Chapter 15: Mood disorder: major depression

Learning activity suggested answers

Learning Activity 15.1 (p. 606)

1 Explain the meaning of the term mood with reference to an example.
   Explanation may refer to:
   • a mental state or overall feeling that colours our perception of the world and influence how we go about daily life
   • often described as an emotional state as it involves emotions, such as happiness, sadness and anger
   • also sometimes referred to as a non-specific emotional state as it can involve feelings that we may not be able to easily label or experience for no apparent reason, such as anxiety or tension i.e. we may have no idea what has caused a mood.

2 Explain the meaning of the term mood disorder.
   A mood disorder is a mental disorder that is characterised by a severe and persistent disturbance in a person’s mood that causes psychological discomfort or impairs the ability to function, or both.

3 When is a mood or a fluctuation of mood considered to suggest the presence of a mood disorder?
   A mood or a fluctuation of mood is considered to suggest the presence of a mood disorder when:
   • it is severe;
   • it occurs for no apparent reason;
   • it persists much longer than the normal ‘ups’ and ‘downs’ that most people experience;
   • it impairs the ability to function in everyday life.

4 a List three experiences that elevate your mood.
   Discuss student responses to clarify conceptual understanding.

   b List three experiences that lower your mood.
   Discuss student responses to clarify conceptual understanding.
Learning Activity 15.2 (p. 609)

1. Explain what major depression is with reference to:
   a. the relevance of a major depressive episode
      
      Major depression (or major depressive disorder) is a type of mood disorder characterised by one or more major depressive episodes.
   b. the key symptoms of a depressive episode and an example of each symptom.
      
      - Key symptoms of a major depressive episode include:
        - depressed mood, e.g. feeling very sad, ‘low’, ‘down in the dumps’, ‘empty’, ‘hopeless’;
        -anhedonia, e.g. ‘not caring anymore’;
        - changes in appetite or weight, e.g. weight loss or weight gain;
        - changes in sleep pattern, e.g. sleeping significantly more or less than usual;
        - changes in psychomotor activity, e.g. increase in or slowing down of movement, thoughts and/or speech;
        - decreased energy, e.g. overwhelming fatigue;
        - feelings of worthlessness or guilt, e.g. thinking one is ‘not good at anything’ and seeing many things as being ‘my own fault’, even if they are not;
        - difficulties thinking or concentrating or making decisions, e.g. easily distracted, can’t focus;
        - recurrent thoughts of death or suicide, plans or attempts, e.g. a belief that one would be ‘better off dead’.

2. What period of time is relevant to the diagnosis of a major depressive episode?

   In order to be diagnosed with a major depressive episode, it is essential that at least one of the person’s five symptoms includes a period of at least two weeks during which they experience either:
   a. a depressed mood, or
   b. anhedonia.

3. What is anhedonia and what is its relevance to the diagnosis of major depression?

   - Anhedonia is the loss of interest in nearly all activities that the individual would normally engage or participate in, or not feeling any enjoyment in activities previously enjoyed.
   - Its relevance to diagnosis of major depression is that it is one of the two key symptoms that the person must be experiencing for at least a two week period in order for a diagnosis to be made.

4. Out of the nine possible symptoms, how many must be person be experiencing according to the DSM, before they can be diagnosed as having a major depressive episode?

   In order to be diagnosed with a major depressive episode, a person must experience a minimum of five of a possible nine symptoms of major depression.

5. Explain how a major depressive episode may affect a person’s energy levels.
During a major depressive episode, a person may experience an overwhelming loss of energy and increase in fatigue.

This overwhelming loss of energy can cause a person to stay home, avoid social interactions, prevent them from starting or finishing projects, maintaining previous interests and hobbies and exercising.

In severe cases, even getting washed and dressed in the morning can seem overwhelming and take twice as long to accomplish if it all.

6 Suggest a possible explanation for why females have a greater risk of developing major depression than do males.

Discuss student responses to clarify conceptual understanding.

7 Consider the description of major depressive disorder, dysthymic disorder and cyclothymic disorder in Box 15.1.

a In what way might the distinction between these specific disorders be unclear?

• Dysthymic disorder could be also described a ‘mild version’ of a major depressive disorder as the symptoms are similar (both disorders are characterised by a sad mood, loss of pleasure, decreased energy and changes in appetite and sleep).

• The dividing line between the two disorders is therefore somewhat arbitrary, i.e. where does dysthymia end and major depressive disorder begin?

• Cyclothymic disorder is characterised by numerous periods of hypomanic symptoms and numerous periods of mild depressive symptoms—it could also be described as periods of hypomanic and dysthymic symptoms over a two year period

• dysthymia could be considered a milder form of major depression, and cyclothymia could be considered a milder form of bipolar disorder

• therefore, in contrast to major depression and bipolar disorder, respectively, dysthymic disorder and cyclothymic disorder are less severe but more chronic, with the dividing line between them being somewhat arbitrary.

b In your opinion, are they best viewed as points along a depression continuum rather than as distinct disorders? Explain your answer.

Discuss student responses to clarify conceptual understanding. Explanation should refer to dimensional approaches to classification (p. 497 - 501).

Learning Activity 15.3 (p. 611)

Data analysis

Consider the data in figure 15.6 and complete the following tasks and questions.

