Social management of depression

Paul E Bebbington/Liz Kuipers, Institute of Psychiatry, London

Depressive symptoms are very common in the general population. In Western societies it is probable that between 5—10 per cent of the population are suffering from a diagnosable depressive disorder at any given time (Brown and Harris, 1978; Weissman and Myers, 1978; Bebbington et al, 1981). Perhaps half of these cases are chronic and they represent a largely untouched pool of suffering, although they are heavy users of primary-care facilities.

A majority of people with these disorders visit their family doctor but they may not reveal their psychiatric difficulties to him, often presenting instead with a physical complaint (Goldberg and Blackwell, 1970). If the doctor recognizes that the patient has a psychiatric disorder it is most likely that he will deal with it himself. Only 5—10 per cent of psychiatric cases recognized by the GP are referred to the specialist services (Shepherd et al, 1966; Kaesar and Cooper, 1971). Even so, depressive disorders constitute a considerable burden for these services.

The introduction of effective medication nearly 30 years ago was a major advance in the management of depressive disorders. The actions, indications, and use of these drugs are now well understood (Mindham, 1981; Nies and Robinson, 1981). However, it is quite apparent that their introduction has not solved all the problems that depressive patients represent both to themselves and to their physicians. Analytically orientated psychotherapy has occasional notable successes but these are unpredictable and the treatment is unavailable or impractical for most patients. However, relatively simple counselling techniques can be used to ease the burden of depressed patients. These depend upon clear assessment and it is the aim of this article to suggest guidelines for a programme of management using these techniques.

A classification of depressive disorders

Depressive disorders can be divided into three broad groups, with some reservations.

In one sense, the first group is not a disorder at all since there are degrees of misfortune that cause symptoms of anxiety, worry, and misery in most people. Not everyone is equally resilient to strife, hardship, and loss but there is a broad range of responses that must be regarded as normal in such circumstances. However, in another sense these responses are not normal since they involve suffering and impair a person's efficiency.

Of course, some people may be to some extent responsible for their own misfortunes because they deal with their circumstances in an inept way while others follow life styles that are likely to be eventful even though the events appear to be accidental.

Where the misfortune is acute and of finite implications, there is a gradual return to normal mood, outlook, and functioning. However, adversity can be prolonged and although some people may gradually adjust to what might seem a fairly intolerable situation, others continue to be unhappy and miserable to a significant degree. In the past the effects of misfortune were often the province of ministers of the Church. Nowadays they also form part of the work of psychiatrists, although the latter cannot claim to have any exclusive expertise in dealing with them and they can equally be managed by other members of a multidiscipline team. Such intervention can be useful for people suffering from this type of acute or chronic distress.

The second group of disorders includes those in which the sufferer, because of some personal characteristic such as low self-esteem, obsessional particularity, or poor coping strategies, is especially prone to respond badly to events that most people would find minor and easy to deal with. Such patients also offer opportunities for intervention of the counselling type.

The final group conforms to the psychiatric concept of depressive illness. Nevertheless, such cases form only a small proportion of the affective disturbances seen by psychiatrists. Episodes may be preceded by adverse events but these are insufficient to account for the patient's symptoms which may include retardation, agitation, early-morning wakening, diurnal variation of mood, pathological guilt, and more extreme delusional beliefs. Such disorders may not be preceded by any adverse circumstances at all, or the adversity may precede onset by a considerable time. Even in such cases, for which physical treatments are usually important, counselling may be of major benefit particularly in a prophylactic role.

Assessment of social factors

Onset: Because affective disturbances may take any of the forms described above, evaluation of the impact of social factors must be tied in with a careful symptomatic assessment. Particular attention should be paid to the accurate dating of onset. The patient should be asked about his symptoms at the time of significant public or private dates in order to establish when he was last normal in mood and capable of enjoying life.

Mood: This should be assessed carefully to determine the level of anguish experienced by the patient. It should be established whether lowered mood persists for days on end, whether it varies, and whether any variation is in response to external circumstances. Symptoms indicative of the so-called functional shift should be sought. Subjective or objective slowing of thought, speech, or movement should be noted as should the presence of early-morning wakening, diurnal variation of mood, loss of appetite, and the subjective loss of emotional feeling. Evidence of pathological guilt, whether overvalued or actually delusional, should be sought.

Personality characteristics: Those likely to affect overall appraisal should be assessed. Patients with obsessional traits may be very susceptible to events that involve a change of routine. Such people may also set very high standards of functioning for themselves and a small recession from these may be seen as absolute failure. Sometimes these recessions may follow events that do not seem very stressful on the surface.

