

Depression

From Nosology to Global Burden

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Depression is now identified as a major health issue, being a major cause of both psychological and physical morbidity. It is predicted to be second only to ischaemic heart disease in terms of total burden of disease burden to 2020 (Murray & Lopez, 1996). However, the definition of depression has undergone a number of changes over time, reflecting clinical and research fashions, evolving theories concerning psychological and biological causations of disease and the wider social context in which the problem is perceived. The changing fashions have affected how depression is viewed and how the construct is measured. This chapter will explore the evolving concepts involved in the nosology of depression, including a consideration of the implications for both genders.

MELANCHOLIA AND DEPRESSION

Melancholia has had much wider currency than *depression* through most of recorded history (Akiskal, 2000; Rush, 1986). The term referred to the presence of black bile associated with coldness, blackness, and dryness, so that melancholic individuals possessed a temperament that was essentially depressive. In a summary of Greco-Roman concepts, Akiskal (2000) noted the description of Soranus of Ephesus, in the second century BC, who characterised those with melancholia as exhibiting “mental anguish and distress, dejection, silence, animosity towards members of their household, sometimes a desire to live, and at other times a longing for death; suspicion that a plot is being hatched against him, weeping without reason, meaningless muttering, and occasional joviality.”

Rush (1986) noted that Burton, in his *Anatomy of Melancholy* (1621), first differentiated grief from melancholy and recognised suicide as

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a manifestation of melancholy. Kraepelin (1921) distinguished manic-depressive insanity from schizophrenia, and then Bleuler (1930) first used the term *affective disorders* to include psychoneurotic depressive reactions and involuntional melancholia. Today, the characteristic features of melancholia described many centuries ago are still recognisable in current descriptions of the construct, signifying a severe and disabling form of depression with a high risk of suicide. Much of the nosological discussion of depression in the past has revolved around nonmelancholic forms of depression. Areas of particular interest have included the definition and quantification of the nature of depression in different populations and applications and how the concept differs from normal human experience.

THE CONTEXT FOR CLASSIFYING DEPRESSION

Stress, distress, and disease originally all meant much the same thing (Rees, 1976) and implied a relationship between lack of emotional well-being and external precipitants. Rees (1976) noted that in the fifteenth century, *distress* was first shortened to *stress*, whereas *disease* meant discomfort or lack of well-being. The term *depression* was first used in the 19th century by cardiologists to describe the effects of a state of lowered (cardiac) function. Since then the term depression has been used more widely than melancholia. It covers a broader range of experience than that conveyed by melancholia, but in the process, it has become less meaningful and harder to define.

There are a number of meanings for the word depression, ranging from scientific to economic to psychological (*Oxford English Dictionary*, 1989). Most commonly, in general parlance, depression is used to describe a normal human emotion. It may also be used to convey an affect (the external manifestation of mood), a predicament (a state of being or condition that is unpleasant, trying, or dangerous), a symptom (a complaint reported), a disease (a constellation of symptoms and signs implying an underlying pathological process), or an illness (a manifestation of disease in the social context).

The purpose of classifying depression relates to the context. In a clinical setting, a diagnosis is linked to clinical goals such as making a prognosis about the likely outcome and management planning. The important diagnostic distinctions from depression in this setting are grief (where there can be similar symptoms and signs, but a clear precipitant leading to the grief and no associated loss of self-esteem) and anxiety disorders (which have their own characteristic sets of diagnostic features and often occur prior to or concurrent with depressive episodes).

In a research setting, the concept of *caseness* is used to determine population trends in morbidity, risk factors for epidemiological studies, and health resource planning. The objective is to determine a threshold for inclusion of subjects who are *cases*, irrespective of whether the subject

considers him or herself to be a case, from *noncases*. The definition relates to the severity and subjective impact of the disorder by determining the impact on indicators such as daily psychological and physical functioning and days absent from normal life roles. There are gender implications as women are overrepresented in clinical studies as they engage in more help-seeking than men. This highlights the importance of using data from general population studies to ascertain rates. The reasons for men not seeking help include fears of their own vulnerability and denial concerns about stigma, all related to male sex-role conditioning (Moller-Leimkuhler, 2002). All of these factors can lead to inflation of women's rates relative to men's.