1 Provide a suitable title for the graph.

Examples:

• The influence of genetics and stressful life events on the chance of developing major depression

• How genetic predisposition and stressful life events interact in the aetiology of major depression
2 Briefly describe the sample used and its composition.
- The sample consists of 2164 female twins
- Based on this figure, the sample consists of a total of 1082 female twin pairs
- Assuming each experimental group is equivalent in number, data in the graph suggests that:
  - 541 of the twin pairs were identical (monozygotic);
  - 541 of the twin pairs were fraternal (dizygotic);
  - It can be inferred that the two groups (identical and fraternal twin pairs) were further divided into those where one twin had a history of major depression and those where neither of the twins had a history of major depression;
  - Then, after dividing the twins into groups based on genetic similarity and depression history, the researchers further divided the groups into those who had experienced a stressful life event and those who had not, i.e.:

3 How were major depression and stress operationalised.
- Major depression: with or without a history of major depression/presence or absence major depression
• stress: presence or absence of a severely stressful event

4 On the basis of the results shown, write a tentative conclusion on the role of both the following factors in major depression, ensuring that you refer to relevant data:

i genes

ii stressful life events.

The results indicate that:

• For individuals at the lowest genetic risk (monozygotic twin, co-twin no depression), the probability of onset of major depression was predicted to be 0.5% in the absence of a stressful life event and this rose to 6.2% when exposed to a stressful life event.

• For individuals at the highest genetic risk (monozygotic twin, co-twin with depression), these probabilities were 1.1% in the absence of a stressful life event, but this risk increased markedly to 14.6% with the occurrence of a stressful life event.

• There is a significant genes and environment interaction in the onset of major depression.

It can therefore be concluded that genes appear to influence the risk of developing major depression, in part by increasing a person’s vulnerability (sensitivity) to the depression-inducing effects of stressful life events and stressful life events appear to be a very powerful risk factor for the onset of an episode of major depression.

Learning Activity 15.4 (p. 617)

1 In what way can genes contribute to the development of major depression?

Genes can contribute to the development of major depression by placing an individual at an increased risk of developing the disorder.

For example, an individual is at a higher risk of developing major depression if they have a biological relative with the disorder when compared with an individual who does not have any biological relative with the disorder. Moreover, the closer the biological relationship, the higher the risk (e.g. identical twin compared with fraternal twin).

2

a What is the risk of a person developing major depression if one of their biological parents has, or has had, the disorder?

25–30%

b What is the risk of a person developing major depression if both of their biological parents has, or has had, the disorder?

70%

3 Why do researchers use twin studies to investigate the possible role of genes in major depression?

Explanation should refer to the aim of isolating relative influences of genetic/hereditary and environmental factors in the development of major depression. In relation to the development of major depression, both genes and the environment are involved and it is difficult to separate their respective influences.
The most useful twin studies compare identical/monozygotic twins who share virtually 100% of their genes with fraternal/dizygotic twins who share on average 50% of their genes.

- With identical twins, any psychological (or physical) difference may be inferred as attributable to the environment as they share identical genes. In contrast, fraternal twins are full siblings and any psychological (or physical) difference may be inferred as caused by difference in genes and/or environment.
- Studying identical twins alone is less useful, since they not only share all their genes but also their intrauterine and early environment, family background, socioeconomic background, schooling etc. Fraternal twins act as a control, as they too share the same early environmental factors, but are no more genetically alike than any other siblings.

4 Does the existence of a genetic component automatically mean that a person will become depressed if a biological parent or relative has or has had the disorder? Explain your answer.

- No
- Having a genetic predisposition may place an individual at a higher risk than that of the general population in becoming depressed, but it does not mean that they will automatically develop the disorder. The chance of someone becoming depressed if a biological parent has major depression is about 20–30%. This also means that 70–80% of the risk (i.e. the greater proportion) is not accounted for by genetics (but is accounted for by environmental/psychosocial factors).

5 What roles are serotonin and noradrenaline believed to play in behaviour and mental processes?

- Serotonin (also called 5-HT) is a neurotransmitter believed to be involved in a wide range of activity, including states such as sleep and wakefulness, dreaming, and eating, sexual and aggressive behaviour.
- Noradrenaline (also called norepinephrine) is a neurotransmitter believed to be involved in attention, alertness, states of arousal and the stress response.

6 One prominent psychologist has suggested that it is ‘not surprising that serotonin and noradrenaline can contribute to depression’. What justification is there for this statement on the basis of the roles of these neurotransmitters and symptoms of major depression?

- Low levels of serotonin are associated with sad and anxious moods, hunger, food cravings and disruptions to the sleep cycle, all of which can be symptoms of major depression.
- High levels of noradrenaline are associated with high levels of arousal and alertness; low levels are associated with low levels of arousal, lack of energy and difficulties concentrating, all of which can be symptoms of major depression.

7 What is the monoamine hypothesis?

Major depression is a consequence of depleted levels (and therefore underactivity) in the brain of either serotonin and noradrenaline or both. Serotonin and noradrenaline belong to a class of neurotransmitters called monoamines.

8 Explain the possible role of neurotransmitters in the development of major depression, with reference to serotonin and noradrenaline.
• Theories about the possible role of neurotransmitters in the development of major depression have been based on the effects that antidepressant medications can have on relieving the symptoms of depression.
• It is believed that these medications are effective because they increase the amount of neurotransmitters, specifically serotonin and noradrenaline, in the brain and subsequently relieve depressive symptoms.
• Although antidepressant medications can change the level of a neurotransmitter in the brain immediately, it normally takes a few (2–6) weeks for a person with depression to feel better.
• Therefore, there appears to be a strong relationship between neurotransmitter levels in the brain and the symptoms of major depression. However, the actual relationship between neurotransmitters and major depression is still not fully understood.

