

Why do people get depressed

Psychology



The condition that today we label depression has been described by a number of ancient writers under the classification of `melancholia`, which perfectly describes the state of depression. Shifts in mood are normal, but in some people the mood shifts are more dramatic, occur more frequently, or last longer. In such cases the person is said to suffer from a mood disorder. Depression is a mood characterized by sadness and a loss of energy and enjoyment in life.

Everyone in the field of mental health recognizes the importance of depression. According to Kline (1964), more human suffering has resulted from depression than from any other single disease affecting mankind. (Beck, 1967; Raulin, 2003). A trend to develop mood disorders, explicitly bipolar disorders show signs of being inherited (Wallace, Schneider & McGuffin, 2002, as cited in Smith, E. E. , Nolen-Hoeksema, S. , Fredrickson, B. L. , and Loftus, G. R, 2003).

A study of people's family histories shows that people with bipolar disorder tend to have first-degree relatives (parents, children, and siblings) who have at least two to three times higher rates of both bipolar disorder and depressive disorders than the relatives of people without bipolar disorder (Wallace et al. , 2002; MacKinnon, Jamison, & De Paulo, 1997, as cited in Smith et al. , 2003). Twin studies of bipolar disorder conformed that the disorder is of a genetic nature. It is agreed upon that the likelihood that both identical twins will have the disorder is very high, when one twin is diagnosed with the bipolar disorder.

This means that the concordance rate between identical twins ranges from 50% to 100% across recent studies (Stoll, Renshaw, Yurgelun-Todd, & Cohen, <https://assignbuster.com/why-do-people-get-depressed/>

2000, as cited in Smith et al. , 2003). There is accumulated verification that depression especially recurrent depression is heritable. Family studies again reveal that first-degree relatives of depressed patients have two to four times higher rates of depression than others (Sullivan, Neale & Kendler, 2000, as cited in Smith et al. , 2003).

However, depressed patient's relatives do not have any greater risk of developing bipolar disorder than the relatives of people with no mood disorder. This suggests that there is a different genetic basis between bipolar disorder and depression. Bipolar disorder is different to depression in that people suffering under bipolar disorder experience manic episodes of behaviour that appears on the surface to be the opposite of depression, resulting in a person `being energetic, enthusiastic, and full of self-confidence.

They talk continually, rush from one activity to another with little need for sleep, and make grandiose plans, paying little attention to their practicality` (Smith et al. , 2003, p. 543). Whereas depression makes people suffering from it feel sad, lethargic and uninterested in any activities-even pleasurable ones. Twin studies have also shown that depression can be inherited but to a lesser degree than bipolar depression (Sullivan et al. , 2000, as cited in Smith et al.). However it is unclear what role genetics play in the mood disorder, it is likely that a biochemical abnormality is involved.

Norepinephrine and Serotonin are both neurotransmitters that play an important role in mood disorders. Neurotransmitters and their receptors connect with each other like a lock and a key, similar to the lock and key model in enzymes. Each neurotransmitter will fit into a specific type of

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receptor on the neuronal membrane. If there is a wrong number of receptors for a certain type of neurotransmitter or the receptors are too sensitive or not sensitive enough, the neurons will not use available amounts of neurotransmitters effectively.

There are several studies which suggest that people with a depression or a bipolar disorder may have irregularities in number and sensitivity receptor sites for serotonin and norepinephrine, especially in the areas of the brain implicated in the management of emotion e. g. hypothalamus (Thase et al. , 2002, as cited in Smith et al. , 2003). In major depressive disorder, receptors for these neurotransmitters are too few in number or they tend to be insensitive.

The abnormalities present in bipolar disorder, are less known nevertheless it is possible that receptors for these neurotransmitters endure poorly timed changes in sensitivity that are corresponded with mood changes (Kujawa & Nemeroff, 2000, as cited in Smith et al.). The structure and the functioning of the brain manifest itself to be modified in people with mood disorders. Neuroimaging studies using computed tomography (CT) scans and magnetic resonance imaging (MRI) have found failure in the prefrontal cortex of people with severe unipolar depression or bipolar disorder (Drevets, 2000; Liotti & Mayberg, 2001, as cited in Smith et al.).