DEBATE ABOUT THE NATURE OF DEPRESSION

Apart from the ongoing debate about what how depression is conceptualised (in terms of reproducible symptom clusters, duration of episodes, and the boundaries with other diagnostic categories), there is a more fundamental question about the nature of diagnostic categories. The question of whether the construct of depression is dimensional or categorical is important in determining how depression is conceptualised (whether on a continuum with normal experience or something that is qualitatively different) and how it is best measured.

Lewis (1938) proposed a dimensional or spectrum model, with depression ranging from mild (being normal mood state/adjustment reaction, then anxiety state) to severe (endogenous/melancholic depression and finally psychotic depression). Others, following on from great European clinicians such as Kraepelin and Bleuler, had taken a categorical approach. The models of depression pre-*Diagnostic and Statistical Manual*, third edition (*DSM-III*; American Psychiatric Association, 1980) and in the *Manual of the International Standard Classification of Diseases, Injuries and Causes of Death*, ninth edition (ICD 9; World Health Organisation [WHO], 1977) were predicated on the assumption of two dichotomous groups. One type, variably labelled as *endogenous*, *autonomous*, or *psychotic* depression, was not considered to be the result of a psychosocial precipitant, but to have a biological causation requiring biological treatments. This endogenous form of depression was seen as synonymous with the early accounts of melancholia and viewed as qualitatively different from the other type, variously named *exogenous*, *reactive*, *neurotic*, or *characterological* depression. Kiloh, Andrews, Neilson, and Bianchi (1971) summarised the position, "Psychotic or endogenous depression is a condition... with an imputed genetic or biochemical basis, whilst so-called neurotic depression is a diffuse entity encompassing some of the ways in which the patient utilises his defence mechanisms to cope with his own neuroticism and concurrent environmental stress."

One criticism of the binary model was that the endogenous/melancholic type was much more clearly identified as a coherent construct than the neurotic/reactive type. The latter tended to be a default category with features more closely identified with anxiety disorders than depression – the “diffuse entity” that Kiloh et al. (1971) alluded to. Another problem was that the terms *psychotic* and *endogenous* often came to be used interchangeably, with many British writers using the term *psychotic* to denote severity of depression (Carney, Roth, & Garside, 1965) rather than the presence of specific melancholic or psychotic features.

For the endogenous depressions, a further distinction (Leonhard, Korff, & Schulz, 1962) was made between bipolar disorder (subjects having a history of manic and depressive episodes) and monopolar disorder (where there is a history of only manic *or* depressive episodes), based on family history studies. Subsequently, the concept of *monopolar depression* has been retained in the current term *unipolar depression*, whereas purely manic episodes have been subsumed under the category of bipolar disorder (American Psychiatric Association, 1980; Boyd & Weissman, 1981; Spitzer, Endicott, & Robins, 1978; World Health Organisation, 1977). There are some subtle differences in phenomenology between unipolar and bipolar depression (Mitchell, Parker, Gladstone, Wilhelm, & Austin, 2001) but they are not sufficiently characteristic to render this a useful concept.

There are generally smaller gender differences in rates and experience of more biological depressions. There are minimal or absent gender differences in rates of bipolar disorder and melancholic depressions, with differences more in nonmelancholic types of major depression and more minor depressions (Jenkins, 1985), where comorbid anxiety plays a significant role (Breslau, Chilcoat, Peterson, & Schlultz, 2000). Thus, men and women seem to have similar expression of established episodes of major depression (in terms of type of symptoms and severity); the differences are more in comorbidities and coping styles (Nolen-Hoeksema, 1987, 2000; Wilhelm, Roy, Mitchell, Brownhill, & Parker, 2002).

THE CHANGING FORTUNES OF THE CONCEPT OF NEUROTIC DEPRESSION

In the ninth edition of the ICD system, ICD-9 (World Health Organisation, 1977), neurotic depression is defined as a “neurotic disorder characterised by disproportionate depression which has usually recognizably ensued on a distressing experience. . . . there is often preoccupation with the psychic trauma which preceded the illness.” A further category, adjustment reaction, covers “mild or transient disorders lasting longer than acute stress reactions . . . often relatively circumscribed or situation-specific, generally reversible”; these may be brief, including grief reactions, or prolonged, lasting up to a few months. The term *adjustment reaction* implies an

understandable reaction to a specific stressor, whereas neurotic depression stipulates a level of depression disproportionate to the presumed stressor. There is also a further category *depressive disorder, not elsewhere classified* for “states of depression, usually of moderate but occasionally of marked intensity, which have no specifically manic-depressive or other psychotic features, and which do not appear to be associated with stressful events or other features specified under neurotic depression.”