Other people may be temperamentally inclined towards wild irrational actions in response to events, resulting in an increase in their adverse implications. Some individuals may be incapable of formulating effective actions because of indecisiveness or an inability to analyse a situation in an effective manner. Certain events have an impact because they detract from an already

impaired self-esteem, emphasizing the hopelessness of the person's situation and the impossibility of self-remedy.

Cognitive disturbances: It is the central tenet of cognitive theorists that the primary disturbance in depression is of a cognitive nature and therefore that a distorted cognition is characteristic of all states of depression (Beck, 1967). Clinically, a distorted cognition is not always equally prominent or important in all areas of the patient's life, and it seems likely that it is not always primary.

However, the presence of distorted cognition is particularly likely to magnify the impact of social events and to deepen a depressed mood. This may quickly lead to a downward spiral of negative thinking that remains and counters other more benign influences upon mood. An assessment of such thinking processes is therefore important.

Arbitrary inference: This occurs when, for instance, the patient sees a stranger looking at him and takes it to mean that he is worthless. This unlikely inference is immediately preferred and clung to by the patient, rather than the more probable explanation that he met someone's eye by chance.

Selective abstraction: This is the process of concentrating on particular negative parts of the environment. For example, the stranger's look and its implication is thought about all day and other more pleasant events are not noticed.

Overgeneralization: This may be seen when, because one stranger looked, everybody is held to feel in the same way that the patient is worthless — even those who do not appear to notice him.

Other aspects: These include the *minimization* of more likely or more positive events and feelings and the *magnification* of negative or unpleasant instances. For instance, a stranger's look, in itself a neutral event, becomes negative and then aversive leading to an avoidance of eye contact with other strangers. Patients often describe the negative thoughts that arise as a result of some intrinsically neutral event as unstoppable or overwhelming. They are frequently very similar to automatic thoughts and thus even harder for the patient to recognize or resist.

A clear picture of the form and development of the disorder and of the subject's personality and characteristic cognitions may serve as the basis against which social factors can be assessed. Such factors are best sought by following a structured line of questioning. Difficulties and disasters should be looked for in the areas of health, sexual function, the family, relationships outside the family, work, and other activities.

The social network: Depressed patients are not as a rule socially isolated and the social network of the patient must therefore be assessed. Relationships may be a source of strain or support. Information must be obtained about the interaction between the patient and his relatives, and of any counterproductive effect of the patient on those close to him. Both the family's and the patient's perception of the illness and expectations from treatment are important.

Social performance: Depressive disorders frequently impair function in various areas of a patient's life and an estimation of any such impairment is an important aspect of assessment, leading as it does to a logical organization of the necessity and timing of particular interventions. Assessment of the patient's social performance ideally requires an informant. The patient's usual level of performance in relationships as well as the practical management of his life and work must be assessed. It is important to note whether there has been a definite change in these related to the onset of illness.

Interactions leading to affective disorder: Having obtained information about the onset, form, and course of the disorder, the patient's usual personality and current mode of thinking, and the social factors described above, the psychiatrist is in a position to assess the interaction between them.

The first aspect to consider is whether social difficulties can account for any part of the affective disturbance. This involves an appraisal of the meaning that social difficulties have for individual patients with particular histories, circumstances, attributes, and attitudes. Cognition influences our susceptibility to events and conversely events can affect our thought processes.

Events have the power to disturb because they change our view of ourselves, those around us, and the way the world works. Therefore, they operate through an effect on our view of the future. In some cases the views that are changed are idiosyncratic, sometimes because of the person's immediate circumstances and sometimes for more historical reasons, and this must be realized before the full impact of an event on the patient can be accounted for.

Some effects of events are general: any event may destroy future plans or prevent people from carrying out particularly valued roles. Events often allow us to perceive emotionally that which we only previously knew intellectually. They may reveal to some people that the world is no longer a smiling place in which good fortune is guaranteed and where bad things only happen to people they do not know. Any event may persuade people that they are less in control of their life than they thought, that their self-image can no longer be one of competent mastery. Events may suddenly demonstrate to people that their actions have consequences and that these may be unpleasant, or that virtue and talent are not always rewarded.

Illness or injury to the patient may have special implications for patients who set particular store by physical attractiveness or physical prowess or those who pride themselves on their constitution. Even physical disorders with a good outcome may change someone's view of their own mortality in an upsetting way. Physical illness in friends and relatives may suggest, possibly for the first time, the impermanence of social situations and the near possibility of death.

