SAMPLE RESEARCH PAPER-3

TOPIC- DEPRESSION

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I. DEFINITION OF DEPRESSION

A. SYMPTOMS OF DEPRESSION

Any definition of depression must begin with the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The DSM-IV represents the official diagnostic classification system of the American Psychiatric Association and provides the criteria that are used to diagnosis depression. These criteria consist of the symptoms of depression. In order to make a diagnosis of depression, at least five out of nine possible symptoms must be present. These include (1) depressed mood; (2) diminished pleasure or interest in activities; (3) significant weight loss or weight gain; (4) insomnia or hypersomnia; (5) agitation; (6) fatigue or loss of energy; (7) thoughts of worthlessness or inappropriate guilt; (8) diminished concentration ability; and (9) thoughts of death or suicide.

Symptoms of depression may vary according to an individual's age and culture. Children who are depressed, for instance, may express symptoms of irritability rather than sadness. They may also fail to make expected weight gains rather than lose weight. On the other end of the age continuum, older adults are more likely than younger adults to experience symptoms such as loss of appetite, loss of interest, and thoughts of death. Cultural differences also exist in report of depressive symptoms. One study, for example, found that depressed Jewish patients reported more somatic symptoms, and less guilt, than did non-Jewish patients. Another study that examined depressive symptomatology in American, Korean, Philippine, and Taiwanese college students found that Taiwanese students reported the lowest numbers of somatic symptoms and the highest numbers of affective symptoms. The other ethnic groups reporting similar levels of these symptoms. One's age and culture thus seems to affect how depression is expressed.

B. COMORBIDITY: THE RELATIONSHIP BETWEEN DEPRESSION AND ANXIETY

Comorbidity refers to the occurrence of more than one disorder at the same time. Although researchers and clinicians generally acknowledge depression as a distinct disorder, it does overlap with a variety of other difficulties. Much current research on this overlap has focused on the relationship between anxiety and depression. This is not surprising, given the high rates of comorbidity found in studies of the two disorder types. For example, one study found that 63% of a group of patients with panic disorder also experienced major depression. One possible explanation provided for such overlap lies in the concept of "negative affectivity." In 1984, Watson and Clark described individuals with high levels of negative affectivity as having a tendency "to be distressed and upset and have a negative view of self, whereas those low on the dimension are relatively content and secure and satisfied with themselves." Other characteristics of high negative affectivity include nervousness, tension, worry, anger, scorn, revulsion, guilt, self-dissatisfaction, rejectedness, and sadness.

Both anxiety and depression seem to consist of high negative affectivity. There are however, important differences between depression and anxiety. While both depression and anxiety are characterized by high levels of negative affect, only depression is related to lowered levels of positive affect. Thus, depressed individuals tend to display both high negative affect and low positive affect, whereas anxious individuals display high negative affect and may or may not have lowered positive affect–the level of positive affect is unrelated to one's anxiety state. Research on negative affect as a link between anxiety and depression is continuing at a rapid pace.

II. DIAGNOSTIC CLASSIFICATION

Earlier we noted the DSM-IV. The DSM-IV is the most widely used classification scheme for psychiatric disorders in North America. According to this manual, there are five types of mood disorders that include depression as a significant component. These are (1) Major Depressive Disorder; (2) Dysthymic Disorder; (3) Bipolar I Disorder; (4) Bipolar II Disorder; and (5) Cyclothymic Disorder. Each of these classifications differs in terms of etiology, course, and symptomatology.

A. MAJOR DEPRESSIVE DISORDER

For a diagnosis of Major Depressive Disorder (MDD), DSM-IV specifies that at least five symptoms must occur for a period of at least 2 weeks. Chief among these symptoms is depressed mood that occurs most of the day, nearly every day for at least 2 weeks, or significantly diminished interest or pleasure in virtually all activities most of the day, nearly every day for the 2-week period.