There were some implicit assumptions in contrasting *neurotic* or *reactive* depressions to *endogenous* or *psychotic* depressions in terms of presumed aetiological factors. The assumption was that neurotic or reactive depressions had an underlying psychological causation (i.e., psychosocial stressors or conflicts), whereas endogenous depression arose more spontaneously and was linked to psychotic depression, two terms that came to be used synonymously (Andreasen, 1982). From the mid-1970s leading up to the publication of the third edition of *DSM* (American Psychiatric Association, 1980), these concepts were rigorously investigated.

Neurotic or reactive depression was characterised partly by the lack of features characterising endogenous depression and was associated with reactivity of mood to environmental stimuli, initial insomnia, self-pity, or doubt rather than guilt and anxiety symptoms (World Health Organisation, 1977). It was defined more by what supposedly caused it rather than by a standard set of symptoms and signs. The concept of neurosis (embedded in that of neurotic depression) implied anxiety driven by conflict of motivations and had origins in psychoanalytic thought.

Neurotic conditions were reflected in diagnostic classifications until the mid-1970s, when Akiskal, Bitarm, Puzantian, Rosenthal, and Walker (1978) criticised the concept of neurosis as covering a multiplicity of conditions, including nonpsychotic depression, mild depression, coexisting neurotic symptoms, reactive/psychogenic depression, and characterological depression. Akiskal's views were important in the construction of new constructs for the third edition of the *Diagnostic and Statistical Manual* (American Psychiatric Association, 1980). These were termed major depression, adjustment disorder, and dysthymia.

The endogenous type of depression has to a large extent been replaced by the construct of major depression. The category of major depression has a set of features that are intended to increase interrater reliability (Kendell & Jablensky, 2003). These developments have been thought to have changed the focus “from a clinically-based biopsychosocial model to a research-based medical model” (Wilson, 1993). The *DSM-III* categories were intended to be descriptive rather than presuming any specific aetiology and have continued into *DSM-IV* with only minor modifications (American Psychiatric Association, 1994a). The 10th edition of the ICD (World Health Organisation, 1992) has now derived similar constructs based on similar premises. This classification system used *depressive episode*

(DE) for a syndrome very similar to major depression and notes that it includes the diagnoses of depressive reaction, psychogenic depression, and reactive depression. The ICD-10 system grades severity on number of symptoms, so that the category of mild DE involves a lower threshold for symptoms to the DE category, with moderate DE having more, while severe DE has superimposed extra symptoms, with or without psychotic symptoms. The concept of neurosis is still present in the category of neurotic, stress-related and somatoform disorders rather than for depression.

The increased interest and confidence in description of symptoms and signs without placing them in a context suggesting aetiology has come at a price. It represents a "significant narrowing of psychiatry's clinical gaze" (Wilson, 1993) at the expense of description of the psychological inner life of depressed people and (arguably) ongoing critical evaluation of the concepts.

Some Americans, notably Winokur (1985) and Wolpe (1986), have argued that the concept of neurotic depression is useful, albeit flawed, and have recommended revisiting the concept – in the light of current thinking. Winokur (1997) conceptualised the depressions as endogenous/psychotic and "those that occur in the context of marked emotional instability," a looser category (p. 105). Wolpe (1986) saw neurotic depressions in terms of their presumed relationship to anxiety states. He proposed a number of purer subtypes, in which depression was hypothesised to be a consequence of various types of anxiety states. These included severe conditioned anxiety (based on erroneous cognitions), anxiety-based interpersonal inadequacy, and an overreaction to bereavement. Wakefield (1998) criticised the drive for a set of atheoretical *DSM* categories as a failure to differentiate between the actual disorder the disorder and its symptoms. He noted that the importance of the role that anxiety plays in the onset of neurotic disorders and the impossibility of doing this without making references of the causation of underlying psychic conflicts.

