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Social Psychiatry of Depression

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Abstract

The sociological factors with a bearing on certain facets of depressive illness are reviewed. They include: Attitude of the patients and the helpers, Psychosocial supports, Suicide counters, Aspects of follow-up and rehabilitation, Socioeconomic status, Migration both within the country and intercountries and Family studies.

Key words -
Expressed emotion,
Confiding spouse,
Illness perception,
Suicide counters,
Worklessness

Social psychiatry of depression assumes that social context determines the occurrence of depressive illness and its course and outcome. Additionally it influences the illness behaviour and treatment seeking patterns. It also deals with the attitudes of the key persons around the patient as well as those that are sought after by the depressed individuals, namely, the general practitioners and other healers. Social status and migration, rehabilitation and after-care fall within the fold of social psychiatry

The role of life events in depressive illness has been discussed elsewhere [1]. The social psychiatrists assign to the life events an important aetiological role. It is not all who are exposed to those events develop depression. Hence, there are other factors which render a person liable to pathology in the event of a stressful life situation.

Attitude

The critical attitude of the care giving key persons around the patient and their 'expressed emotion' play a part in the inception and the recurrences of depressive episodes. The depressive illness is likely if the 'critical comment' score of the important persons exceeds two or three as contrasted with six or seven in the schizophrenics thereby implying that impairment of self-esteem is of prime importance in depression. "Expressed emotion" from the key relations acting in conjunction with a life event may result in depression.. It has been suggested that it may be possible to predict the course of the illness from the knowledge of the expressed emotion of the key persons at the time of first admission itself. A family history of either alcoholism or antisocial personality renders the individual to succumb more

easily to the impact of the life event. There are a set of other factors that need to be taken account of.

Psychosocial Support

These pertain to the social resources, personality factors (general psychological) and specific coping mechanism. The social resources consist of support from persons and other material support. It involves a network of many individuals. They indicate to the individual as to what material support to expect from the social system and also the emotional feelings whether he is wanted, loved and cared for or not. The general psychological factors involve the concept of self-esteem, self-denigration and a sense of mastery over the situation. A poor self-esteem, a high degree of self-denigration and a low level of mastery of the situation prepare the ground for depression. On the other hand, a high sense of self-esteem, absence or a low level of self-denigration and a sense of mastery can offset the depressive episode. There are varieties of coping mechanisms which the individual utilises either to alter the meaning of the situation, or to forestall the occurrence of situation itself or to modify the course of the event. The coping mechanisms are discrete and are effective in a particular area while not useful in other areas. For example, mechanisms to cope with marital problems are different from those employed in work area. Depressive illness is spoken of as a failure in coping mechanism. Carstairs refers to his experience with university students who withdrew into themselves, avoided their fellow students and rejected offer of friendship with a falling off to the standard in their studies [1a]. Many of them passed through existential crisis, self-doubts, and questioned themselves whether the course of study they had undertaken was not a grave mistake. This is an example of breakdown of coping mechanism in early adolescence.

Brown et al. reported that the working women are more susceptible to depression especially in the presence of vulnerable factors: loss of mother before the individual's eleventh year, three or more children below fourteen, a lack of occupation outside the home and absence of a person to confide her problems [2]. However, Costello from Calgery, Canada could confirm only the absence of a confiding person as the most important factor and other vulnerability feature were not clear [3]. He pointed out some factors are likely to be community specific. the observation of Brown, Bhrolchain and Harris with 458 depressed women exposed to stressful events confirm the importance of social supports [4]. One percent of those with little stress, and much support, 4 percent with little stress and little support, 41 percent with much stress and little support suffered depression. Other factors are also of significance. These are social isolation from lack or loss of friends, emotional isolation from the absence of a confiding partner, a sense of emptiness when there is none to nurture, and a sense of worthlessness from worklessness and a feeling of being unwanted when social support is lacking. A good social support and a confiding spouse may act as prophylactic against the onset of depression or its relapse even in the face of stressful event. It has been suggested that the coping mechanisms together with social support may prevent a normal sadness from becoming morbid. The findings from Madurai study revealed that integration of an individual into the family was far more important than the social isolation [5]. Staying in a family does not ensure integration. Similarly staying alone does not necessarily spell social isolation. There were many who were within the family but were rejected or unaccepted by the family members. Yet they were able to preserve the external social ties. There were

others who were staying alone but were getting on well with their friends and commanded a wide network of social relations. The important point is that staying alone need not be equated with social isolation and lack of integration.