MDD can be further classified according to severity (i.e., mild, moderate, severe without psychotic features, severe with psychotic features), course (e.g., single episode versus recurrent episodes), and presentation (e.g., with catatonic features, with melancholic features). Psychotic features of depression include such experiences as delusions (i.e., false beliefs) and hallucinations (i.e., sensory experiences that have no basis in reality). A delusion, for example, would be a person who believes that she is dead. Catatonic features of depression involve psychomotor disturbances such as excessive movement or stupor. Melancholic features include the inability to experience pleasure even when good things happen and a lack of interest in previously pleasurable activities. No matter what the specific characteristics of a given individual's disturbance, MDD is, by definition, extremely distressing to the sufferer and is associated with significant impairment in important areas of the person's life (e.g., at work, home or school).

B. DYSTHYMIC DISORDER

Dysthymic Disorder is characterized by a chronic depressed mood that lasts at least 2 years in adults and at least 1 year in children and adolescents. This depressed mood is accompanied by at least two of the following six depressive symptoms: (1) poor appetite or overeating; (2) insomnia or hypersomnia; (3) low energy or fatigue; (4) low self-esteem; (5) poor concentration or difficulty making decisions; and (6) feelings of hopelessness. As fewer depressive symptoms are required to make a diagnosis, Dysthymic Disorder is often considered a milder form of depression than MDD. However, it can be just as upsetting to the sufferer and can cause just as much impairment. In addition, Dysthymic Disorder may occur in combination with episodes of major depression. When Dysthymic Disorder occurs along with major depression, the individual is considered to be suffering from a "double depression." The co-occurrence of MDD and dysthymia is not uncommon.

C. BIPOLAR I DISORDER

The hallmark characteristic of Bipolar I Disorder is mania. According to DSM-IV, a manic episode is characterized by elevated, expansive, or irritable mood that is persistent and distinctly different from normal elevated or irritable moods. This period is accompanied by at least three of seven possible symptoms. These symptoms include (1) inflated self-esteem; (2) a decreased need for sleep; (3) unusual talkativeness; (4) the feeling that one's thoughts are racing; (5) increased distractibility; (6) increased activity; (7) involvement in pleasurable but potentially harmful activities (e.g., sexual indiscretions).

Bipolar I Disorder is typically recurrent; according to DSM-IV, additional episodes occur in more than 90% of individuals who have had a single manic episode. The manic episodes of those with Bipolar I

Disorder are often intermixed with periods of depression. Like those with MDD, people with Bipolar I Disorder may exhibit psychotic, catatonic, and melancholic features as part of either their mania or their depression.

D. BIPOLAR II DISORDER

Bipolar II Disorder is characterized by periods of hypomania intermixed with periods of depression. Hypomanic episodes are characterized by the same symptoms as manic episodes. However, hypomanic episodes are shorter (e.g., 4 days in duration) and are associated with less impairment. While manic episodes may include psychotic features, interrupt daily functioning, and require hospitalization, hypomanic episodes typically do not. The depression experienced as part of Bipolar II Disorder, however, can be just as severe as that experienced in MDD and Bipolar I Disorder.

E. CYCLOTHYMIC DISORDER

Cyclothymic disorder is characterized by hypomanic periods intermixed with depressive periods that are not as severe as those experienced in MDD, Bipolar I Disorder, and Bipolar II Disorder. In Cyclothymia, the periods of mood disturbance may alternate rapidly, with little respite from affective difficulties. For a diagnosis of Cyclothymia these periods of shifting moods must be problematic for at least 2 years in adults and at least i year in children and adolescents.

In addition to the five official diagnoses, DSM-IV has denoted four classifications for further study that include depression as a significant component. Such classifications are not yet considered to be disorders and more information is needed on factors such as symptom presentation, etiology, and degree of impairment to sufferers before these might be considered disorders in their own right. Nevertheless, these may represent serious problems and even though they are currently exploratory, we describe them here. They are: (1) Premenstrual Dysphoric Disorder; (2) Minor Depressive Disorder; (3) Recurrent Brief Depressive Disorder; and (4) Mixed Anxiety-Depressive Disorder.

