Compare and contrast two theories of major depression

Depressive disorders are the most frequently diagnosed psychopathological disorders; the two most common forms of depression are unipolar and bipolar disorders. This essay will focus on unipolar disorder and for simplicity, will be referred to as ‘ depression’. Even though social factors evidently contribute to depression, it makes more sense that such disorder should have biological basis. Hammen, 1997 proposed four different reasons to support such belief: Symptoms of depression include physical changes, depression appears to run in families, success of medication and particular kinds of illness/injury/drugs could give rise to depression. This essay will explore the similarities and differences between the biological and psychological explanations of depression, specifically looking at neurotransmitter dysfunction (biochemical factors), genetic factors (twin/adoption studies), Beck’s theory of depression (cognitive explanations), Freud’s theory (psychodynamic explanation) and life events (socio-cultural factors).

One biological account for depression is that biochemical factors are involved; the view indicates that depression is caused by a deficiency of neurotransmitters; norepinephrine and serotonin. Norepinephrine levels in the brain are often low in depressed patients. In addition, post mortem studies have revealed an increased density of norepinephrine receptors in the brains of depressed suicide victims (Bunny and Davis, 1965). On the other hand, the link between low synaptic serotonin level and depression is supported by the fact that the cerebrospinal fluid in depressed patients holds a smaller amount of a major serotonin by-product, demonstrating a lower level of serotonin in the brain (McNeal and Cimbolic, 1986). Moreover,

Delgado (1994) demonstrated low serotonin levels was associated with depressive symptoms by giving depressed patients (on antidepressants) a special diet which lowered their level of tryptophan, one of the precursors of serotonin; patients reported depressive symptoms which disappeared when their diet returned to normal. Although the biological explanations of depression have received more research support, the psychological explanations have also been significant. It is likely that, the biological factors cause the development of depression, while the psychological factors maintain the disorder. It is also likely that two or more factors are needed for such disorder to develop. People may become depressed only if they have low levels of serotonin, feel helpless and blame themselves for the negative events that happen to them (Comer, 2003).

An alternative explanation for depression is Beck’s, 1967 (cited in Davey, 2008) cognitive theory of depression, a psychological account. He proposed that depressed individuals feel the way they do since their thinking is biased towards negative interpretations of the world; this is caused by acquiring a negative schema during childhood. Such negative schemas are triggered whenever an individual encounters a new situation similar to the original conditions in which the schemas were learnt. Negative schemas are also subject to certain cognitive biases in thinking; both negative schemas and cognitive biases maintain the negative triad, a negative view of one self, the world and the future. Other cognitive explanations include the learned helplessness theory (failing to control unpleasant experiences) and the hopelessness theory (negative expectations of the future).

Both explanations differ in terms of treatment. Treatment stemming from the biochemical account (antidepressants) treats the symptoms and not the ultimate cause with only about 65% effectiveness; in contrast the cognitive accounts are associated with successful therapies for depression. Butler and Beck (2000) concluded that about 80% of adults benefited from cognitive therapy which aims to treat the cause of the disorder. Beck's cognitive therapy was more successful than drug therapy and had a lower relapse rate, supporting the proposition that depression indeed has a cognitive basis. In support, Wu, Buchsbaum, Hershey, Johnson and Bunney (1999) demonstrated that uncontrollable negative events (learned helplessness) led to changes in norepinephrine and serotonin levels; further illustrating how by treating such biochemical changes, the ultimate cause of depression is not dealt with. Despite these differences in treatment, a similarity between the treatments is the effects are not immediate. It takes a number of weeks before the effects of drugs (antidepressants) on depression can be noticed regardless of the fact that antidepressants raise serotonin levels immediately; low levels of neurotransmitters therefore cannot be the straightforward explanation for depression (Kennett, 1999 cited in Cardwell & Flanagan, 2004). Moreover, cognitive therapy sessions are taken over weeks, even months before results are noticed. An additional similarity is that not everyone who suffers from depression is helped by serotonin-based drugs and cognitive therapy (individual differences), suggesting that there are other causes for the disorder. In terms of biochemical factors, it is not clear why some people become depressed when their serotonin or norepinephrine levels are low, whereas others with low levels of serotonin or norepinephrine remain depression free.

