that seasonal affective disorder (SAD) is a relatively common condition affecting 1–3% of adults in temperate climates and is more prevalent in women. The disorder is shown by big mood swings during different seasons of the year. Sufferers from SAD usually get more depressed in the winter and may experience high moods or mania in the spring. The current criteria for SAD are that there should be at least three episodes of mood disturbance in three separate years. Baldwin and Hirschfeld (2001) state that for this diagnosis to be made the person needs to have experienced the symptoms of SAD for 2 consecutive years.

Partonen and Lonnqvist (1998) state that the recurrence of depressive episodes occurs during the winter months and even though the person does not generally warrant hospital admission, does not have psychotic symptoms or is not at risk of suicide, the person does suffer socially and also may experience impaired functioning within the working environment. The symptoms are treated with
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Light therapy. The person sits in front of a light box for 30–120 minutes depending on the severity of the condition. Partonen and Lonnqvist (1998) found that by treating patients with bright light in the mornings and monitoring the effect every 2–3 weeks resulted in remission in two-thirds of patients with mild episodes. They also found evidence to suggest that drug therapy was also effective but there was no evidence to support the effectiveness of psychological treatments for SAD. International studies have been undertaken to establish the effectiveness of light therapy and drug therapy.

Back in 1984, Rosenthal et al. undertook research which looked at the effectiveness of light therapy on patients with SAD. Lewy et al. (1988) compared the effectiveness of morning versus evening light therapy for patients with winter depression.

Schwartz et al. (1996) undertook a follow-up study to characterize the long-term course of patients with SAD. They studied 59 patients on the National Institute of Mental Health Seasonal Studies Programme after an interval of 8 years.

The study concluded that winter depression and summer remissions remained fairly consistent over the period of time. It identified that light treatment although effective for many patients was less effective for the more severely depressed. It also concluded that non-seasonal depression in patients who suffered from SAD showed a greater severity of the illness and these patients were less likely to respond to light treatment. From this evidence, it can be determined that drug treatment would be more effective for these patients.

Lam et al. (2006) undertook a randomized control trial which compared the effectiveness of light therapy and the antidepressant drug fluoxetine in patients with winter SAD. This study showed that the light treatment had a better response earlier on and a lower rate of side effects compared to the fluoxetine; however, there were no significant differences between the two treatments and the conclusion was that both treatments were equally effective in treating SAD and that maybe the patient’s preference should determine the choice of treatment.

There has also been research undertaken by Lewy et al. (2006) who considered sleep and circadian rhythm as a basis of winter depression. There has also been previous research undertaken to study the possible role of seasonal mood changes in relation to myocardial infarction.

Lurie (2006) stated that SAD is underdiagnosed in primary care and can be confused with other diagnosis. He highlighted that SAD had been linked with seasonal alcohol abuse and attention deficit hyperactivity disorder (ADHD). As a consequence of not having SAD diagnosed some patients with seasonal alcohol abuse could be self-medicating to cope with their underlying depression. This demonstrates the importance of correct investigation and diagnosis and the importance of the role of the GP and other mental health professionals.

Postnatal depression

Some women suffer from postnatal depression after childbirth. Baldwin and Hirschfeld (2001) suggested that approximately 10% of women experienced
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significant depression in the first few months after childbirth. Many will recover but up to half of these women will still suffer from depressive symptoms 6 months after the birth of their baby. Risk factors likely to determine if a woman will suffer from postnatal depression include:

- History of depression before conception
- History of depression during pregnancy
- Poor marital relationship
- Lack of social support
- Recent stressful life events
- Severe maternity blues in the week after delivery
- Irritability or poor motor control in the infant

Postnatal depression will be discussed in more detail throughout Chapter 3 which includes postnatal depression and depression throughout the female life cycle.

Anxiety

All people will experience anxiety at times in their lives. Anxiety can be identified as a normal reaction to stressful events. Despite this normal reaction, anxiety is often associated with depression when the experience becomes an abnormal reaction to stress. It is unsure whether the anxiety causes the depression or whether the depression causes the anxiety. Anxiety causes a person to experience physical symptoms such as headaches, dizziness, palpitations and sweating. If not treated appropriately, anxiety can cause physical exhaustion. Baldwin and Hirschfeld (2001) highlighted that a person can also experience psychological responses to anxiety which include fear, irritability, disturbed sleep, tension and poor concentration. Thus, anxiety symptoms are more significant when they are abnormally severe, prolonged, impair normal functioning and occur in the absence of stress.