Attempts have been made to study the effect of drugs on the prevention of relapse of depressive illness in the face of emotional and social adverse factors. Pleas were advanced for intervention programmes for those facing events like bereavement and other undesirable social events [6]. Paykel and Tanner could not find unequivocal evidence of the protective influence of maintenance treatment with amytryptaline against life events [7]. With the use of lithium there was no proof of its buffering effect against life events in precipitating relapses [8]. This is contrary to the action of Phenothiazine in schizophrenia.

Next social factor is the treatment seeking behaviour of the depressed individual. The attitude of both the patients and those offering help determine this. In their Madurai study, Venkoba Rao and Madhavan pointed out that the prevalence of depression was several times more in the community than in the psychiatric clinic [5]. Two among the forty one in the community sought treatment while the rest did not. A failure to perceive the depression as an illness by the members of the community and the family was evident in their geriatric survey. This was in marked contrast with the hospital attendance for organic brain syndrome cases and the manic ones, which situations community was quick to recognize as illness and referred to the hospital. Srinivasa Murthy and Wig reporting upon the perception of depressive illness in the rural population, observed that the depression was not commonly perceived as a health problem or even as a mental problem as often as other psychoses [9]. The help suggested were more social than medical. If medical help was suggested, they indicated more of general nature rather than psychiatric [10]. That the knowledge and the attitude of the general practitioners were limited was revealed in the study of Wig et al [11]. In a large proportion of cases, the physicians misdiagnosed the cases of depression and suggested wrong drugs and in inaccurate dose. This is paradoxical in view of large scale prescription of antidepressants by general practitioners and physicians. This may partly be explained by their awareness that aches, pains and sleeplessness are generally depressive in their basis and hence the prescription of antidepressant for these common symptoms. This leads to an erroneous notion of a high prevalence of depression but with an inadequate perception. Among the symptoms that are influenced by social factors are the suicide behaviour of the depressed patients. The responses of the patients to their symptoms determine both their illness behaviour and treatment seeking [12]. Venkoba Rao and Nammalvar have commented on the suicide counters in the depressives which avert the ideas of proceeding to an act of suicide [13]. Social attitudes and norms act in this way. The condemnatory attitude of the society towards suicide, social stigma attached to the act, social ostracization of the survivors especially the children to be married tend to counter the suicide impulse. The suicide rate among the depressives in India is considerably lower than in the West and this is attributable among other factors, to the family support. Many of the patients live either in a joint or an extended family. The key members in the family offer psychological support with the result, the depressed individual desires to live for them though not for himself. These counters have been dealt with by Venkoba Rao and Nammalvar [12]. These concepts are to be incorporated into the psychotherapy of depression. This is similar to the approach in the psychotherapeutic management of alcoholics where they are persuaded to abstain for the sake of those for whom they would like to live.

Follow-up and Rehabilitation

It is an inescapable fact that depression is a chronic recurring illness. Biological and psychosocial factors, playing in concert, make it so. Two Indian studies have offered data regarding follow-up of cases of depression indicating that chronicity sets in a fairly seizable proportion of the patients: 26.3 percent [14] and 24.0 percent [15]. Venkoba Rao and Nammalvar found while 14 of their 122 patients had to shift to another job, eleven became dependent upon their family, needing supervision and guidance [15]. Basit found that 28 per cent of housewives were experiencing moderate or severe disturbance in their domestic efficiency [14]. This raises the social and other consequences of depressive illness. The family members experience distress but are prepared to look after the patients. The important consequences of depressive illness are in the marital sphere. Marital conflicts, discord and divorce from depression are reported to be common in Western culture [16].

