

Depression A Common Mental Disorder: An Overview

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Abstract

Depression is a common and often debilitating reaction to chronic illness. Up to one third of all medical in-patients with chronic disease report at least moderate symptoms of depression and up to one quarter suffer from severe depression. Depression increases with the severity of the illness. The experience of pain and disability in particular lead to depression which in turn increases pains and disability. These problems are aggravated in those who are experiencing other negative life events, social stress, and lack of social support. Moreover, depression can exacerbate the symptoms and complicate the treatment of many diseases, including diabetes, cancer, CHD, stroke, hypertension, MI, AIDS and epilepsy. Depression over illness and treatment has also been linked to suicide among the chronically ill. Perhaps most importantly, depression complicates treatment adherence and medical decision making; it may confer enhanced risk of mortality from a broad array of chronic disease. For all these reasons, the assessment and management of depression in chronic illness has become of paramount importance to health care providers and health psychologist.

Keywords: Depression, Chronic Illness, in patient, Disease, Pain, Disability & Hypertension.

Introduction:

Depression is defined in different ways by various authors. For instance, Morgan and his colleagues (Morgan et al., 1986) defined depression as an emotion characterized by “Sadness”, crying, withdrawal from others, and feelings of inadequacy. In the words of Carson, Butcher, and Mineka (2005), depression refers to an emotional state characterized by extraordinary sadness and dejection. However, another very clear and elaborative definition of depression is given by Taylor (2016). According to him, depression is a neurotic or psychotic mood disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent, sleeping, feelings of dejection and hopelessness, and sometimes suicidal thoughts or an attempt to commit suicide. Chronic illnesses, on the other hand, refer to those illnesses that are long lasting and usually irreversible (Taylor, 2016).

Many Chronic diseases affect all aspects of a patient’s life (Maes et al., 1996; Taylor & Aspinwall, 1990). Immediately after a chronic disease is diagnosed, a patient can be in a state of crisis marked by physical, social, and psychological disequilibrium. If the problems associated with a chronic disease fail to respond to the patient’s usual coping efforts, the result can be an exaggeration of symptoms and their meaning, indiscriminate efforts to cope, an increasingly neurotic attitude, and worsening health (Epker

& Gatchel, 2000). Anxiety, fear, and depression may temporarily take over. Here we will briefly discuss on the role of depression in chronic illness.

Depression is a common and often debilitating reaction to chronic illness. Up to one third of all medical in-patients with chronic disease report at least moderate symptoms of depression and up to one quarter suffer from severe depression (Moody, Mc Cormick, & Williams, 1990). Depression is especially common among stroke patients, cancer patients, and heart disease patients, as well as among those people experiencing more than one chronic disorder (Egede, 2005; Taylor & Aspinwall, 1990).

Rationale of the study:

At one time, depression was treated as an unfortunate psychological consequence of chronic illness, but its medical significance is increasingly being recognized. Depression can be a sign of impending physical decline, especially among elderly men (Anstey & Luszcz, 2002). Depression exacerbates the risk and course of several chronic disorders, most notably coronary heart disease (CHD). Depression complicates treatment adherence and medical decision making. It interferes with patients adopting a co-managerial role, and it may confer enhanced risk of mortality from a broad array of chronic diseases (Anstey & Luszcz, 2002). For all these reasons, the assessment and management of depression in chronic illness has become of paramount importance to health care providers and health psychologists.

Objectives of the study:

Thus the objective is to make the readers aware of the following facts:

- Most acceptable definition of Depression and chronic illness.
- Significance of depression in chronic illness.
- Assessing depression in chronic illness.
- Who gets depressed?

The Significance of Depression:

Let us throw some light on the significance of depression, assessing depression, and who gets depressed, one after another.

Depression is important not only for the distress it produces but also because it has an impact on the symptoms experienced and on the overall prospects for rehabilitation or recovery (Schaeffer et al., 1999). Depressed stroke patients have longer hospital stays and are more often discharged from the hospital to nursing homes than are other patients (Cushman, 1986). They show less motivation to undergo rehabilitation and are less likely maintain gains during rehabilitation or to restore their quality of life to pre stroke Levels (Niemi, Laaksonen, Kotila, & Waltimo, 1988).

Depression is very common among patients with irritable bowel syndrome, an emotional overlay that can complicate treatment (Trikas et al., 1999). Rheumatoid arthritis patients with high levels of depression are more likely to catastrophize, over generalize, and negatively interpret their situation (Smith, Peck, Milano, & Ward, 1988). Myocardial infarction (MI) patients who were depressed while in the hospital are less likely to be back at work a year later and are more likely to be re-hospitalized than are those patients who were not depressed (Stern, Pascale, & Ackerman, 1977). Depression can exacerbate the symptoms cancer, coronary heart disease, and hypertension, which are briefly discussed below:

A complication of diabetes is the depression that often accompanies it (De Groot et al., 2001). Especially as symptoms increase and the disease intrudes increasingly on life activities, patients may become depressed (Sacco et al., 2005). Depression reduces self-efficacy, compromises adherence, and leads to poor glucose control and poor compliance with the diabetes treatment regimen (Sacco et al., 2005). Depression is also linked to an enhanced risk of CHD among women diagnosed with diabetes, thus it represents a particularly problematic complication (Clouse et al., 2003). As a result, depression is often an object of treatment, as well as a symptom of the disease.