Other events may also threaten the likelihood or possibility of having to do without someone important or supportive. Some events involve a decline in moral esteem for someone close, for example because of a betrayal of trust. Events involving a person's children may sometimes be of this type, especially with people who apply rigid adult standards to the relatively young. Any occurrence that reduces a patient's expectations of his children can be very upsetting.

Robberies and burglaries may carry the realization, correct or not, that the neighbourhood is a dangerous and threatening place. Burglaries have implications beyond the obvious material results in that they represent a gross invasion of privacy.

Sudden events that impose a financial burden on those who are already in financial difficulties may suggest that their struggles are unavailing and doomed to failure; they struggle and endure but get nowhere. When people who are living in bad housing suddenly find that a real prospect of rehousing has been lost, they may take this to mean that they are going to be stuck for ever in an awful place.

Events at work are often the cause of emotional disorder. In someone of set habits, the mere appointment of a new and unknown boss may be sufficient to cause distress. Failure to gain a deserved and expected promotion or pay rise may result in aggravation, as may the sight of a supposedly incompetent colleague gaining promotion, especially if this is at the expense of the subject's chances. Such events may confirm a pessimistic view of the way the system or the world operates.

Practical Psychiatry

Volume 1

Edited by Sidney Crown

PhD, FRCP, FRCPsych

A review of contemporary psychiatric theory and practice from the *British Journal of Hospital Medicine.*

Practical Psychiatry is a new book containing 51 articles written by experts — each a recognised authority in his field — and compiled by the eminent psychiatrist and author Dr Sidney Crown. The articles cover a wide range of topics from general clinical psychiatry to the major subspecialties, including two important symposia on schizophrenia and epilepsy. The book is divided into eleven sections and contains the following chapters:

General Clinical Psychiatry: Prognosis of schizophrenia / Family processes in schizophrenia / The biochemistry of schizophrenia / Paranoid states / Hallucinations / Uncommon psychiatric disorders / The management of depression / Electroconvulsive therapy: its current clinical use / Hypochrondriasis / Psychiatric emergencies / Clinical aspects of suicide and its prevention / Clinical measurements and index numbers

Organic psychiatry: The diagnosis and investigation of epilepsy / The surgical treatment of epilepsy / Epilepsy: brain and mind / Temporal lobe epilepsy / Abnormal movement disorders

Psychotherapy and Behavioural Modification: Individual psychotherapy / Family and marital psychotherapy / Group psychotherapy / Behavioural psychotherapy / Encounter and the new therapies / Psychotherapy

Social Psychiatry: Living with a schizophrenic patient / Self-help groups / Industrial therapy / Construing doctor-patient relationships / Psychiatric assessment and the immigrant patient

Psychopharmacology: Practical considerations in the use of depot neuroleptics for the treatment of schizophrenia / Current status of monoamine oxidase inhibitors in psychiatry / Lithium salts: therapeutic and unwanted effects

Substance abuse: Analgesic abuse / Alcoholism / Clinical features and treatment of alcoholism

Psychosexual: Pornography: a psychological appraisal / Sexual fulfilment for the handicapped / Psychotropic drugs and sexual behaviour

Child and Adolescence: The psychiatry of adolescence / Psychological problems of handicapped children

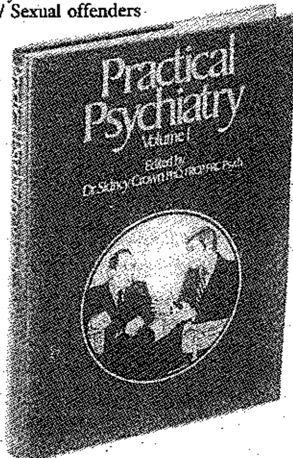
Subnormality: Down's syndrome / Growing up with Down's syndrome

Psychosomatics and Liaison psychiatry: Clinical applications of biofeedback / The management of patients in pain / Psychological reactions to physical illness / Stress and coronary artery disease / Psychiatric disorders in industry

Legal and Forensic psychiatry: The Mental Health Act, 1959: with special reference to the mentally abnormal offender / Preparing psychiatric court reports / The psychiatric assessment of homicide / Operating the Mental Health Acts / Sexual offenders

Each article is a critical review of the subject under discussion and provides a useful synthesis of current thought in psychiatry. The concise and accurate information given in *Practical Psychiatry* makes this volume an invaluable aid to revision for the MRCPsych examinations as well as for all psychiatrists in training, psychologists, GPs and those working in allied fields who require a quick reference to specified areas of psychiatry.