In the treatment of depression, social factors are to be employed although it is difficult to assess or prove their efficacy. Manipulation of a difficult social situation is called for especially at work or at home. The difficulties are to be explored carefully during the session with the family members. Many depressives feel comfortable while at work and hence they may be encouraged to busy themselves and hold on to work. Though marriage is known to exercise a preventive effect on the occurrence of depression marital conflicts by themselves may generate depression.

The close relationship between depressive illness and social factors have not been clearly and convincingly demonstrated as much as in the case of schizophrenia. Bennett has remarked that there is no automatic prescription of social work in depression [17]. However, some serious attempt has to be made towards rehabilitation of the depressives especially when one realises the risk of chronicity. In Indian setting, with a serious shortage of trained personnel, inadequate facilities at the rural level, lack of basic social organisations for mental health programme, poor perception of depressive illness by the community and profession alike, alternate methods to the ones practised in the West have to be conceived. The ultimate responsibility to rehabilitate the patients rests on the family with provision of health care facilities. The non-professionals like multipurpose workers, health supervisors and others, primary health centre medical men and general practitioners are to be trained for action. The public education programme should be organized to improve perception of illness. Administration of simple antidepressants may be undertaken at the primary health centre level just as in cases of anti tuberculosis, leprosy and malaria programmes. The complicated cases may be referred to the Psychiatric clinics or mental hospitals for investigation and treatment. Lack of drugs limits the management of cases. The members of the community and family should be cautioned of the risk of suicide among the depressed and informed on appropriate measures of intervention. Instead of shifting the patients to mental hospitals or special rehabilitation homes or even the homes for the aged, it is economical and feasible to treat and rehabilitate them in their homes and in rural area. Rural setting tend to minimise the risk of chronicity [18] and management in the family diminishes the drug dosage.

The emphasis should be on early diagnosis and effective treatment concentrating on secondary type of prevention. These have been discussed by Wig and Srinivasa Murthy [19]. Rehabilitative measures which involve work and instrumentation and which are currently available for mentally retarded and the schizophrenics in several institutions are hardly applicable to the depressed population. Nevertheless considering the vocational impairment in the depressive, allotment of work is not without benefit as was demonstrated by Wing [20]. "It nourishes and enlivens the higher man and urges him to

produce the best he is capable of" [21]. The aim of the rehabilitation is restoration or improvement of person's adaptation. Adaptation, Phillips observed is the responses to the complexities in living in society [22]. It requires a degree of social competence which involves intellectual capacity for mastery of the objective world, a capacity for relationship to others and a capacity to choose alternate paths of action during times of stress. Until one knows more for certain the usefulness of social therapy, the traditional treatment of depression with biological and psychological is to be supplemented by measures of social resources and social support. The view that depression is a social casualty and social measures can overcome it has not been proved.

Finally, it may be observed that in some refractory cases, a breakthrough may be obtained by exploring social area in the individual's biography and rectifying social pathology.

Socio-economic Status

Few studies in India have treated the relationship between socio-economic status and mental illness in general and depression in particular. There are in India two scales which have been employed to assess the socio-economic status. The one used for urban population devised by Kuppusamy is based on there main variables: education, occupation and income [23]. The scale has 5 categories of social classes: I upper, II upper middle, III middle, IV lower middle and V lower class. The other scale for rural population was devised by Parikh and Trivedi and has 9 items: caste, occupation, education, social participation, land, house, farm powers; material possession and family [24]. The satisfaction of class are same as on the Kuppusamy's scale. Using these scales Chopra, Bhaskaran and Varma found that one half of their manic depressive patients belonged to middle class while the other fell under lower middle class, upper and lower class in that order [25]. Earlier, Venkoba Rao reported a concentration of two-thirds of cases in the middle class with higher class coming second [25].