Research has found a positive association between depression and cancer (Carney et al., 2003). Depression can be associated with elevated neural endocrine responses such as cortisol and nor epinephrine, which may in turn, have implications for cancer via their impact on the immune system. Psychological distress more generally has been tied to colorectal cancer mortality (Kojima et al., 2005). At present, evidence suggests a modest association between psychological factors, including stress, personality, and social support, and the development of at least some cancers.

Considerable research also indicates a role for depression in the development and progression of coronary heart disease (CHD), so much so that it is now generally recommended that patients at high risk be assessed and, if necessary, treated for depression (Davidson et al., 2006). Depression is not a psychological by-product of other risk factors for CHD but an independent risk factor in its own right, and it appears to be environmentally rather than genetically based (Lett et al., 2004). This risk that depression poses with respect to heart disease is less than that of smoking but greater than that posed by second hand smoke. Accordingly, depression constitutes a major independent risk factor in the onset of coronary disease (Wulsin & Singal, 2003).

Hypertension, also known as high blood pressure or cardiovascular disease (CVD), occurs when the supply of blood through the vessels is excessive. It can occur when cardiac output is too high, which puts pressure on the arterial walls as blood flow increases. It also occurs in response to peripheral resistance – that is, the resistance to blood flow in the small arteries of the body. Recent research suggests that hostility may be associated with hypertension via its effects on interpersonal interaction – namely, by increasing the number of conflict-ridden or unpleasant interactions in daily life (Brondolo, Rieppi, & Erickson, 2003). Other evidence suggests that negative emotions, including depression and anxiety, may be prospective risk factors for hypertension well (Rutledge & Hogan, 2002). Depression, hostility and lack of social support are quite closely linked (Raynor et al., 2002).

Depression over illness and treatment has also been linked to suicide among the chronically ill (Goodwin et al., 2003; Rollman & Shear, 2003). For example, one out of every six long-term dialysis patients over age 60 stops treatment, resulting in death (Neu & Kjellstrand, 1986). The rate of suicide among cancer patients is approximately one-and-a-half times greater than that among adults who are not ill (Marshall, Burnett, & Brasure, 1983), and the rate of suicide among men with AIDS (acquired immune deficiency syndrome) is higher than the national rate for their age group. Perhaps more importantly, depression is a potent risk factor for death among the chronically ill (Herrmann et al., 1998; Wulsin, Vaillant, & Wells, 1999). Moreover, unlike anxiety, which ebbs and flows during the course of a chronic illness, depression can be a long-term reaction. For many illnesses it may last a year or more following onset of the disorder (Lustman, Griffith, & Clouse, 1988; Robinson & Price, 1982).

Assessing Depression:

Assessing depression in the chronically ill can be problematic. Many of the physical signs of depression,

such as fatigue, sleeplessness, and weight Loss, may also be symptoms of disease or side effects of a treatment. If depressive symptoms are attributed to aspects of illness or treatment, their significance may be less apparent and consequently, depression may go untreated (Ziegelstein et al., 2005). For example, one study of depressed stroke patients found that only one third had been referred for treatment of the depression (Lustman & Harper, 1987). These issues are especially problematic for illness that can affect brain functioning, such as cancer, stroke, diabetes, AIDS, and epilepsy (House, 1987; Primeau, 1988). Depression may also lead patients to make extreme decisions about their care, such as withdrawal of dialysis among end-stage renal disease patients (Mc Dade-Montez et al., 2006). Depression, as well as anxiety, is so prevalent among chronically ill patients that many experts recommend routine screening for these symptoms during medical visits (Löwe et al., 2003).

Who Gets Depressed?

Depression increases with the severity of the illness (Moody, McCormick, & Williams, 1990). The experiences of pain and disability, in particular, lead to depression (Wulsin et al., 1999), which, in turn, increases pain and disability. These problems are aggravated in those who are experiencing other negative life events, social stress, and Lack of social support (Thompson et al., 1989).

Moreover, physical limitations may predict depression somewhat better earlier in chronic illness, whereas psychological factors may better explain depression later on. For example, one study of stroke patients found that the location of stroke damage predicted depression in the first 6 months, whereas later on, cognitive impairment, physical disability, social support, changes in body image and self-esteem and the adverse mood effects of therapeutic drugs, were stronger determinants of depression (Morris & Raphael, 1987.)

In recent years, a variety of effective cognitive and behavioral interventions have been developed to deal with the depression that so frequently accompanies chronic illness. Treatment for depression may not only alleviate psychological distress but also improve functioning by reducing symptoms associated with the illness (Mohr, Hart, & Goldberg, 2003).

Conclusion:

Thus, the significance of emotional responses, in a broader sense including denial, anxiety and depression, to chronic illness, then lies in the fact that negative emotions compromise quality of life, and coexisting psychiatric conditions can complicate assessments of symptoms (Feldman et al., 2005) and exacerbate risk of deteriorating health or death. In summary we can say that chronically ill patients often experience denial, intermittent anxiety, and long-term depression. But too often, these reactions, especially anxiety and depression, are under diagnosed, confused with symptoms of disease or treatment, or presumed to be normal and so not appropriate for intervention. Anxiety is reliably tied to illness events, such as awaiting test results or obtaining regular checkups. Depression increases with the severity of disease, pain, and disability. Depression is a common and often debilitating reaction to chronic illness.

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