III. EXPLORATORY CATEGORIES OF DEPRESSIVE DISORDERS

A. PREMENSTRUAL DYSPHORIC DISORDER

Premenstrual Dysphoric Disorder is characterized by several hallmark symptoms of depression (e.g., decreased interest in usual activities, depressed mood, difficulty sleeping or sleeping too much) in addition to symptoms such as affective lability, feelings of being overwhelmed or out of control, and food cravings. In order to meet the criteria that have been proposed for this diagnosis, such symptoms must have occurred during the late luteal phase of most of a woman's menstrual cycles in the past year. As a number of authors have pointed out, such a classification has potentially serious social, political, and legal ramifications for women. For example, some have argued that if this classification is adopted as an orificial diagnosis then women might be stigmatized as more unstable than or inferior to men. Arguments such as this keep the classification of Premenstrual Dysphoric Disorder a topic of considerable debate.

B. MINOR DEPRESSIVE DISORDER

Minor Depressive Disorder is characterized by fewer depressive symptoms than are seen in MDD. The level of impairment is also less than that associated with MDD. To meet the proposed criteria for Minor Depressive Disorder, a person must demonstrate either a depressed mood or loss of interest and two additional symptoms of a Major Depressive Episode. If this classification were included in future DSM editions as a disorder, it would constitute a residual category to be used only after the other mood disorders have been ruled out.

C. RECURRENT BRIEF DEPRESSIVE DISORDER

The principle difference between Recurrent Brief Depressive Disorder and MDD is one of duration. Recurrent Brief Depressive Disorder is characterized by periods of depression that meet all of the criteria for a Major Depressive Episode except for the duration requirement. While in major depressive episodes, symptoms must last at least 2 weeks, in recurrent brief depressive episodes, symptoms must last at least 2 but less than 14 days. In addition, these brief episodes must occur at least once a month for 12 months to meet criteria for the classification of Recurrent Brief Depressive Disorder. Recurrent Brief Depressive Disorder is quite similar to MDD in its age of onset and family incidence rates, thus raising questions as to whether this should be considered a distinct disorder.

D. MIXED ANXIETY-DEPRESSIVE DISORDER

The impetus behind a mixed anxious-depressed category lies in the finding that there are many people suffering from symptoms of anxiety and depression who do not meet criteria for any DSM anxiety or mood disorder, but who are nonetheless significantly impaired by their difficulties. The classification of Mixed Anxiety-Depressive Disorder is characterized by a dysphoric mood for at least 1 month in addition to at least four additional symptoms that primarily reflect anxiety (e.g., mind going blank, worry, hypervigilance). The primary argument in favor of adopting this proposed disorder is that it would cover the large number of people who have significant impairment linked to depression and anxiety but who do not fall into any currently existing diagnostic category. The primary argument against this classification is that people suffering from both depression and anxiety could in fact be categorized into already existing disorders with the use of more precise assessment methods.

IV. EPIDEMIOLOGY

Epidemiology refers to information about the incidence and prevalence of disorders in a population. A prevalence rate refers to the number of people who have a given disorder during a particular time period (e.g., the percentage of people in given location diagnosed with MDD within a 1-year period of time). An incidence rate refers to the number of new cases of a disorder which occur during a given time period (e.g., the number of people diagnosed with Dysthymic Disorder during April 1996). Because the distribution of a disorder can be examined to determine whether it correlates with other factors, epidemiological information can be important for understanding some of the possible causes and correlates of depression.

A. PREVALENCE

1. NATIONAL PREVALENCE

Two recent large-scale surveys of psychopathology in the United States have provided differing prevalence data on depression. Using diagnostic criteria from the revised 3rd Edition of the DSM (DSM-III-R), the Epidemiologic Catchment Area (ECA) study examined the rates of depression in five sites: New Haven, Baltimore, St. Louis, Los Angeles, and Durham. The ECA study found the lifetime prevalence of major depression (i.e., the number of people experiencing major depression during any point in life) to be 4.9% and the lifetime prevalence of dysthymia to be 3.2%. Alternatively, the National Comorbidity Survey (NCS) reported much higher prevalence rates: 14.9% for lifetime major depression and 6.4% for dysthymia. The discrepancies between these two studies may be accounted for by the different assessment instruments used, slightly different diagnostic criteria employed, and different age ranges studied (i.e., the ECA sample was 18 years of age or older, whereas the NCS sample ranged in age from 15 to 54 years). According to the ECA study, prevalence rates for bipolar disorders were much lower; lifetime prevalence of these disorders was .8% for Bipolar I and .5% for Bipolar II. The NCS lifetime prevalence for manic episode was somewhat higher: 1.6 %. Even though

these epidemiological studies reported somewhat discrepant rates, they are in agreement that mood disorders are relatively common in the United States.