The relationship between the social class and depressive illness continues to be undecided and the reports in the literature have been contradictory. A higher prevalence of MDP in the upper social class was reported in the pioneering work of Farris and Dunham [27] and later by Maltzberg [28], Ruesch [29] and Hollingshed and Redlich [30]. Similar association between social status and MDP has been reported earlier. Though the study of Farris and Dunham indicated that there was random distribution of MDP in the city of Chicago in contrast with that of schizophrenia which was more prevalent in the poor, socially disorganized and overcrowded central area of the city, Hare proceeded to show that distribution of MDP was not just random but was more common for those parts of the English city where people lived in more comfortable circumstances [31]. That admission of depressive psychosis was more evenly distributed through the social classes was reported by Brooke [32], Bodan et al. [33] and Silverman [34]. In general, the theory of social class as a factory for the appearance of mental illness in a population has not been adequately decided. While the mid town study stressed on the lower socio-economic status, the Sterling County study added the concept of the degree of integration. Thus the rate of mental illness was not higher but lower in the low status persons if the community is integrated than in high status persons if they are in disintegrated community. The well known study of Hagnell [35] indicated that those in the lowest income groups and lowest occupational status had the least risk of developing mental illness. Among the geriatric population two important surveys, one in Denmark [36] and the other in New Castel upon Tyne [37] failed to find any association between mental

illness and social class. There are reports of many field surveys employing more precise definition of mental illness which did not confirm association between mental illness and social class. In a study of tribal population in West Bengal, Nandi et al. reported that mental illness was four times less among the Brahmins. Though the depressive illness was the most common one among both these, it was definitely less in the tribal than in Brahmin. This indicates that in spite of lower social economic status the tribal population possessed certain degree of integration and a composite culture which acted as defence against mental illness. As opposed to the above reports, Hall found the 'U' shaped pattern of distribution in the socio economic class for all psychiatric diagnoses with the highest rates at both extremes of the social scale, though neuroses fell in the trough of middle class [38]. As is evident, the area needs further exploration with inclusion of some more variables than mere socio-economic status.

Migration

India has witnessed a massive migration following partition. The main influx has been from Pakistan, Bangladesh, Sri Lanka and Burma. Though many of the migrants have been accorded the status of refugees and thereby provided with rehabilitation measures like housing, financial help, employment and education for children, the problem of immigrants continues to be difficult. Considering the extent of migration the studies devoted towards its mental health implications have been disproportionately few. Apart from this inter country migration, there has been throughout migration of people from one part of India to another necessitated by employment opportunities. The socio-cultural consequences of this inter and intra country movements have not been studied in depth. The available reports indicate that migration has brought in its wake a higher psychiatric morbidity. Sethi, Gupta and Mehendru studying the refugee families who had migrated to Lucknow following partition of India noted psychiatric disturbances among them more than the double in the non-migrants [39]. The rate for depression was 14.9 per 1000 among the migrants while it was 5-7 in the non-migrants. Depression accounted for 15.5 per cent of the psychiatric patients among the migrated and 13.5 per cent among the non-migrated ones. The authors observed that when a person was uprooted from his own environment and displaced on to the other, he goes through an adaptational crisis. On the other hand, Dube observed that uprooting by itself may not be a casual factor for psychiatric morbidity but the latter is determined by the stress the uprooting brought about [40]. He reported a higher rate of total mental morbidity in an uprooted community under stress than in a group of local population. He also reported absence of significant difference between psychiatric morbidity among the local people and amongst those who went through a smooth process of migration. To clarify the point as to what aspect of migration would lead to psychiatric morbidity, Nandi and colleagues found that the uprooted population had a higher level of aspiration compared to the other local population though both belonged to same lower socio-economic class [18]. The high level of aspiration brings with it more stress and a greater stamina to strive and a different attitude towards living. They found the depression in the uprooted population at 28.1 per 1000 as compared to 22 among the local population. They view depression as a stress disorder along with hysteria, phobia and anxiety.