9

a What are antidepressants?
Antidepressants are medications to relieve symptoms of major depression.

b About how long do antidepressants take to relieve the symptoms of major depression?
Antidepressants have a delayed onset of action between two and six weeks.

c Explain how SSRI’s act to alleviate symptoms of major depression.
• SSRI (Selective Serotonin Reuptake Inhibitors) alleviate symptoms by reducing or inhibiting the reabsorption (‘re-uptake’) of serotonin by the presynaptic neurons that release the neurotransmitter serotonin.
• Consequently, a relatively normal or high level of serotonin (depending on the dosage) is allowed to accumulate at the synapse and to influence the activity of the postsynaptic neurons.
• The overall level of serotonin in the person’s brain is therefore increased, thereby alleviating their symptoms of depression.

d List three common side effects of SSRIs.
Side effects include:
• nausea
• headaches
• agitation
• sleep disturbance
• sexual dysfunction
• withdrawal symptoms (if stopped suddenly)

Learning Activity 15.5 (p. 619)
Evaluation of research by Seligman and Maier (1967)
Prepare a flow-chart summary of the key features of Seligman and Maier’s research (1967) on learned helplessness. Your flow chart should include brief descriptions of:

- a relevant research hypothesis experiment
- the operationalised variables
- the experimental and control conditions
- results
- conclusion

Example:

**Operational hypothesis**
Mongrel dogs with prior experience of inescapable shocks will take longer to escape a shock and fail to learn to escape the shock when compared with mongrel dogs with prior experience of escapable shocks.

**Subjects**

**Random assignment**

**Phase 1**

**Experimental conditions**

**Group 1: escape condition**
- 8 dogs strapped in a hammock one at a time
- given 64 shocks at random with a mean of 90 second intervals
- IV: *some* control over shocks, i.e. could turn off

**Group 2: Yoked control condition**
- 8 dogs strapped in a hammock one at a time
- paired with one ‘associate’ dog in Group 1
- whether or not shock is given depends on whether its Group 1 associate turns off shock

**Group 3: Normal control condition**
- 8 dogs not used in the experiment in any way during Phase 1, e.g. not strapped in a hammock
- No exposure to IV
**Chapter 15: Mood disorder: major depression**

2 Name the experimental design.

Independent-groups: each dog was randomly allocated to a separate group and the scores of the different groups were compared.

3 What generalisation(s) was/were made from the results of the experiment?

- The results of the experiment were generalised to human behaviour, providing a model for explaining the development and maintenance of major depression.
- Seligman and Maier proposed that individuals who are depressed behave in much the same way as the Group 2 dogs behaved in Phase 2 of the experiment.
- Humans also ‘learn’ from their past experiences whether or not their actions will be beneficial or useless in changing a situation.
- Both the Group 2 dogs and humans who are depressed are passive (i.e. fail to initiate actions), behave as if they have no control over their circumstances, lose their appetite and show little interest in others.

4 Is/are the generalisation(s) valid? Explain your answer.

Students should consider whether generalisations from animal experience of this type to humans is valid.

Note: According to Maier and Seligman (1976), other studies have found that ‘cats, fish, rats, and man’ ... ‘do not subsequently initiate escape response in the presence of shock’ after they ‘have been exposed to inescapable shocks’ ... ‘With regard to man, we review a variety of studies using inescapable noise and unsolvable problems as agents which produce learned helplessness effects...’ (p. 3)

5 Give an example of a situation in which people might learn to be helpless.
Learned helplessness occurs when an individual believes they are unable to have any effect on events in their lives. Over time the individual begins to believe that it doesn’t matter what they do, nothing will change anyway, so they ‘give up’ trying and become helpless.

Examples may refer to:

- finding a job, e.g. if repeated efforts are not rewarded with getting a job and one remains unemployed for a lengthy period of time;
- losing weight, e.g. if repeated attempts to lose weight yield no results;
- academic performance, e.g. a young person who performs poorly on math tests and assignments despite studying hard and having a tutor may begin to feel that nothing they do will have any effect on their maths performance—when later faced with any type of maths-related task, they may experience a sense of helplessness;
- finding a partner, e.g. if going on repeated dates never results in finding a partner;

**Learning Activity 15.6 (p. 622)**

1. What is learned helplessness?

Learned helplessness is a learned feeling or belief by an individual that they are helpless and unable to have any effect on events in their lives, so they give up trying.

2. What behaviour did the dogs in the Seligman and Maier (1967) have in common with people who have major depression?

Seligman proposed that people with major depression tend to share particular characteristics with the dogs in Group 2 of his experiment:

- sadness
- anxiety
- passivity (that is, failing to initiate actions)
- behaving as if they have no control over their circumstances
- sleep problems
- loss of appetite
- show little interest in others
- feeling that their actions are pointless and useless
- finding themselves powerless when confronted with loss, business failure, serious illness and other problems or stressors

3. Explain how learned helplessness may contribute to major depression with reference to Seligman and Maier’s (1967) experiment.

- It is believed that learned helplessness has a number of motivational, emotional and cognitive consequences.
- Learned helplessness can lead to an almost ‘numbed’ acceptance of a negative situation so that an individual no longer tries to change that situation for the better because they perceive that nothing they do will make any difference.
• For the same reason, learned helplessness can lead to an inability to learn that new responses are available that do affect outcomes (just like the dogs in Group 2 whose prior experience affected their ability to learn a simple escape response).

• As a result of both of these processes, learned helplessness can lead to the development of major depression.

4

a Explain the meaning of attributional (explanatory) style?

• An individual’s attributional (explanatory) style is the usual, or typical, way a person interprets observed behaviour or events and then draws on their experiences to understand and explain what causes those behaviours or events.

• Certain patterns or combinations of attributional judgements (e.g. usually interpreting events in a negative or pessimistic way) have been closely associated with major depression.

b What pattern or combination of attributional judgements is most closely associated with major depression? Explain why this is the case.

• Those who generally interpret events in a negative or pessimistic way are likely to develop depression.

• More specifically, those who attribute unfavourable or negative events to the following causes are at a high risk of developing depression:
  - internal (their own fault) and
  - stable (unlikely to change, last forever) and
  - global (occurring in a lot of settings, affect everything).

• It is proposed that this particular combination of attributional judgements leads people to feel helpless about the possibility of making any changes in their lives.