There are gender implications in that women tend to rate higher on scales reflecting neuroticism and anxiety and have higher rates of anxiety disorders (Breslau et al., 2000). The greatest gender differences in rates of depression are within the potential childbearing age bands (Kessler, McGonagle, & Swartz, 1993; Wilhelm, Mitchell, Slade, Brownhill, & Andrews, 2003), when women also have higher rates of anxiety disorders that have been thought to be contributory (Breslau et al., 2000). This effect could be mediated as an effect of gonadal hormones on limbic system hyperactivity and may carry a biological advantage at times when women needed to be alert (Parker & Brotchie, 2004).

METHODS OF RATING DEPRESSION

The method of measuring depression will also reflect whether it is seen as dimensional (in which caseness is determined by a minimum score on a

dimensional scale) or categorical (i.e., certain characteristics are necessary for inclusion in the category).

In screening populations, an instrument is applied to a wide range of patients to detect those who may benefit from closer assessment, including identifying whether individuals are likely to be cases. Screening tools may include self-report measures, such as the Center for Epidemiological Studies-Depression Scale (CES-D) (Radloff, 1977), the K-10 (Kessler et al., 2002), and the Beck Depression Inventory (BDI) (Beck et al., 1961); clinician-rated tools, such as the PRIME-MD (Spitzer et al., 1994); or case finding instruments (used by clinicians or lay interviewers, of which the most widely used is the Composite International Diagnostic Interview (CIDI) (World Health Organisation, 1996). Upon identification of subjects at increased risk, assessment tools are used to assist in making a diagnosis. These may be clinician rated, such as the CORE (Parker et al., 1994) for melancholic depression, or self-report instruments, such as the BDI (Beck et al., 1961). Finally, outcome measures are used to quantify the effect of interventions and progress of patients. Self-report measures such as the BDI, and clinician-rated instruments such as the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960) and the Montgomery-Asberg Rating Scale (Montgomery & Asberg, 1979) are commonly used.

In general, women tend to score slightly higher on these types of self-report measures. This seems to reflect differences in perception of distress as well as their tendency to report a wider emotional range in both directions (Wilhelm, Parker, & Dewhurst, 1998). Only more recently has there been much emphasis on positive affect and on whether positive affective states, such as happiness and contentment, are the polar opposites of negative affective states. This approach is reflected in measures of positive and negative emotion (e.g., the Positive and Negative Affect Schedule [PANAS; Watson, Clark, & Tellegen, 1988]) and positive and negative attitudes to life (e.g., the Life Orientation Test [LOT; Scheier & Carver, 1985]).

DEPRESSION CATEGORIES IN CURRENT DIAGNOSTIC SYSTEMS

The current diagnostic systems in clinical and research use are the International Classification of Diseases (ICD), originating in Europe under the auspices of the WHO, and the *Diagnostic and Statistical Manual*, currently in its fourth edition, originating in the United States. The prevailing definition of a depressive episode equates with the construct of major depression based on operational criteria (symptoms and signs), with cut-offs for inclusion in a diagnostic category and minimal reference to presumed aetiology. The DSM system relies on a multiaxial classification to provide other important contextual information, with the diagnosis of psychiatric disorder (i.e., symptom diagnosis) located on the first axis, with four further axes describing personality, any concurrent medical conditions, predisposing life events, and level of functioning in the preceding year.

DIAGNOSTIC SYSTEMS USING OPERATIONAL CRITERIA

The development of the Present State Examination (PSE; Wing, Cooper, & Sartorius, 1974) in England included an index of definition for sub-threshold, threshold, and definite cases, which fitted with the then-current *International Classification of Disease* (World Health Organisation, 1977) categories. The Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978), which were developed from an earlier diagnostic system (Feichner, Robins, & Guze, 1972), similarly relied on strict operationalised criteria intended to increase interrater and test-retest reliability of diagnosis for research purposes. In the RDC, primary depression was divided into major (unipolar) depression and bipolar depression (subjects who had also experienced manic episodes). Two new categories, minor depression and intermittent depressive disorder, were also included. These categories were intended to afford a broad coverage of depressive experience and to encompass the endogenous and neurotic depression categories that had been discarded.