Freud, 1917 (cited in Strachey, 1961) established a further psychological account for depression. He described how, when a loved one is lost, there is a phase of mourning however for some, this phase never seems to end; they continue to exist in a state of ‘ melancholia’ (Freud’s term for depression). Freud also believed that we unconsciously harbour negative feelings towards those we love and when we lose those we love, these negative feelings are turned on ourselves. In some cases, we continue a pattern of self-abuse and self-blame; according to this view, “ depression is anger turned against oneself”. A further psychological account is life events (socio-cultural factors). Brown and Harris (1978) studied depressed women in London and found two situations which appeared to increase a person’s helplessness to life events. First was the presence of long-term difficulties and secondly the existence of vulnerability factors. Dohrenwend, Shrout, Link, Martin and Skokol (1986) supported this by claiming that depressed patients characteristically experience higher level of negative life events in the year before a depressive episode.

The psychological accounts reject the view that the disorder is caused by genetics and brain chemistry but by life events – the environment. Similarly, the biological accounts reject the view that depression is caused by psychological factors; instead it favours the idea that the disorder is caused by a deficiency of neurotransmitters, neurocognitive impairment and genetics. Freud focused on the relationship between an individual and a loved one whereas the genetic explanation ignores the impact of the environment. The genetic explanation is an alternative biological account; the view considers that certain individual’s have certain genes which

predisposes an individual to the disorder. Moreover the disorder can be inherited; as a result of this we would anticipate to find that relatives (i. e. twins) have similar chances of developing depression. Studies of twins have consistently found concordance rates of around 46% for monozygotic twins compared to 20% for dizygotic twins (McGuffin, 1996) suggesting depression has a substantial inheritable component. Further evidence comes from adoption studies; Wender in 1986 studied the biological relations of adopted people who had been hospitalised for serious depression and found there was a much higher incidence of depression in these relations than those of a non-depressed control group. The evidence for biological factors in the onset and progress of depression is strong but not as strong as that for schizophrenia; as with schizophrenia, many of these biological factors (i. e. genes, biochemical factors) are not ultimate causes and may be only peripherally or indirectly involved.

A fundamental difference between the biological accounts (biochemical and genetic factors) and the psychological accounts (Freud’s theory and life events), is that the biological accounts are based on an internal origin of depression within an individual, both our genes and our biochemical levels are within us, whilst Freud’s theory and life events are focused on external events from our bodies (i. e. the loss of a loved one). A similarity between the biological accounts and Freud’s theory is both are determinist, indicating that depression is down to factors outside our control (genes, biochemistry, subconscious, thoughts). Some would argue that depression is developed due to factors within our control (i. e. way we think), the approach Beck’s cognitive theory of depression takes. Additionally, Beck’s theory of

depression is not determinist; it explains how depression is down to our thinking and how we have the ability to change these thoughts, especially through successful cognitive therapy.

A similarity between the biological accounts, Freud's and Beck's theory is that they can all be argued to be reductionist. The biochemical and genetic explanation does not take into account significant psychological stressors (i. e. life events), making the theories over simplistic when considered as an explanation of depression; reducing the explanation of depression down to biological factors alone. However, research has shown that our environment can affect factors such as our biochemistry (Wu et al., 1999) suggesting that other factors do in fact play a part in the development of depression. The fact that these explanations do not consider both environmental and cognitive factors as reasons to the development of depression is a negative criticism. Both Freud's and Beck's theory of depression reduce depression down to the loss of a loved one and the way we think, in addition both theories do not consider other possible factors such as genes. A further similarity is that, all accounts for depression do not provide a complete explanation of the disorder, ignoring important factors which have evidently shown to influence the development of depression.

It is perhaps best to consider an approach which incorporates both biological and psychology factors in explaining the development of depression. The " diathesis-stress" model indicates that there is a genetic vulnerability to the disorder but this triggered when an individual has been exposed to a stressful life event. Both these factors are necessary for such disorder to develop, this is way not all children (twins) with depression develop the

disorder and why the concordance rate for the disorder in monozygotic twins is nothing like 100%. To conclude, both biological and psychological accounts are related to some successful therapies. They are interdependent in so far as it is clear that some people are vulnerable to becoming depressed and for example, life events may trigger the onset of depression. Both explanations are determinist since they suggest that internal/external events cause depression; differences between both the biological and psychological explanations can be found by looking at specific accounts, and for example, looking at the lack or strength of research evidence and the implications.