• Example: If someone believes an unfavourable or negative situation is their fault, nothing is ever going to change and will affect many aspects of their lives, he or she is more likely to think that there is ‘no point’, ‘give up’ trying to bring about any change and become helpless.

c Construct two flowcharts such as those in figure 15.11 to contrast patterns of favourable and unfavourable attributional judgements for a negative event other than failing a test/exam or the break of a relationship.
d Does a depressive explanatory style cause major depression or does major depression cause a depressive attributional style? Explain your answer.

- It is more appropriate to refer to risk level rather than causation.
- There may be two-way relationship, i.e. a depressive explanatory style could increase the risk of major depression and major depression could increase the risk of adopting a depressive explanatory style.
- Schacter, Gilbert and Wegner (2009) report that some psychologists believe a depressive explanatory style begins in childhood with experiences that foster the development of pessimism and low self-worth (e.g. abuse, harsh discipline, neglect).
- If a depressive explanatory style does actually begin in childhood, then a depressive explanatory style could significantly contribute to the development or onset of major
depression, i.e. an internal, stable and global outlook can make an individual prone to depression and act to ‘trigger’ depression in those experiencing negative life events.

**Learning Activity 15.7 (p. 622)**

Research investigation on attributional style

Working in a small group, plan and conduct an investigation to assess attributional style using two situations and questions such as those in the modified version of the Attributional Style Questionnaire in Box 15.6.

Your investigation should test a research hypothesis relevant to gender differences in major depression.

The data collected different groups will be combined to form the class results. The population, sample and sampling procedure should be determined through a class discussion.

Each participant should receive a copy of the questionnaire and a briefing statement. The briefing statement should be completed as a class exercise and should describe what the research investigation is about, what it requires of participants and how the results will be used. The questionnaire should also provision for recording relevant participant variables, such as sex and age.

All participants should be volunteers, give informed consent and complete the questionnaire anonymously. Ensure all other relevant ethical guidelines are followed.

Prepare a report on the research investigation. Your report should include:

1. a statement of the aim of the investigation
2. the research hypotheses
3. a summary of the results using appropriate descriptive statistics
4. a conclusion(s) based on the results and referring to the hypothesis
5. a potential limitation that may have affected the results in an unwanted way
6. other relevant information that may be requested by your teacher.

Students’ research investigations will vary.

**Learning Activity 15.8 (p. 627)**

1. Name and briefly describe three models that link stress and major depression.
   - Stress exposure model: individuals who have been ‘exposed’ to a significant stressor (e.g. life event) or have many stressors in their life (e.g. chronic stressors, daily hassles) will be more likely to develop major depression than those who have not. Major depression is therefore a response to stress and exposure to stressors precedes and increases the risk of developing major depression.
   - Stress generation model: individuals with major depression contribute to the occurrence of stressors in their lives (dependent stressors) and therefore actually ‘generate’ stress. Stress is therefore a response to major depression. The stress generated typically centres around difficulties in interpersonal relationships.
• Reciprocal model: this combines the stress exposure and stress generation models and proposes a bi-directional (two-way) relationship between stress and major depression. Stress can ‘trigger’ major depression but depressed individuals may also create or seek stressful events. Stress can therefore be both a predictor of the onset of major depression as well as a consequence of major depression.

2 Use a diagram and examples to explain how stressors and stress responses can interact and create a ‘vicious cycle’ resulting in recurrences of major depressive episodes.

3 Explain how stress can contribute to the development of major depression with reference to different types of stressors and relevant examples.

Stress research has focused on the influence of two broad types of stressors, discrete and continuous stressors:

- discrete stressors (often called stressful life events) are significant but rare events that require psychological, social and/or biological readjustment on behalf of the individual, e.g. the death of a relative, a break-up of a relationship, divorce, unemployment, illness/injury, changing school, an assault or retirement (see table 12.3, p. 603 for further examples).

Discrete stressors can be independent or dependent and can increase the risk of developing major depression (particularly a first episode).

- Independent stressors are those stressors that occur ‘independently’ of, or have nothing to do with, the major depression, e.g. losing your job because the company has gone broke, not because you have depression.

- Dependent stressors are those stressors that occur as a consequence of the major depression, e.g. losing your job because, as a consequence of your depression, you are lethargic, sleeping all day and have been repeatedly unable to get to the workplace.

- continuous stressors are ‘ongoing’ stressors. Two types are commonly described as:

- independent stressors:
  - having to care for a terminally ill parent

- stress response:
  - activation of SNS and HPA axis (exhaustion)

- dependent stressors:
  - conflict with peers, behind with school work

- major depressive episode
- chronic stressors are stressors that involve persistent or recurrent difficulties in life and therefore result in the presence of stress over a relatively long period of time. Chronic stressors are particularly stressful because of the uncertainty about when the stressful event will end and if it will end at all, e.g. unresolved marital/relationship problems, long-term financial difficulties, having to care for a chronically ill relative, chronic pain, problems with a neighbour, living in a noisy and polluted area;

- daily hassles are relatively minor events arising out of day-to-day living. Life events do not occur every day, but daily hassles do and it’s the constant, daily frustration caused by these hassles that can cause stress, e.g. misplacing your locker key, being stuck in a traffic jam, minor arguments with friends, having to queue or wait, unexpected time pressures, a flat tyre on your bicycle.

**Learning Activity 15.9 (p. 630)**

Developing more helpful and balanced automatic thoughts

For each of the negative automatic thoughts below (which have led to the person experiencing a depressed mood), write an alternative, more helpful and balanced thought that is less likely to lead to a depressed mood.