As the RDC system was intended for use in both clinical and nonclinical situations, allocation to RDC categories also requires the imposition of functional impairment criteria (i.e., seeking professional help, taking medication for the episode, or a subjective judgement of a significant impact on life of the episode) studies. The *DSM-III* criteria were intended for clinical use rather than primarily for research, with the term *disorder* intended to imply that the episode is clinically significant. The reader is referred to a paper comparing *DSM-III* and RDC criteria if more specific information is required (Williams & Spitzer, 1982).

In the 1950s, the advent of antidepressant medications brought a new focus to the discussion of depression types. The biogenic amine dysfunction theory of depression (Akiskal & McKinney, 1973) was advanced in response to the greater appreciation of the potential role for neurotransmitters, stating that depression was maintained by dysfunction of the norenergic transmitter system in the central nervous system. Not long after, Beck published the first book on his cognitive treatment of depression (Beck, Rush, Shaw & Emery, 1979), which was part of the vanguard for a plethora of structured psychological approaches for depression. Although it was cognitive therapy, the theory stated that depression was precipitated and maintained by negative thinking patterns, there was a presumption of a final common pathway at a cellular level, such as that suggested by Akiskal.

With the advent of the structured definitions in the later DSM and ICD systems, *clinical depression* has become synonymous with *major depression*, a depressive episode with functional impairment warranting treatment. Akiskal et al. (1978) had argued against the inclusion of the subjective experience of conflict and other personal experiences that were difficult to

validate and replicate. Akiskal et al. (1980) had raised the notion of characterological depression and dysthymia as alternatives to more chronic depressions. Besides major depression, the *DSM* affective disorders included dysthymia and *adjustment disorder with depressed mood*. The construct of adjustment disorder is different from other affective disorder categories in its being the only one in which there is a link between the presumed precipitant and the disorder. Despite the reservations implicit in the two current diagnostic systems concerning neurotic depression, a recent UK general population study elected to use the Clinical Interview Schedule-R (Lewis, Pelosi, Araya & Dunn, 1992), a structured case-finding instrument developed from the PSE (Wing et al., 1974) to consider neurotic disorders (which included *depressive episode* and *mixed anxiety and depressive episode*). This illustrates the issue that studies in primary care and general population settings will generate more cases that are subthreshold or have mixed symptoms of anxiety and depression and the need to convey more information about these episodes than is apparent in the major depression category. By contrast, in secondary and tertiary settings, there are likely to be different issues, as studies will generate more depressive episodes with melancholic and psychotic features, greater severity, chronicity, and more extensive medical and psychological comorbidities (Wilhelm et al., 2002).

Thus the field has both evolved and gone full circle. Both *DSM* and *ICD-10* major depression categories are based on a number of objective criteria rather than any putative causative factors. Both systems describe mild, moderate, and severe forms, fitting with the earlier unitary model, but then also describe a biological form. This then begs the question of the status of major depression, which has become the most widely used term to categorise depressive episodes. Paykel's review (1987) of the current classification systems concluded that they "serve to operationalize rather than solve the problem of classifying depression (p. 69)." Current diagnosis and treatment is based on the assumption that major depression is a single entity that varies mainly in its severity and duration, with one type of treatment being effective for all patients. Kendell and Jablensky (2003) have noted that the improvement in reliability in diagnosis "has shifted attention to the more fundamental issue of the validity" of diagnosis (p. 4). The emergence of papers on minor depression, subthreshold depression, and subsyndromal depression implies that there are a number of depression types that are not being captured in the current diagnostic rubric.

Thus, although the major depression category appears to be relatively homogeneous, it appears to consist of a number of potential subtypes (Parker, 2003), including those with anxious and irritable depressions, those who are very withdrawn, and those with atypical features (Parker, 2003; Parker et al., 2002). Specifically, an Australian group has argued for the need to differentiate between melancholic depression and nonmelancholic depression. Within the category of melancholic depression, which

generally appears as severe major depression, the subtypes of psychotic depression and most episodes of bipolar depression are subsumed. The second category, nonmelancholic depression, is seen to encompass a number of subtypes that reflect underlying personality styles (Parker et al., 2002). Generally, these styles are all lumped together as mild or moderate major depression. Similarly for dysthymia, the construct is not as homogeneous as it first appears. It may reflect those who have a longstanding clinical depression, a characterological disorder, a sustained period of demoralisation or learned helplessness, or a partially treated major depression.