This is linked with abnormalities in metabolism in this area of the brain, according to positron emission tomography (PET) studies (Buchsbaum et al. , 1997, as cited in Smith et al.). The prefrontal cortex plays a major role in cognitive activity and in the management of emotion. The prefrontal cortex also has substantial analogy with many other areas of the brain including the <https://assignbuster.com/why-do-people-get-depressed/>

thalamus, hypothalamus, amygdala, and hippocampus, which are concerned, with the management of feedback to stress and in sleep, appetite, sexual drive, motivation, and memory.

People with mood disorders have abnormalities in metabolism in these areas of the brain. These structural and functional brain defects could be signs and causes of mood disorders, or they could be biochemical processes in the mood disorders that have a toxic effect on the brain. Precise meanings of these abnormalities are unknown. Cognitive theories mainly concentrate on depression. In compliance with the theories, depression is caused by the interpretation of events in people's lives in hopeless and pessimistic ways. (Abramson, Metalsky, & Alloy, 1989; Beck et al., 1979; Peterson & Seligman, 1984, as cited in Smith et al. , 2003).

Aaron Beck, known as one of the most influential cognitive theorists grouped all negative thoughts of individuals into the different categories, which he called the cognitive triad consisting of negative thoughts about the self, about present experiences and about the future. Negative thoughts about the self, show the depressed person's belief that she or he is worthless and is not able to do anything with their lives, they simply accept what they are depressed but do not attempt to change their situation.

Whenever the depressed person thinks about the future, there will be a vast space of hopefulness. Depressed people believe that their weaknesses and defects will restrain them from continuing with their life, and changing their situation. Beck proposes that these negative attitude of a depressed person are formed during childhood and adolescence through negative experiences

such as the loss of a parent, social spurning by peers, criticism by parents and teachers, or a sequence of tragedies.

These negative beliefs are retained when a new situation mirrors the conditions in which the beliefs were learned, and depression may result. Furthermore as claimed by Beck, depressed individuals make systematic errors in thinking that lead them to misperceive reality in a way that contributes to their negative beliefs about themselves, e. g. magnifying small bad events and minimizing major good events in evaluating performance. Therefore they make it impossible for themselves to escape from depression, and as a result they are pulled further into it.

A recent study that followed students through their college careers provides strong evidence that negative cognitive styles do precede and predict depression. Researchers measured the students' likelihood towards negative thinking patterns early in their first year of college and followed them for the next few years in college. Students who evidenced a negative cognitive triad or a pessimistic attributional style were much more likely to experience episodes of depression during their college years than those who did not, even if they have never been depressed before going to college (Abramson et al., 1999, as cited in Smith et al.).

From a social perspective depression is seen as a reaction to loss, whatever the nature of the loss (rejection by a loved one, being fired from a job), the depressed person reacts to this `loss' tremendously, as the current situation reminds the person of a negative experience involving loss during childhood e. g. loss of parental affection. Generally people are affected whose needs for affection and care were not satisfied during childhood.

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Therefore it can be seen that the depressed person's behaviour represents a cry for love, seeking the security and affection of a parent (Bibring, 1953; Blatt, 1974, as cited in Smith et al. , 2003). However there is not only depression generated by this situation, despite that anger is released. Anger towards the person responsible for the loss created. A depressed person will turn all his or her anger inwards; to make sure that no one is hurt in his or her environment as they are still dependant on him or her for support.

The self-esteem of a person vulnerable to depression depends primarily on external sources: the approval and the support of others. When these supports fail, the individual may be thrown into a state of depression. Depression results from many different factors, from a biological approach it is said to be evolved through inheritance, however it is also argued that it is a malfunction of the brain resulting in irregularities of the number of receptor sites or the sensitivity of receptor sites.

Overall it lets us assume that it results in the some kind of damage in the brain that makes it impossible for serotonin and norephinephrine to bind with its receptor sites. From a cognitive point of view it is the person's false interpretation of experiences, and the negativity in thinking that lead he or she into depression. The loss experienced in the early stages of life e. g. childhood, reoccurs in the form of memories and the depressed person is faced with these memories when he or she experiences a loss in his current life. The anger and sadness perceived will be turned inwards, resulting in depression.