**Examples:**

<table>
<thead>
<tr>
<th>Negative automatic thoughts</th>
<th>Alternative thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I met Harry in the street today he didn’t smile at me. I must have done something to offend him.</td>
<td>It is true that he didn’t smile at me, but I have no reason to think that he is annoyed with me for any reason. It is possible that it had nothing to do with me at all. Maybe he just had a lot on his mind.</td>
</tr>
<tr>
<td>My husband didn’t eat that chocolate cake I baked for him. He thinks I am a terrible cook.</td>
<td>All I know for sure is that he didn’t eat it. I don’t actually know whether he thinks I am a terrible cook or not. Maybe he just wasn’t hungry. I can ask him.</td>
</tr>
<tr>
<td>This is hopeless. I should be able to do this by now. I’m never going to get the hang of roller-blading.</td>
<td>It’s no good telling myself I should be doing better by now. What I need is practice, and if I keep putting myself down I will give up instead of practising. Thinking in this way is not going to help me get the hang of roller-blading- it just makes me feel worse.</td>
</tr>
<tr>
<td>I did that really badly. I might as well not bother at all.</td>
<td>The fact is, I didn’t do as well as I wanted to. But that does not mean that it was no good at all. I can’t expect to get everything 100% right. If I do, I’ll never be satisfied.</td>
</tr>
<tr>
<td>Matilda doesn’t like me at all. She would never have shouted at me like that if she did.</td>
<td>I’m not the only person Matilda shouts at. She is always ‘on edge’ when things are not going well for her and she shouts at whoever is around. So her shouting at me has nothing to do with the way she feel worse.</td>
</tr>
</tbody>
</table>


Learning Activity 15.10 (p. 633)

1
a Suggest a suitable aim of cognitive behavioural therapy (CBT) in the treatment of a client with major depression.
   Example: to help the client identify and change the thoughts and behaviours responsible for maintaining their symptoms of major depression.

b What key assumption would underlie this aim?
   • The key assumption underlying this aim is that the way people feel and behave is largely a product of the way they think.
   • People with major depression think differently to people without major depression.
   • In particular, people who are depressed typically think in a biased, negative way and have a high number of negative automatic thoughts.
   • These negative automatic thoughts lower mood and contribute to a number of unhelpful (maladaptive) behaviours.

c Give two examples of roles required of the client during CBT.
   Examples may include:
   • keep a ‘thought diary’ with records of what they think and how these thoughts make them feel;
   • check their ‘thought diary’ and look for objective or ‘factual’ evidence that supports their negative automatic thoughts and evidence that does not support them (i.e. examine evidence ‘for’ and ‘against’);
   • directly identify and challenge any cognitive biases that may be occurring in their thinking;
   • develop alternative and more appropriate and balanced thoughts;
   • prepare an activity schedule (together with the mental health professional).

2
a What are automatic thoughts?
   Automatic thoughts are habitual ways of thinking that involuntarily ‘pop up’ in a person’s mind in response to a specific situation or event.

b Outline the key characteristics of negative automatic thoughts.
   Characteristics may include:
   • automatic—they simply ‘pop’ into mind without any effort of the part of the individual;
   • involuntary—people do not choose to have them and they are very difficult to avoid;
• unhelpful—they keep a person depressed, make it difficult to change and prevent them from getting what they want out of life;
• plausible—accepted as facts and not questioned or challenged;
• habitual—difficult for people to isolate and pinpoint.

c Give an example of how automatic thoughts can affect behaviour.

Negative automatic thoughts can cause a number of maladaptive and unhelpful behaviours.

Examples:

3

a Name and briefly describe the three components of the cognitive triad of depression, with reference to examples.

The three components are:

• negative view of self: perceiving one’s self as worthless, helpless, inadequate and ‘not good enough’, e.g. 'I'm a failure', 'No one loves me';
• negative view of the world and environment: perceiving one’s immediate and wider environment in a negative way, e.g. 'There is nothing good out there';
• negative view of the future: expecting negative outcomes/failure when approaching significant tasks or events and anticipating that suffering and difficulties will continue forever, e.g. 'Things will never improve', 'I will never be happy again'.

b Explain the relevance of the cognitive triad to major depression.

• Aaron Beck proposed the cognitive triad as a way of explaining major depression.
• According to Beck, people appraise themselves in relation to each component of the cognitive triad (self, world/environment and future).
• People with major depression judge themselves negatively or as ‘lacking’ in one or more aspects of each component (but positive appraisals are necessary for happiness).
• Examples of negative appraisals by someone with major depression include 'No one loves me' (self), 'There is nothing good out there' (world/environment) and 'Things will never improve' (future).
• Beck proposed that major depression is not caused by situations or events but by distorted perceptions which impair one’s ability to appraise oneself and events in a balanced way.

c Give an example of another cognitive bias common among people with major depression. Examples may refer to:
• overgeneralisation, e.g. no-one likes me because Svetlana does not like me;
• selective abstraction, e.g. someone attends a party and afterward focuses on the one awkward look directed their way and ignores all the smiles they received;
• dichotomous thinking, e.g. I am a complete failure because I did not get 100% on my science test;
• personalisation, e.g. a point of sale operator is rude to you and you believe that you must have done something to cause it;
• arbitrary reference, e.g. believing that someone does not like you without any actual information to support that belief.

4

a What is the aim of the cognitive component of CBT in the treatment of major depression? Aim should refer to:
• helping the person to identify their negative automatic thoughts, and
• evaluate how realistic they are, and
• develop alternative (more realistic, helpful and balanced) thoughts.

b Outline a procedure that may be used to achieve this aim.
Keeping a ‘thought diary’ in which they:
• record what they think and how these thoughts make them feel;
• examine the evidence ‘for’ and ‘against’ their negative automatic thoughts;
• examine and challenge any cognitive biases identified;
• develop alternative (more realistic, helpful and balanced) thoughts.