2. INTERNATIONAL PREVALENCE

A number of studies have examined the community prevalence of major depression in countries besides the United States. International lifetime prevalence rates vary widely, from a low of 3.3% in Seoul to a high of 15.1% among New Zealand residents aged 25 to 46. While such differences may indeed reflect true international differences in the occurrence of depression, other factors such as cultural differences in the sensitivity of the instruments used to assess disorder and different sample ages may also account for this range. In prevalence studies focusing on bipolar illness, ranges from .07% in Sweden to 7% in Ireland have been reported. Most studies, however, place prevalence at about 1% for bipolar illnesses, consistent with data from the ECA and NCS studies.

B. AGE DIFFERENCES

The ECA study also reported incidence rates of depression for various age groups. For men, major depression was highest among those aged 18 to 29. A large decline in incidence was noted for men aged 45 and older. For women, the incidence of major depression was highest in the group aged 30 to 44 and did not decline until age 65.

C. SEX AND ETHNIC DIFFERENCES

According to the ECA study, lifetime prevalence rates of major depression, dysthymia, and all mood disorders are approximately twice as high for women as for men. Women's lifetime rates were 7.0%, 4.1%, and 10.2%, respectively, while rates for men were 2.6%, 2.2 %, and 5.2 %, respectively. These differences occur across a variety of ethnic groups (e.g., African American, Hispanic, Caucasian) even when differences in education, income, and occupations are controlled. Sex differences are also found in countries besides the United States. While sex differences in depression are among the most stable of findings across studies, no sex differences in the rates of bipolar disorder are reliably found.

Although sex difference in the incidence of depression occur across different ethnic groups, there are some differences among these groups overall. For instance, the ECA study found higher rates of Major Depression and Dysthymia among Caucasians and Hispanics than among African Americans. However, few difference in the rates of bipolar disorders among the three groups were found.

D. ENVIRONMENTAL CORRELATES

The ECA study also examined a number of environmental correlates of depression and bipolar disorders. This study found that people who were separated or divorced had higher 1-year prevalence rates of major depression (6.3%) than those who were never married (2.8%), currently married (2.1%), or widowed (2.1%). This was also true of those with bipolar disorders, although the rates for those separated or divorced versus never married were nearly identical (1.7% versus 1.6%). The 1-year prevalence rate of major depression was also higher among the unemployed than the employed (3.4% versus 2.2%), but the rate was nearly identical for those with bipolar disorders (1.1% versus 1.0%). In addition, the ECA study found higher rates of major depression among white-collar workers and those with at least 12 years of education, but lower rates of depression among those with annual incomes of $15,000 or more. Consistent with the major depression findings, bipolar disorders were also less prevalent among those with annual incomes of $15,000 or more. Bipolar disorders were also found to be the most prevalent among none-white-collar workers with less than 12 years of education. Overall, these socioeconomic status differences were quite small.

V. ETIOLOGICAL THEORIES OF DEPRESSION

A variety of different psychological theories of the causes of depression have been proposed. These can be grouped in psychoanalytic, interpersonal, and cognitive.

A. PSYCHOLOGICAL THEORIES

1. PSYCHOANALYTIC APPROACHES

The first psychoanalytic writers to theorize about the etiology of depression were Sigmund Freud and his student, Karl Abraham. As would be expected, there are a number of similarities in the theories proposed by Freud and Abraham. First, both Freud and Abraham believed that some people are predisposed to experience depression. For Abraham, this predisposition consisted of anatomical anomalies that allowed a person to experience a great deal of oral eroticism. For Freud, this predisposition consisted of narcissistic object choices (e.g., object choices which are so similar to the self that love of the object is truly love of self). Second, both believed that a predisposition to experience depression was not, in and of itself, enough to cause depression. In order to experience a depression, a predisposed individual must also experience the loss of a loved object (e.g., through death or rejection).