Physical causes linked to depression

It is also important to recognize that depression can be caused due to an underactive thyroid. The thyroid gland produces a substance called thyroxin which helps to control metabolic rate. If there is evidence of an underactive thyroid then symptoms of depression can be experienced which include lethargy, slow movements, feelings of depression and weight gain. An overactive thyroid can also show similar symptoms to mania where the person becomes overactive, has weight loss and inability to settle and sleep (MIND, 2007).
Beliefs about depression

The move towards patient-centred health care and patient empowerment mean that patients' own perceptions and health beliefs regarding depression need to be identified and considered. Lay beliefs are beliefs that ordinary people think cause depression and can be influenced by a variety of factors. These may include previous experience of mental health, family influences, gender, social class, cultural influences, social influences and knowledge and understanding of mental health issues.

These factors require careful consideration when determining the causes of depression.

Tausig et al. (1999) suggested that mental illness is a social status given to people by others and goes on to suggest that when abnormal behaviour matches the criteria for depression, then the medical profession labels them as depressive. This view needs to be treated with caution as when a person is diagnosed with depression, he or she can legitimately access treatment and care. However, it also needs to be acknowledged that some people may not wish to be labelled with a diagnosis of depression as this creates a stigma of being labelled as mentally ill. There is evidence to demonstrate that society views mental health in a negative manner. This was highlighted in a study undertaken by Evans and Jones (2001), where they undertook a survey of mental health in the Western health board in Ireland. Many changes have occurred since 2002 and with the influence of better education within both primary and secondary care services, and the influence of mental health frameworks and guidelines, it is hoped that a gradual acceptance of mental illness will be attained within society. This highlights the important role of health professionals in promoting the health of the mentally ill.

Cultural beliefs about depression

Goldbort (2006) believed that within the UK, there is cultural acceptance of certain types of intervention and treatment for depression which is primarily based upon a biomedical approach.

If people from other cultures have different beliefs and believe that their depression is caused through their living circumstances and life experiences then they may not access the treatment and care provision on offer. Studies have been undertaken across different cultures to determine beliefs about depression. One such study was undertaken by Suen and Morris (2006). This study demonstrated that Taiwanese American adults had very different beliefs about causes of depression compared with doctors in the Western world. The issue here is whether individual beliefs about the causes of depression influence the individual's ability to access appropriate health and social care provision. As a consequence, this has major implications for the diagnosis, treatment, access and provision of services.
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The health beliefs of people suffering from depression are important. If the patients’ beliefs are identified, it will be easier to involve them in their own care. By empowering patients to take some responsibility for their illness, they will be supported to manage their illness. This will then have an impact upon their recovery and management of their condition. This is particularly important within primary care where patients are supported in their own communities as opposed to being treated as inpatients.

Lay beliefs and depression

William and Healy (2001) undertook research into the perceptions of illness causation among new referrals to a community mental health team. They highlighted previous research which had identified explanatory models. Their research demonstrated that these explanatory models should be called explanatory maps. Their rationale being that as people expressed a variety of causes of illness and as their beliefs were changeable, it was more appropriate to refer to them as explanatory maps rather than models. These maps could then outline individual thought processes by helping them to understand reasons as to why they were experiencing particular psychological problems. Brown et al. (2000) supported this perception when talking about the importance of interaction between treatment and an individual’s locus of control.

This was demonstrated in Brown et al.’s study in 2000 when patients who perceived that they had more self-control of their health and who were receiving standardized treatments experienced less depressive symptoms. This view is important as it may influence an individual’s recovery rate from depression.

Lauber et al. (2003) undertook a study using a telephone survey with 873 interviewees in Switzerland. The survey assessed lay beliefs about causes of depressive behaviour. The study also analysed the influence of labelling and demographic factors when asking about causes of depression. The study findings showed that more than half of the respondents stated that relationship or familial difficulties were the main cause of depression, followed by occupational stress and traumatic events, depressive disorder and lastly unspecified illness. This highlights that the people in this study recognized reactive depression more than endogenous depression. However, it cannot be ignored that about a third of the study respondents acknowledged that disease or biological factors did influence the cause of depression.

Tully et al. (2006) undertook a study to investigate whether patient’s beliefs about depression concurred with their diagnosis. It highlighted that patients were able to distinguish different causes of depression.