5

a What is the aim of the behavioural component of CBT in the treatment of major depression? Aim should refer to:
• using behavioural techniques to maximise engagement in mood-elevating activities, and
• overcoming the behavioural inactivation symptoms that can frequently accompany major depression.

b Outline a procedure that may be used to achieve this aim.
Preparation of an ‘activity schedule’, which involves:
• monitoring current activities
• developing a list of rewarding activities
• planning rewarding activities
• completing planned activities
• evaluating the schedule.

Learning Activity 15.11 (p. 633)
Visual presentation on CBT
Construct a flow chart that summarises the possible management of major depression using CBT. Ensure your flow chart:
• starts with a list of commonly occurring thoughts, feelings and behaviour associated with major depression
• refers to the aim(s) of the therapy in relation to major depression
• outlines key assumptions of CBT when used for major depression
• identifies possible therapeutic techniques
• distinguishes between key roles of the mental health professional and the client during the therapy.
Example: see next page.
Person with major depression is experiencing:

- thoughts: I’m so stupid, I bet I’ve failed at that, everyone else is better than me, it’s my fault everything went wrong, there’s just no point, I’m better off dead
- feelings: sadness, guilt, worthlessness, hopelessness
- behaviours: reduced activity levels, loss of appetite, sleeping all the time, can’t make decisions, not exercising or going out.

Person is offered COGNITIVE BEHAVIOURAL THERAPY (CBT) which

- Assumes that the way people feel and behave is largely a product of the way they think.
- People with major depression think differently to people without major depression.
- They typically think in a biased, negative way and have a high number of negative automatic thoughts (NATs).
- These NATs lower mood and contribute to a number of unhelpful (maladaptive) behaviours.
- Aims to assist someone with depression identify and change the thoughts and behaviours responsible for maintaining their depressive symptoms.
- Requires mental health professional to clearly explain the difference between thoughts, feelings and behaviour and their interrelationship; be structured and focus on the ‘here and now’.

COGNITIVE COMPONENT

- Aims to help the person to identify their negative automatic thoughts, evaluate how realistic these are and develop alternative (more realistic, helpful and balanced) thoughts.
- Requires client to keep a ‘thought diary’ in which they record what they think and how these thoughts make them feel; examine the evidence ‘for’ and ‘against’ their negative automatic thoughts; examine and challenge any cognitive biases identified; develop alternative (more realistic, helpful and balanced) thoughts.

BEHAVIOURAL COMPONENT

- Aims to use behavioural techniques to maximise engagement in mood-elevating activities and overcome the behaviour inactivation symptoms that can frequently accompany major depression.
- Requires client and mental health professional to prepare and evaluate an activity schedule.
- Requires client to engage in the planned activities according to the schedule in between CBT sessions and rate each activity for mastery and pleasure.
Learning Activity 15.12 (p. 636)

1.
   a. What is psychodynamic psychotherapy?

   Psychodynamic psychotherapy is a type of therapy that aims to help people understand the ‘roots’ (origins) of their emotional distress by exploring unconscious conflicts, motives, needs and defences.

   b. What is its key assumption?

   - All mental disorders are caused by unresolved psychological conflicts that occur in the unconscious part of the mind, beneath conscious awareness; and
   - These psychological conflicts have their origins in early childhood experiences during which our instinctive impulses and society’s views of what is ‘acceptable’ clash.

2. How did Freud explain major depression?

   - In 1917 Freud observed similarities between people suffering from depression (which he called melancholy) and people who had just experienced the death of a loved one (i.e. those who were grieving).
   - Freud observed that both groups experienced sadness, loss of appetite, disturbed sleep and withdrawal from social life.
   - Based on these observations Freud proposed that major depression is caused by unconscious grief over real or imagined losses.
   - In response to the real or imagined loss, the person then develops feelings of self-hatred that they turn ‘inwards’ and consequently becomes depressed.

3. Briefly describe, with reference to examples, how each of the following may be used in the treatment of major depression by a psychodynamic psychotherapist:

   a. Free association

      - Free association is a therapeutic technique in which the client is encouraged to say whatever comes to their mind, regardless of how painful, embarrassing, illogical or irrelevant it might seem, without any interference by the psychotherapist.
      - Free association may be used in the treatment of major depression because while the client is ‘free associating’, the psychotherapist is listening carefully and would identify and assess which ‘themes’ are the most involved in the development (and maintenance) of the person’s depression.
      - Themes identified during free association may include low self-evaluation, self-criticism, exaggeration of problems and difficulties, unconscious wishes to escape or die.

   b. Dream interpretation

      - Psychologists adopting the psychodynamic perspective (i.e. as psychodynamic psychotherapist) believe that dreams symbolically represent information stored in the unconscious mind.
• Dream interpretation may therefore be used in the treatment of major depression because the psychotherapist believes that dreams may shed light on what is occurring for the person unconsciously.

• It has been found that the content of the dreams recalled by people with major depression typically reflect three common themes: loss, defeat and deprivation, e.g. a man might dream that he would constantly lose money to a soft-drink machine without ever receiving a drink.

c identification of defence mechanisms

• Defence mechanisms are unconscious psychological processes used to protect against anxiety arising from psychological conflicts.

• Psychologists adopting the psychodynamic perspective believe that defence mechanisms may block or temporarily ease painful feelings in the short term, but in the long term they can worsen symptoms.

• Identifying defence mechanisms may therefore be used in the treatment of major depression because the psychotherapist believes it is important to help clients become (consciously) aware of the specific defence mechanisms they are using so that their symptoms do not worsen.

• It is believed that people with major depression typically use the defence mechanisms denial, displacement and repression.

d transference

• Transference occurs when a client unconsciously responds to the therapist as if they are a significant person in their life (often a parent), and shifts or ‘transfers’ unresolved conflicts and fantasies onto their therapist.