Despite these basic similarities, the two theorists diverge somewhat on how depression occurs once a loss has been experienced. For Abraham, the loss of a loved object in a person predisposed to depression triggers a regression to the oral stage of psychosexual development. Such a regression is meant to achieve three purposes: (1) to increase pleasure; (2) to hold on to the object through oral incorporation; and (3) to discharge one's aggressive impulses on to the object. Such a regression manifests itself most saliently in the depressive symptoms of eating too much or too little. For Freud, the loss of a loved object possesses different implications. Since the lost object was a narcissistic choice and thus represented the self, loss of the object means loss of the self. This loss of self triggers feelings of anger and depression. The energy associated with these negative feelings is withdrawn from the lost object and brought inward, in a process called introjection. Thus, depression as conceptualized by Freud is often summarized as "anger turned inward." For Freud, the difference between sadness and "true" depression was the difference between "this is awful" and "I am awful." Freud further extended his theory to account for the mania characteristic of bipolar depressive disorders. He hypothesized that, once the feelings of anger and depression over loss of the object are resolved, the energy associated with these negative feelings is freed for other purposes. In a person with bipolar disorder, this freed energy is used to zealousy search for new objects, thus accounting for the symptoms of mania.

More recent psychoanalytic theorists have focused on the superego's role in depression. Some theorists, for example, have suggested that depression is distinguished from other states such as shame, apathy, or resentment by the presence of guilt. As guilt results only from an intrapsychic conflict of the superego, the superego is necessarily implicated in depression. One result of these differences in etiological focus has been the proposition of two forms of depression: anaclitic and introjective. Anaclitic depression is characterized by feelings of helplessness, inferiority, and being unloved. Anaclitic depression is proposed to be associated with the earlier stages of development and is most closely associated with the theorizing of Abraham and Freud. Alternatively, introjective depression focuses on feelings of unworthiness and failure to measure up to expectations and standards. It is associated with later stages of development, and more closely aligned with the works of later psychoanalytic theorists. Although much of psychoanalytic theory has been criticized on grounds that it has not been empirically tested, the distinction between anaclitic and introjectire depressions has been empirically examined and found to be valid. Psychoanalytic theorists have

accounted for the development of bipolar disorders as well. Most notable amongst these theorists is Melanie Klein, who expanded upon the work of Freud.

2. INTERPERSONAL APPROACHES

Interpersonal approaches to the ethology and maintenance of depression focus on the interplay between a depressed person and his or her relations with others. Empirical research in this area has taken several directions. For example, some researchers focus on the role of social skills in depression, asking such questions as whether depressed people have poor social skills and whether the lack of such skills results in decreased reinforcement from others and consequent depression. Other research has evaluated the types of communications depressed people emit (e.g., sadness, hopelessness) and the effects these communications have on others. If others find the communications of depressed persons aversive, they will likely avoid such persons, which may then exacerbate depressive symptoms such as isolation and loneliness. Still others address the interplay between stress, social support, and depression. All of these lines of research have found some support; interpersonal research highlights the fact that depression is caused by a multitude of factors in interplay with one another.

Much of the research converges on the theoretical idea that depression is maintained by a vicious cycle that is caused by disruptions in interpersonal interactions. For instance, many depressed individuals quite understandably seek out social support from others. If this support does not alleviate the negative feelings, further support is sought. This intensified support seeking, however, has the paradoxical effect of pushing away those who have been supportive. That is, as individuals begin to feel that their support capacity has been exhausted they pull back from the depressed person, leading to an even further intensification of social support seeking, and the further distancing of potentially supportive people.

Interpersonal factors in the etiology of bipolar depressive disorders have not received as much research attention as such factors in unipolar depressive disorders. Nonetheless, persons with both types of depressive disorders seem to have difficulties in retaining social support. Indeed, in one recent study, people with bipolar disorder perceived their social supports as less available to them and as less adequate in the amount of support received than people in a community sample. Furthermore, perceptions of social support availability seemed to decrease as the duration of illness increased. Thus, it seems likely that social support plays a role in bipolar as well as unipolar depressive disorders.