Andreason and Winokur (1979) had previously suggested that depression could be further subdivided into familial pure depressive disease, sporadic depressive disease, and depressive spectrum disease, with depressive spectrum disease being "a type of major depression characterized by families in which male relatives are alcoholic and females are depressed" (Cadoret et al., 1996). They continued to propose similar ideas to the Australian group: "Depressions, though similar clinically, are of heterogeneous etiologies," which can be separated into endogenous/psychotic groups and a group of depression spectrum diseases that "occur in the context of marked emotional instability" and are separable on the basis of personality, clinical, follow-up, familial and treatment variables (Winokur, 1985, 1997, p. 105). Winokur's (1997) depressions caused by marked emotional instability represent another attempt to characterise these nonmelancholic depressions.

An international group (Szadoczky, Rozsa, Patten, Araro, & Furedi, 2003) weighed into this debate by using a grade of membership model to produce six subtypes of depression: severe bipolar depression with early onset (which is essentially melancholic); nonmelancholic somatisation, with late onset; nonmelancholic nonsevere bipolar depression (with male preponderance); depression secondary to anxiety (with female preponderance); melancholic depression with suicidal ideation; and melancholic depression with panic attacks (with female preponderance).

A recent review (Haslam, 2003) of the arguments for categorical and dimensional models of mental disorder noted that psychiatrists (i.e., medically trained researchers and clinicians) have favoured categorical approaches to classification, whereas most psychologists and those trained with a psychodynamic framework have generally favoured a dimensional model. He stated that taxometric studies of mood disorders have considered three issues – the continuity versus discontinuity of depression in general, of depressive subtypes, and of temperamental vulnerability. He concluded that depression cannot be regarded as a single entity and concluded that a categorical model works best for melancholic depression, where there is an identifiable disorder, whereas a dimensional model works best for neurotic depression, where depression types are less discrete and tend to "shade smoothly into everyday unhappiness (p. 698)."

This conclusion is similar to those of Parker's and Winokur's groups, but is arrived at by different means.

Thus, at the current state of knowledge, it may be best to view depression as depressions, involving both categorical and dimensional approaches. Here melancholic depression is a categorical diagnosis, whereas nonmelancholic depressions may be seen as dimensional categories, reflecting affective instability related to responses to a variety of psychosocial and biological precipitants.

SUICIDE AND DEPRESSION

Depression and suicide are related concepts but are not synonymous, as many people have episodes of depression and may or may not have suicide ideation, attempts, or completed suicide. Women generally have higher rates of deliberate self-harm, with a number of studies demonstrating a male/female ratio of 1:1.3 to 1:3. Although men have higher rates of completed suicide (male/female ratio of 4:1) at all ages, both sexes have had an increase in suicide rates in developed countries (Hawton, Fagg, Simkin, 1997; National Institute of Mental Health [NIMH], 2003; Weissman et al., 1999; Winokur, 1985, 1997). The rates vary with age, with among the highest rates being for young white men (aged 15–19 and 20–24 years) (Hawton et al., 1997; Hawton, 2005; Hawton & James, 2005).

The 16-site WHO Multicentre Study on the epidemiology of parasuicide, the first major registration study of deliberate self-harm (Bille-Brahe et al., 1997), revealed a large variation in the rates across sites from 2.6 to 542 per 100,000 population. Females at all sites were found to have higher rates of self-harm than males, with comparison data of the female-to-male ratio ranging from 1.36:1 to 1.57:1. In all countries, the highest rates for males are in the 25–34 year range and for females the 15–24 year age range.

Thus, the consistent gender differences in rates of deliberate self-harm and completed suicide are different from the reported trends for depression. Rates of completed suicide are related to depression type (higher in those with melancholic and psychotic depression), comorbidity (higher in those with chronic medical illness, drug and alcohol abuse and dependence, presence of personality disorders), and a number of social issues including poor social support. A full review of this area is beyond the scope of this chapter.