• When transference is occurring, a client (unconsciously) believes that their therapist is similar to someone else they already know and will therefore feel and behave in ways that are similar to how that other person would feel and behave.

• Transference may aid the treatment of major depression because the therapist can use the process to help the client regain or discover more ‘normal’ feelings by responding in ways unlike those of the person to whom the original feelings are relevant, e.g. when a therapist reminds a client of a ex-boyfriend who broke off their relationship and they feel sad, rejected and ‘not good enough’ when interacting with the therapist, if the therapist does not reject the client (i.e. responds unlike her ex-boyfriend), the client is helped to recover from that unresolved former experience.

4 Give two examples of roles required of the person with depression during psychodynamic psychotherapy.

Roles of the client may include:

• sets the agenda for each session by saying whatever comes into their mind, regardless of how embarrassing, illogical or irrelevant it may seem (‘free associating’);

• keep a record of their dreams and discuss them with the therapist;

• be committed as psychodynamic psychotherapy can be long-term, e.g. many years.
Learning Activity 15.13 (p. 636)

Visual presentation on psychodynamic psychotherapy

Construct a flow chart that summarises the possible management of major depression using psychodynamic psychotherapy. Ensure that your flow chart:

• refers to the aim(s) of the therapy in relation to major depression
• outlines key assumptions of psychodynamic psychotherapy when used for major depression
• identifies possible therapeutic techniques
• distinguishes between key roles of the therapist and the client during the therapy.

Example:
PSYCHODYNAMIC PSYCHOTHERAPY:

- **assumes** that all mental disorders are caused by unresolved psychological conflicts that occur in the unconscious part of the mind (beneath conscious awareness); these conflicts have their origins in early childhood experiences during which our instinctive impulses and society’s views of what is ‘acceptable’ clash.

- **aims to**:
  - help people understand the origins of their emotional distress by exploring unconscious conflicts, motives, needs and defences;
  - make unconscious conflicts conscious so the client can deal with them; help the client gain an awareness of the ‘losses’ in their lives and cope with losses more effectively.

The psychotherapist uses a number of different techniques to achieve these aims:

FREE ASSOCIATION

- client is required to say whatever comes to mind, regardless of how painful, embarrassing, illogical or irrelevant it may seem
- therapist is required to not interrupt, listen for ‘themes’, later on help the client make links between what they say and their unconscious conflicts

DEFENCE MECHANISMS

* therapist is required to – help the client become more aware of the specific defence mechanisms they are using in order to prevent a worsening of symptoms

TRANSFERENCE

- client is required to (unconsciously) ‘transfer’ their unresolved conflicts and fantasies onto the therapist
- therapist is required to use the transference to help the client discover more ‘normal’ feelings by responding in ways unlike those of the person to whom the original feelings are relevant

DREAM INTERPRETATION

- client is required to share their dreams with the therapist
- therapist is required to make links between the content of the dream and the client’s unconscious
Learning Activity 15.14 (p. 640)

1

a  Explain the meaning of abuse with reference to different types of abuse.

Abuse is psychological and/or physical maltreatment of a person by another, often to intimidate them and to get them to do what the abuser wants.

Four commonly described types are:

- physical abuse: when someone suffers, or is likely to suffer, significant physical harm from an injury inflicted by someone else, e.g. bruises, cuts, burns or fractures;
- sexual abuse: when a person uses power or authority over someone else to involve them in sexual activity of some kind;
- emotional abuse: passive or neglectful acts and/or the deliberate, cruel and active rejection of someone; also known as ‘mental cruelty’ with the intention of causing psychological harm;
- neglect: abuse by omission/failure to take required action, e.g. not providing a child with basic necessities such as food, clothing, medical attention and their development and health consequently suffers.

b  In what way is abuse a risk factor in major depression? Explain with reference to both child and adult victims of abuse.

Explanation may refer to the fact that:

- childhood abuse can predispose an individual to respond to stressors in their later life by developing major depression;
- abuse is associated with an earlier onset of major depression;
- the depressive effects of abuse tend to be longer lasting for people who experience onset of major depression at an early age, as compared to people who experience onset of major depression at an early age but have no history of abuse;
- adults who are in an abusive marital or de facto relationship can develop a feeling of helplessness (leading to the development of major depression) which may explain why they stay with their abusive partners—when helplessness is learned by women in abusive relationships, they believe that nothing whatsoever can be done to stop the repeated episodes of abuse.

2  Why is it difficult to isolate the potential effects of abuse in the development of major depression?

- It is difficult to isolate the potential effects of abuse in the development of major depression from other negative aspects of parenting and the home environment that are likely to co-occur with the abuse, e.g. the effects of either parent suffering from a mental disorder and/or substance abuse problem, low socio-economic status of the family, marital problems experienced by the parents.
- For instance, studies have found that within families where a child had been sexually abused, there was also more marital breakdown, unemployment, communication problems and mothers tended to have poor mental health than in families were sexual abuse had not occurred.
• Therefore, it is difficult to tell whether it is the effect of the abuse alone or the combined effect of the abuse and the associated social and environmental factors that accounts for the development of major depression.

3

a Explain the meaning of poverty.

Poverty is an enforced lack of socially perceived necessities (e.g. people living in poverty usually suffer a level of deprivation to the extent that they are unable to meet minimum standards of wellbeing and are unable to participate as they would like to in everyday life).

b How is poverty commonly measured? Suggest another way of operationalising poverty for research purposes. Give a reason for your answer.

• Poverty in Australia is commonly measured in terms of economic resources which is most easily measured and described in terms of level of income and whether that prevents people from obtaining a minimum standard of living and from fully participating in society.