3. COGNITIVE APPROACHES

Currently, cognitive approaches are among the most widely studied theories in the etiology of depression. One of the most influential of these theories was proposed by Aaron Beck in 1967. Beck argued that all individuals possess cognitive structures called schemas that guide the ways information in the environment is attended to and interpreted. Such schemas are determined from childhood by our interactions with the external world. For example, a child who is constantly criticized may begin to believe she is worthless. She might then begin to interpret every failure experience as further evidence of her worthlessness. If this negative processing of information is not changed, it will become an enduring part of her cognitive organization, that is, a schema. When this schema is activated (e.g., by a poor grade on a test or any other failure experience), it will predispose her to depressive feelings (e.g., I'm no good). Beck stated that, as a result of this faulty information processing, depressed persons demonstrate a cognitive triad of negative thoughts about themselves, the world, and the future. He further extended his argument to include the manic phases of bipolar depressive disorders. Beck stated that such phases are characterized by a manic triad of irrationally positive thoughts about oneself, the world, and the future. Like the depressive triad in unipolar depressive disorders, the manic

triad in bipolar depressive disorders was hypothesized to lead to the symptoms of mania, such as inflated selfesteem and extremely elevated mood.

There is widespread agreement that depression can be caused by different factors. Some theorists have argued that dysfunctional cognitions cause only a subset of depressions. Termed the "negative cognition" subtype, this type of depression is brought about by either the kinds of schemas discussed by Aaron Beck or by dysfunctional attributional patterns that lead depressed people to take responsibility for the occurrence of negative events, and to avoid taking responsibility for positive events. This dysfunctional attributional pattern can lead to a sense of hopelessness that results in a "hopelessness depression," a component of negative cognition depression.

B. BIOLOGICAL THEORIES

Although there are a variety of biologically based theories of depression, they can be broken down into two general approaches: genetic and neurotransmitter.

1. GENETIC APPROACHES

Genetic approaches suggest that depression is the result of inheriting genes that predispose to occurrence of depression. Three types of studies that are used to investigate genetic inheritance of depression illustrate this approach. These studies consist of family studies, twin studies, and adoption studies. In a typical family study, families with a depressed member are interviewed to determine how many other family members have or had an affective disorder. In twin studies, the concordance rate of affective disorder between monozygotic and dizygotic twin pairs is compared. Because monozygotic twins have identical genes, if genetic theories are correct then concordance rates of depression should be higher than for dizygotic twins (who have similar but not identical genes). In adoption studies, two strategies are most often used. In the first, the rate of depressive disorder in the biological parents of adopted persons with and without affective disorders is compared. In the second, the rate of depressive disorders is compared between adopted children with and without affectively disordered biological parents. Adoption studies have an advantage over family and twin studies, as the effects of environment on affective disorder are reduced in this design. However, adoption studies constitute the least-used approach to investigating genetic factors in depression; the difficulty of obtaining complete records on adoptees and their biological parents makes this design quite prohibitive.

Despite design differences, all three genetic approaches to the etiology of depression have yielded similar results: depression is heritable to at least some degree. A recent review of the research literature, for example, found rates of affective disorders among first-degree relatives of unipolar-disordered individuals ranging from 11.8% to 32.2%. Rates of affective disorders among first-degree relatives of bipolar disordered individuals ranged from 10.6% to 33.1%. Rates of affective disorder among first-degree relatives of normal individuals ranged from 4.8% to 6.3. In twin studies of unipolar and bipolar depression, concordance rates ranged from .04 to 1.0 for monozygotic twins, and from 0.0 to .43 to dizygotic twins, with the majority of studies reviewed reporting no concordance for dizygotic twins. The results of genetic investigations clearly suggest that there is a genetic component to depression, although the exact nature and functioning of this component is thus far still unknown.