288 pages with line drawings & tables, large format (A4 size) fully casebound



Price £22.95
(plus £1.25 p&p)

Order now from: Northwood Books, Northwood House, 93-99 Goswell Road, London EC1V 7QA

Please send me ______ copy/ies of Practical Psychiatry at £24.20 (including post & packing)

I enclose cheque/PO for £______ payable to Northwood Publications Ltd.

Name ______________________

Address ______________________

However, the events most commonly associated with distress are those that threaten to disrupt a person's most intimate relationships. Such events are distressing in proportion to the subject's powerlessness to reverse their effect or manage their consequences. Events that have implications for our sexual self-image often have particularly powerful effects.

By and large, people know when a misfortune has upset them. The upset follows closely on the event, or at least on the full realization of its implications (which may take a little time). The individual becomes preoccupied with the event, brooding on it at the expense of other everyday concerns. However, occasionally a patient can be upset without quite realizing why. The reason becomes apparent if the psychiatrist explores with the patient the possible implications of recent happenings. The preoccupation of sorrowing for a recent misfortune is usually distinguishable from the morbid preoccupations of those with the more classic features of an endogenous depressive illness. In the latter, the event may appear to be quite trivial even when assessed in the context of its likely meaning for the patient. It is often an event that has occurred some time before the onset of the illness and there seems to be no apparent reason for its delay in that nothing further has happened to modify the impact of the event. Moreover, the same event may feature in the patient's preoccupations in subsequent illnesses.

Social management of depression

The first principles of the management of depression are to hinder suicide, assuage anguish, provide nutrition, rest, and sleep, and to encourage occupational interest. The object of social management is to preserve the patient's place in his social world and to equip him with more effective coping strategies.

The decision to admit to hospital: Admission is a major form of social treatment (providing asylum). It removes the patient from a situation of stress and gives a breathing space in which it may be possible to renew his capacity to cope. On the other hand, especially in milder cases, admission can undermine the ability to cope, disrupt social circumstances, reduce the opportunity to bolster self-esteem, and create stigma. Day hospitals are often appropriately used as a compromise in this context. The indications for admission include danger (for example of suicide), malnutrition, severe anguish or social incompetence, inability to cooperate with outpatient treatment, failure to benefit from outpatient treatment, or inadequate support from relatives.

The patient with severe depression should not have weekends at home for the first 2—3 weeks since this may set him back a long way if the family fails to cope.

The patient should be given the opportunity for ventilation. The role of the psychiatrist should be to advise, encourage, reassure, and inform. One of the greatest fears of the depressive patient arises from the feeling that things are running out of control. This fear can be dispelled by giving information about the patient's illness that may change his view of himself and by implying that the psychiatrist can (and will) control the situation.

Taking control of the patient and his situation carries the risk that the patient may become dependent. The psychiatrist should counteract this by emphasizing that when the patient begins to improve he will again be required to put an effort into solving his own problems, whether they are the occasion of his condition or are occasioned by it. This implies to the patient that complete dependency is inadmissible but also alleviates his guilt at letting go. Support should not be designed to prop up someone who is falling down but to augment and use the strengths of the patient to enable him to master the situation himself.

Specific strategies: The best use must be made of the coping strategies open to the patient. Such strategies can be divided into those that change the situation, those that change the meaning of the situation, and those that control the stress.

Changing the situation: This strategy is sometimes possible. If certain settings or interactions exacerbate the depressed mood these may be open to modification. For instance, spending time alone at home or even on the ward is often felt by the patient to increase this depression. A graded activity programme can be useful as a first step in counteracting this although patients may need considerable support and encouragement to attempt it.

Changing the meaning of the situation: In order to do this there is some evidence that the specific approaches of cognitive therapy are useful, particularly for nonpsychotic depressed patients. This consists of a direct and structured attempt to show the patient his distorted and negative beliefs about himself and to modify them accordingly. As described in detail elsewhere (Beck et al, 1980; Goddard, 1982; Mackay, 1982), the patient is helped to recognize his dysfunctional cognitions and to test them against reality. If this is combined with a programme of increasing activity, new opportunities for discussing and rebutting the accompanying negative distortions can be provided.

Depressive patients typically have grandiose ideas of what is required of them and tend to measure their failings against these. This often leads to feelings of worthlessness and guilt. The therapist can attempt to change this by rehearsing recent events with the patient and leading him to a more probable and less negative interpretation. In the context of a good relationship with the patient, gentle raillery at the grandiosity and improbability of the depressive's feelings can be very powerful, for example: "I suppose it's down to you to overhaul completely the whole tax structure of the UK. On your own."