Sociological beliefs

Depression can affect people from all classes and groups in society; however, much of the literature has been focused upon socially and economically
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disadvantaged people. Poverty has been linked with depression where low income, poor life chances and chronic illness and disability can have an impact on an individual’s ability to cope with everyday living.

Jorm et al. (2005) identified many international surveys undertaken which had asked the public about their beliefs about the causes of mental illness. Most of these respondents had identified the social environment as a strong cause of mental disorder. Jorm et al’s (2005) study aimed to determine if these views had changed over time in Australia.

The findings showed that even though there was an increased belief about the genetic causes of mental disorder, the public’s perception was that social causes were still the main reason for mental disorder.

Additional factors included lower family income and limited social support. Brown and Harris (1978) research looked at social origins of depression and undertook a study of psychiatric disorder in women. Their study found that lack of close, confiding relationships made women more vulnerable to depression. This demonstrates the importance of both the social environment and support networks in preventing depression. Depressed people also may find it harder to access support networks, so it is important for professionals to intervene to ensure this support is provided. It is evident from Badger’s (1996) research that family support was strongly associated with improved prognosis from depression.

However, if the family is already weakened by additional factors such as poverty, unemployment and relationship issues then the prognosis may be poor and depression can take the individual into a downward spiral where they see no hope for the future. This demonstrates how some depressed people may be less able to cope, become more stressed and find it hard to solve problems.

Some individuals are more likely to suffer from depression than others and this may be due to their previous experiences, family backgrounds and ability to cope with life events. Thus, it is this inability to cope with changing life events or the inability to express feelings or inability to explore thoughts and feelings that can determine the severity of the depression.

Kessler (1997) looked at the effects of stressful life events on depression. He suggested that to determine whether stress causes depression would need to be evaluated through rigorous experiments. He suggested that previous studies undertaken had generally been undertaken using non-experimental research and as a result of methodological problems, it was difficult to determine the effects of life events on depression.

It is evident that the sociological beliefs of individuals are important to consider when determining the causes of depression upon individuals within any society.

Conclusion

The American Psychiatric Association (1994) recognized that depression affects the whole body in relation to a person’s thinking, feelings, body and behaviour.
As a consequence, individual’s coping strategies vary and some individuals will become a danger to themselves and may even attempt or actually commit suicide. One of the challenges for future public health is recognizing the people who do not come forward for treatment or who have not been diagnosed with a depressive illness.

If GPs, mental health workers and carers are able to recognize the early symptoms of depression and support people to seek the appropriate treatment and access the right services, then maybe depression will become less of a chronic long-term illness for some people and for others their quality of life and family relationships can be maintained.

Reflection and discussion

Why is it important to consider cultural beliefs about depression?

- Within the UK, there is a cultural acceptance of certain types of intervention and treatment for depression which is primarily based upon a biomedical approach.
- If people from other cultures have different beliefs and believe that their depression is caused through their living circumstances and life experiences then they may not access the treatment and care provision on offer.
- Individual beliefs about the causes of depression influence the individual’s ability to access appropriate health and social care provision.
- Poverty has been linked with depression where low income, poor life chances and chronic illness and disability can have an impact on an individual’s ability to cope with everyday living.
- Lack of close confiding relationships make some women more vulnerable to depression. This demonstrates the importance of both the social environment and support networks in preventing depression.

Recognize some causes of depression

- Death of a loved one
- Relationship breakdown
- Financial worries
- Stressful events in a person’s life
- Difficult childhood experiences leading to depression in adulthood

Recognize some of the symptoms of depression

- Tiredness and lack of energy
- Persistent sadness
- Loss of self-confidence and loss of self-esteem
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- Difficulty concentrating
- Not being able to enjoy things usually pleasurable or interesting
- Undue feelings of guilt or unworthiness
- Feelings of helplessness and hopelessness
- Sleeping problems, difficulties getting off to sleep or waking up much earlier than usual
- Avoiding other people, even your close friends
- Finding it hard to function at work/school/college
- Loss of appetite
- Loss of sex drive and/or sexual problems
- Physical aches and pains
- Thinking about suicide and death
- Self-harm

Name some of the different types of depression

Major depression
Dysthymia
Manic depression or bipolar disorder
Seasonal affective disorder (SAD)
Postnatal depression

Discuss the importance of recognizing the signs and symptoms of depression and how this influences patient care

References

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