CROSS-CULTURAL PERSPECTIVES

The literature from which this chapter is drawn has been from a predominantly Western perspective. However, there is now a much greater awareness of cross-cultural perspectives (Bhugra & Matrogianni, 2004)

and needs (Murray & Lopez, 1996). For example, a recent review of the prevalence of depression in the Chinese, the largest population on earth (Bhugra & Matrogianni, 2004; Parker, Gladstone, & Chee, 2001), concluded that depression appeared to be less evident and was more likely to be expressed somatically than in the West. This was due to a combination of factors: lower reporting rates due to stigma and greater acceptance of distress, differences in representation of mind–body connections, greater use of neurasthenia as a concept, and (until recently) lack of detection and identification of cases. Prior to the advent of operationalised diagnostic systems and more standardised case-finding instruments, cross-cultural studies tended to report culture-specific syndromes but these instruments have enabled cross-national studies (Cheng, 2001).

Depression is now seen as an important disorder in the global context. The greater uniformity in case-finding techniques has an emphasis on disability and economic burden rather than simply on clinical issues (Murray & Lopez, 1996). Cheng's (2001) review of the methodological issues involved in cross-national studies concludes that cultural variation is more in the presenting features than the "nature and frequency of the underlying neuropsychiatric impairments and disorders (p. 103)," and that the evidence-based approaches reported in one part of the world can be applied to benefit those in other parts of the world. Depression is described as a "highly prevalent disorder" that can "serve as a paradigm in the discussion of the impact of globalisation in the prevalence of mental disorders, idioms of distress and pathways to care" (Bhugra & Matrogianni, 2004, p. 13; Murray & Lopez, 1996). Additionally, reviewing the concepts from the cross-cultural perspective adds depth to the appreciation of how the concepts of depression had developed in the West (Murray & Lopez, 1996).

IMPLICATIONS FOR MEN AND WOMEN

Epidemiological Implications

The material presented in this chapter is building a case that the term *depression* covers a wide range of experience. It is not a simple homogeneous concept but a series of constructs subsumed under a single word. Although the gender differences are often taken as a given, it is not surprising that on closer examination, the situation is not quite so straightforward. In terms of diagnostic subtypes of affective disorders, the rates for bipolar disorder are roughly equal, although women are more likely to have a rapid cycling course. For melancholic and psychotic subtypes of major depression, there are no differences in rates, age of onset, or course.

The differences are greatest (i.e., in the range of male/female ratio of 2:1) for mild to moderate severity of major depression, minor depression,

and dysthymia. Differences in rates are greatest around the ages of 18–55 years, the years of potential childbearing for women. When considering gender differences in the longer-term course of depression, the National Comorbidity Shedy (NCS) data (Kessler, 2000; Kessler et al., 1993) showed no gender differences in the probability of being chronically depressed or having an acute relapse in the year following an acute episode, but found that women had higher rates of later recurrence.

There is evidence of cross-cultural variation (Weissman et al., 1996), with lifetime rates of major depression ranging from 1.5% in Taiwan to 19.0% in Beirut (Lebanon), mean ages of onset from 25.6 years in the United States to 34.9 years in Florence (Italy), and female to male ratios ranging from 1.6:1 in Taiwan and Beirut to 3.1:1 in Germany. This raises the possibility that the gender differences in current prevalence rates are not universal, but vary with factors such as depression type, how depression is conceptualised, age, setting, and the time period under observation. The differences in rates of depression are affected by the changing fashions in diagnosis, which instruments are selected, and the time course.

Women had previously been considered to have higher rates of some neuroses; indeed, the concept of hysteria was predicated around references to female anatomy. The considerable literature around the higher rates of major depression and dysthymia, as well as anxiety disorders (Breslau, Chilcoat, Peterson & Schultze, 2000; Weissman & Klerman, 1977), has shed some light on the area. There are few differences in the actual experience of established episodes of depression (Wilhelm et al., 2002), and the female preponderance is related to increased onsets of nonmelancholic depressions that emerge in adolescence and continue into adulthood (Kessler, 2000). This may be related to increased rates of preceding anxiety disorders (Breslau et al., 2000) as well as some factors related to female physiology and help-seeking (Nolen-Hoeksema, 1987; Weissman & Klerman, 1977). Alternatively, a series of factors may decrease the rates in men, such as masking by alcohol and substance abuse, increased rates of suicide, shorter life span, and decreased acknowledgement and help-seeking. Men may have modes of expression of depression that are not identified by the generally accepted diagnostic criteria (Brownhill, Wilhelm, Barclay, & Parker, 2002; Mitchell, Parker, Gladstone, Wilhelm, & Austin, 2003; Moller-Leimkuhler, 2002). Women have higher rates of physical and mental morbidity and help-seeking and higher rates of anxiety disorders and suicide attempts. There has also been added concern that depression may be seen as a “women’s problem,” a concept that can become self-reinforcing. Presentations in men may be overlooked or downplayed (Blacker & Clare, 1987; Brownhill, Wilhelm, Barelly, & Parker, 2002). However, if health is associated with strength and control (said to be manly virtues), then loss of health may mean loss of masculinity, with attendant anxiety, sadness, and fear (Moynihan, 1998). With their emphasis on reliability and validity, the