Controlling the stress: Strategies that control the stress for the patient can be beneficial. The depressed patient may find himself in all sorts of practical difficulties with finances, family relationships, employment, and the general management of his affairs. A therapist can engage to relieve the burden of these for the present. The resources of social support should be mobilized to reduce pressure on the patient and improve his ability to cope. These resources are sometimes easier to tap if relatives are given information about the nature of depressive illness. If they are able to attribute behaviour to an outside cause such as illness rather than it being under the patient's own control, it may make it easier to deal with and easier for them to be supportive.

Although the initial assessment of the depressed patient and the monitoring of physical treatment is the special expertise of the psychiatrist, the social management of depression along the above lines can be carried out by various members of the psychiatric team — psychiatrist, psychologist, nurse, and social worker — depending on resources available.

General principles of continuing management

Beware the suicidal patient who is recovering — apathy resolves before hopelessness, particularly with ECT, and this may increase the risk of suicide.

Full recovery from a depressive illness implies that the functional shift described above is reversed. Recovery is incomplete if the patient still shows evidence of, for instance, diurnal variation (as reflected by a difficulty in getting moving in the mornings) or early waking. Medication should not be discontinued while such symptoms remain since relapse is virtually guaranteed.

When the symptoms are in abeyance, medication should be continued for 4—6 months. Maintenance antidepressant therapy may have to be countenanced in some patients.

The continuing social management of depression

This should incorporate a graded resumption of the demands of social roles. The aim should be caution: never ask the patient to attempt anything that is at all likely to be beyond his powers. Small steps provide for a continuity of successes, which gradually restores self-esteem and resilience. A start may be made by engaging the patient in small tasks around the ward and later by similar structuring of activities in occupational therapy. Evenings, days, and weekends outside the hospital should also form a graded progression. The major difficulty in such a programme is the return to work which cannot often be accomplished in small steps, although even here liaison with a sympathetic employer or personnel officer (with the patient's permission) can help. In general, effective resumption of all social roles and the return of relationships to normal tend to occur later than symptomatic recovery.

The adjustment of the patient's coping strategies probably has its major effect in the prevention of future relapses, both spontaneous and provoked, although enthusiasts for cognitive therapy argue that it has a therapeutic as well as a preventive role even in moderately severe depression. While maintenance tricyclic-antidepressant therapy can protect the patient against spontaneous relapse, it does not seem to mitigate the effects of acute misfortune. The patient's relatives are often invaluable as a source of information about relapse, although they are sometimes discounted. Practical changes in environment (such as re-housing) sometimes help but not always.

Perhaps 10 per cent of "old long stay" and 15 per cent of "new long stay" mentally ill patients are suffering from chronic affective disorders. Inpatients and outpatients who fail to respond to treatment tend to be middle-aged and relatively socially isolated. They suffer from persistent residual disabilities affecting work capacity and relationships, both marital and general. Impairment of role performance is often relatively selective. Such disabilities provide a source of continuing stress.

There are certain special principles of management in chronic depression over and above the general principles applying to all chronic patients. The aims should be to restore or improve the ability to respond to the complexities of living in society, enhance practical problem solving, and enhance the emotional capacity for dealing with social relationships.

The value of occupational and industrial therapy in such cases is less from their role in the rehabilitation of work performance and discipline than from their potential in restoring confidence and feelings of mastery and self-esteem. Therapy should be planned with this in mind.

Bebbington, P, Hurry, J, Tennant, C, Sturt, E, Wing, J K (1981) *Psychological Medicine*, **11**, 561

Beck, A T (1967) Depression: Clinical, Experimental and Theoretical Aspects. Harper and Row, New York

—, Rusk, A J, Shaw, B F, Emery, G (1980) Cognitive Therapy of Depression. John Wiley, London

Brown, G W, Harris, T O (1978) Social Origins of Depression. Tavistock, London

Goddard, A (1982) *British Journal of Hospital Medicine*, **27**, 248

Goldberg, D P, Blackwell, B (1970) *British Medical Journal*, ii, 439

Kaesar, A C, Cooper, B (1971) *Psychological Medicine*, **1**, 312

MacKay, J (1982) *British Journal of Hospital Medicine*, **27**, 242

Mindham, R H S (1981) *in* Handbook of Affective Disorders (edited by Paykel, E S). Churchill Livingstone, Edinburgh. p.231

Nies, A, Robinson, D S (1981) *in* Handbook of Affective Disorders (edited by Paykel, E S). Churchill Livingstone, Edinburgh. p.246

Shepherd, M, Cooper, B, Brown, A C, Kalton, G (1966) Psychiatric Illness in General Practice. Oxford University Press, London

Weissman, M M, Myers, J (1978) *Acta psychiatrica Scandinavica*, **57**, 219 □