While considering the socio-cultural aspects in these studies it is pertinent to remember that so-called migrants have not entered into a new culture. They all lived in the same culture of India prior to partition. The migration has not brought about any fresh cultural conflict. The stress associated with

migration were more socio-economic in nature than cultural. There is a single report on migration among the industrial population from within India from South to Eastern India [41]. While these authors observed a higher incidence of paranoid illness and psychosomatic reactions among the migrants than in the control population, reactive depression was about equal in both groups (6% and 5%).

The types of studies discussed above ought to be viewed from a different angle from the migration from European countries to the more developed ones. Here the influence of the alien culture of the host country brings conflict with cultural value of the parent country of the migrants.

There are a few accounts of psychiatric morbidity among the Indians and Pakistanis in Britain. However, it is not clear from the literature the real frequency of affective disorders among them. Many workers have cited loneliness, social isolation and frustrated ambition as causes of psychological distress besides specific cultural conflict [42], [43], [44], [45]. The children of Indian and Pakistani parents born in Britain become more or less "Anglicised" and wish to participate and strive for achievement in the British culture [46]. This often runs counter to the parental conservation attitude and results in the conflict of culture within the family as well as in social life. The Asian families living as a large cohesive group exercise a protective effect on its members [47]. However, the family can be a centre for interpersonal conflict especially when its traditions are challenged by the youngsters. Family loyalty is generally strong and joint family living continues to operate among the Indian and Pakistanis in Britain. While this can offer social and emotional support, some perceive it as restrictive in the British culture. Pinto reported on the higher rate of isolation, poor housing conditions and a loss of socio-economic status among the Asian patients than the Asian non-patients [48]. There is also a report that psychiatric illness was more prevalent among the Asians living in the sectors of the city with few other Asians living there lending support to the factor of the lack of the protective support of ethnic enclave [49]. Conversely, others have reported that such individuals were more successful and better adaptable. The variables like recent arrivals and the long-stay migrants have also been correlated with mental morbidity without much significance. For example, Hill commented that the longer the immigrant resided in Britain the more neurotic he became [50]. Cochrane [51] and Joseph [52] on the other hand, relate morbidity to recent arrival. It has been observed that immigrants hailing from poor conditions and rural areas of their parent culture seem to be less morbid than those from class of better education and aiming at greater satisfaction [53]. Astrup and Odegaard have recorded the migration from a rural to rural or urban to urban [54]. This may explain the partial protection against psychiatric morbidity among migrants from rural areas of India. The Asians in Britain have been shown to have a higher incidence of schizophrenia though this has not been proved [55], [56]. The picture of the "West Indian Psychosis" as a culturally variant form of affective illness [57]. Several workers referred to frequent somatization of emotional distress [58], [59], [60]. Left pointed out the difficulties caused by culture and language in the accurate diagnosis of affective disorders [58], [59], [60], [61], [62] [63]. Joseph reported that in the Asian patients the diagnosis changed more often after the period of inpatient observations [51]. All these indicate that the picture of psychiatric morbidity among the immigrants is yet to become clear.

Family Studies

There are very few studies directed to the depressive illness in relation to the family and there are some dealing with psychiatric illness in general in relation to the families. There is a general agreement that the typical joint family with all its implications is gradually disappearing from the Indian subcontinent. Many workers have reported that depressive illness has occurred more often in the unitary or the nuclear families. Lal reported that 60.2 per cent of his depressive patients came from the unitary families [64]. Similarly Sethi and Sinha found unitary families over represented among the depressive series [65]. Bagadia in his analysis of 233 depressive patients, found 57.5 per cent from the nuclear families as compared to 37 per cent among the schizophrenics [66]. Dube on the other hand found the prevalence of mental illness including depression significantly higher in the joint families than in the nuclear families [39]. It was especially so in regard to hysteria. This highlights the fact that jointness does not confer any immunity against mental illness and especially so against depression. As against these observations, Carstairs and Kapur in their well known survey in the West Coast of Indian village did not find any relationship between family jointness and mental illness [67]. Thus the exact relationship between the family jointness and mental illness is still uncertain.

There have not been any important studies on family dynamics leading to depressive illness in Indian setting.

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