issues of the effects of sex role and culture are often left unaddressed by the current diagnostic systems but deserve more emphasis in future editions. There are specific gender issues for both men and women that need to be considered, as well as those for different cultures. This has a positive side in that the variation between individuals in the social and cultural realms broadens our perspective and understanding of the concept of depressions.

Economic Implications

In the Global Burden of Disease study (Murray & Lopez, 1996), more than 80% of the healthy years lost occur between the ages of 15 and 44 years, with women losing twice as many years of healthy life to depression as men. In terms of years lost to disability (YLD) only, depression was the leading cause of burden for both men and women (6.2% and 9.8% of total YLD respectively). The report has been described as a “watershed for psychiatry” (Scott & Dickey, 2003, p. 92) as it provides an effective means of communicating the global impact of depression, while also allowing cross-national comparisons and the evaluation of the economic impact of depressions and their treatments.

More recently, methods have been developed for evaluating the burden of disease (Andrews, Sanderson, & Beard, 1998) that can be applied in general populations and across cultures. One of the best known is the use of disability adjusted life year used in the Global Burden of Disease study (Murray & Lopez, 1996), which found that depression is the second leading cause of healthy life years lost in the developed world, and fourth leading cause in the developing world, causing 5 to 6% of total global burden globally. In these studies, depression generally refers to major depression (as defined by DSM-IV and ICD-10), the most widely used and accepted concept of depression when assessing economic and social impact.

Later chapters in this book will deal with the areas of economic burden in more depth. To set the stage, a recent review found that self-reported anxiety or depression is the most important cause of workplace absenteeism in the United Kingdom and has a significant effect on workplace productivity in the United States, as well as affecting self-esteem and social networks in the workplace (Knapp, 2003). Further, a recent study of the cost of depression for adults (from 15 years) in the United Kingdom in 2000 (Thomas & Morris, 2003) calculated direct clinical costs, consumption of prescribed drugs, and indirect costs from morbidity and mortality data. They estimated the cost of depression to the nation as over £9 billion, “despite the availability of effective treatment (p. 518).” They noted that 72% of the cases were female, and 20% of cases occurred in the 35–44 year age band, with women losing over twice as many days from depression-related work absence as men. However, they also noted that depression-related death rates were 2.5 to 4.5 times higher for men in every age band.

This chapter has presented the historical background to some of the notions about depressions. Both the concepts themselves and the social context in which they are placed are constantly evolving. It is critical that researchers continue to appraise the definitions of depression types and the purposes for such definitions and to evaluate the risk factors for both men and women.

CONCLUSION

The classification of depressions reflects current understanding of neurobiological mechanisms, current trends in psychological mechanisms, and current research needs with clinical, economic, and health planning imperatives. It is important to review the historical roots of our nosology and to observe the consistent themes, as well as the themes that may change according to fashion. The word *depressions* is used advisedly to cover a number of types, of which a categorical type (i.e., melancholia) and a number of dimensional types (various personality characteristics amplified by a number of stressors) may exist. These personality characteristics may be biological (i.e., genetic, familial, resulting from illness or injury) or psychosocial (as part of earlier or current environment) and are likely to be multifactorial.

The focus on gender differences provides a useful framework for examining various psychosocial issues related to the appearance of depression. Notwithstanding, there is evidence that when men and women have equal social opportunities (such as work, social support, and education), gender differences in rates of depression are diminished or disappear (Egeland & Hostetter, 1983; Jenkins, 1985; Weissman & Klerman, 1977; Wilhelm & Parker, 1989, 1994). Thus, it is important to continue to question observed gender differences in depression and to evaluate the risk factors of depression for both genders, while continuing to appraise the accepted definitions and conceptualisations of depression.

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