2. NEUROTRANSMITTER APPROACHES

Research on brain chemistry as an etiological factor in unipolar depression has focused on two monoamine neurotransmitters: norepinephrine (NE) and serotonin (5-HT). Initially, researchers believed that depression was due to a lack of NE in the brain, and later, to a lack of both NE and 5-HT. However, several difficulties with these hypotheses arose: (1) While the effects of antidepressants on

monoamine levels start within hours of taking the medication, decreased depression levels do not become apparent until weeks later. (2) Some drugs that do not affect monoamine levels alleviate depression. (3) Some drugs that increase monoamine levels do not alleviate depression. Thus, researchers have directed their efforts to investigating more complicated relations between these neurotransmitters and depression. Recent efforts have included the study of receptor site hyposensitivity, relationships between NE and 5-HT, and relationships between. 5-HT and the neurotransmitter dopamine (DA).

Research on brain chemistry as in etiological factor in bipolar depression has followed much the same course as such research on unipolar depression. Initially, researchers believed that the mania characteristic of bipolar disorders was due to excesses of the neurotransmitters NE and 5-HT, exactly opposite the belief for depression. However, difficulties arose with this hypothesis, including findings that (1) lithium, the medical treatment of choice for bipolar disorder which seems to affect both NE and 5-HT, was effective at controlling both depression and mania, and (2) both depression and mania may be characterized by lower levels of 5-HT. Thus, as with unipolar depression, researchers of bipolar depression have begun investigating more complicated relationships between bipolar depression and neurotransmitters. Similar to the recent efforts concerning unipolar depression, researchers have investigated interactions between 5-HT and DA, interactions between NE and DA, and receptor site hypersensitivity. These types of investigations represent promising areas of research in elucidating the multifaceted etiology of depression. Certainly, biology and psychology are implicated in the causes of depression, both unipolar and bipolar forms.

VI. PROTECTIVE FACTORS

Given the potentially devastating effects of depression, many researchers have devoted their efforts to studying factors that decrease the likelihood of becoming depressed or decrease the amount of time spent in depressive episodes. Among the most widely studied of such protective factors are social support and coping styles.

A. SOCIAL SUPPORT

There are numerous facets to the concept of social support. For example, social support can be conceived as the number of persons one can rely on for support. Social support can also be conceived as the amount of support received, regardless of the number of persons one receives support from. In addition, socially supportive relationships can be conceptualized on a continuum of quality from very poor to very good. Examination of all these facets has proven important in understanding relationships between depression and social support.

Overall, people in contact with numerous socially supportive persons are less likely to have mental health difficulties, including depression. In addition, those who perceive a great deal of support from others are less likely to be negatively affected by stressors that might lead to depression. For people who have become depressed, having a confidant such as a spouse or best friend and a supportive family is related to greater success in treatment. The quality of such relationships is also important to treatment. In one study, for example, depressed persons with good-quality confidant relationships needed shorter periods of treatment than those with poor-quality confidant relationships.

The effects of social support for people with bipolar depressive disorders have not been as well studied as the effects for people with unipolar depressive disorders. Nonetheless, research suggests that social support is indeed beneficial for people with bipolar disorders. In one study, for example, a great deal of available social support was related to fewer psychological symptoms, better social adjustment, and better overall functioning.

B. COPING STYLES

Ways of coping with stressors can be roughly divided into two categories: approach strategies and avoidance strategies. Approach strategies are characterized by identifying the problematic situation, devising reasonable solutions to it, an implementing those solutions. Avoidance strategies include trying not to think about the problem, wishing the problem did not exist, and fantasizing about life without the problem. Overall, approach strategies seem to help people cope with stressors that might otherwise lead to depression. In addition, use of approach strategies is associated with better treatment outcome for those who become depressed. Conversely, people who use avoidance strategies to cope with stress seem more likely to become depressed and to have poorer treatment outcomes.

As with the effects of social support, research on coping styles among people with bipolar depressive disorders is scarce. Nonetheless, one recent study that examined differences in coping between high- and low-functioning people with bipolar disorders suggested that avoidant coping styles are associated with poorer functioning. Thus, relationships between coping styles and bipolar depressive disorders and coping and unipolar depressive disorders may be similar.

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