• Other ways of operationalising poverty may include:
  - residency in government funded accommodation
  - dependency on government funded unemployment benefits
  - homelessness
  - housing conditions
  - amount of savings
  - ownership of assets, household appliances etc.
  - suburb/area in which people live
  - self-reports.

c Identify two groups in Australian society which you believe are likely to be in poverty or experience a higher incidence of poverty. Give a reason for each choice.

Examples may include:

• homeless people
• long-term unemployed people
• people with disabilities
• people with mental illness
• pensioners
• migrants and refugees
• sole parent families
• Aboriginal Australians.

Reasons may refer to:

• lack of work and income
• lack of access to education
• lack of access to housing
• lack of access to services
• poorer physical and mental health
• reliance on some form of welfare payment.

4 Does poverty lead to major depression or does depression lead to poverty? Explain with reference to the social drift and social causation hypotheses and relevant examples.

• According to the social drift hypothesis major depression leads to poverty—major depression affects a person’s ability to maintain their economic resources (e.g. ability to earn money, pay their rent, buy food/clothing) so they become poorer.

• According to the social causation hypothesis poverty leads to major depression—people living in poverty are subjected to a higher number of stressors (which place them at a higher risk of developing major depression—as explained by the ‘stress exposure’ model) and have access to less social support than people of a higher socioeconomic status.

5 Would you expect a victim of abuse living in poverty to be more or less predisposed to the development of major depression? Explain your answer.

• A victim of abuse living in poverty is more predisposed to the development of major depression.

• Both abuse and poverty are risk factors in the development of major depression and there would consequently be a cumulative effect thereby increasing the risk even further.

Learning Activity 15.15 (p. 647)

1

a Explain the meaning of social isolation.

Social isolation is the absence of social contacts, interactions and relationships with family, friends, neighbours, colleagues and acquaintances on an individual level, and with people in the wider community and society at large on a broader level.

b Give two examples of social or cultural groups in Australian society you believe may be vulnerable to social isolation. Give a reason for each answer.

Examples may include:

• people living in remote and outlying rural areas of Australia
• elderly
• people who are physically disabled or mentally ill
• migrants
• refugees, asylum seekers.

c Describe the circumstances under which someone with lots of pets would be considered socially isolated.

• The term social isolation is specifically used in relation to contact with members of the same species.
This means that someone may have lots of pets and enjoy contact and interaction with these pets, but still be socially isolated if there is no contact with other PEOPLE when needed.

d  Distinguish between perceived and actual social isolation.

- Perceived social isolation is the individual’s personal interpretation of having little or no access to social contact, interaction and relationships with other people—the individual’s perception of social isolation, and the feelings accompanying it, occur regardless of the actual number of people in the individual’s social network.
- Actual social isolation occurs when the individual actually is socially isolated—the person may have a social network but the number of people in it is usually limited and most or all people are likely to be difficult to access or inaccessible when needed.

Differences may refer to:

- In the case of perceived social isolation, the person could potentially have access to, contact and interactions with others but believes that they cannot, whereas with actual social isolation, the person is actually (objectively) unable to have access to, contact and interactions with as many or specific others as desired.
- The number of people in an individual’s social network is typically much higher among people experiencing perceived social isolation than among those experiencing actual social isolation, e.g. for people experiencing perceived social isolation there are normally quite a few people they do or could potentially come into contact with, whereas for people experiencing actual social isolation, the objective availability of people in the social network is very limited.

e  Explain how social isolation may contribute to the development of major depression with reference to research evidence.

- Some psychologists propose that we all possess basic social needs to feel a sense of belonging and acceptance and to have connections and close interpersonal relationships with others. These social needs are considered to be a motivating force that can drive, direct and sustain our behaviour until the needs are met.
- Not having close interpersonal relationships with others when this is desired can lead people to feel lonely, rejected, unmotivated to sustain their behaviour and negatively affect their self-esteem and confidence.
- Studies have found that having a supportive social network can reduce a person’s risk of developing major depression (see pp.721–2).
- Therefore, a lack of social support can reduce a person’s ability to cope with stressful life events, thereby making a person more vulnerable to depression.
- Numerous studies have been conducted with various populations that have examined the relationship between social isolation and major depression:
  - animal studies: animals (e.g. monkeys, rats) that are socially isolated during infancy develop behaviour patterns and symptoms similar to those experienced by people with major depression;
  - Australian adults: ‘perceived’ social isolation was found to be a very strong predictor of major depression and people living alone were twice as likely to have major depression when compared to those living with others;
Australian adolescents: major depression and youth suicide has been found to be a particular issue for adolescents living in regional (rural) Australia.

2

a What is rumination?
Rumination is repeatedly thinking about or dwelling on undesirable thoughts and feelings, such as problems or moods, without acting to change them.

b Explain a possible relationship between social isolation, rumination and major depression.
• Rumination is more likely to occur when a person is by themselves ('alone with their thoughts') and less likely to occur when a person is in the company of others.
• This is because when someone is ruminating, they tend to be very self-focused and preoccupied.
• Therefore: the more socially isolated a person is the more they are on their own the more prone they may be to rumination the more prone they may be to developing major depression.

3

a Explain the meaning of social stressor with reference to an example.
Social stressors (or interpersonal stressors) are stressors arising from social roles we perform in everyday life that are generally considered problematic or undesirable, e.g. problems getting along with friends, family, work colleagues, a partner; being bullied or harassed.

b Explain how role disputes and role transitions may function as social stressors and consequently contribute to the development of major depression.
Role disputes:
• A role dispute occurs when an individual and at least one other person of significance in their life have different or unequal expectations about the terms and/or guidelines for behaviour within the relationship, e.g. an adolescent argues with their parents about career choice, a married couple argue about whose responsibility it is to do the household chores, an employee is in dispute with a co-worker about whose role it is to re-stock the photocopier if it runs out of paper and keep the stationery cupboard stocked.
• A role dispute can function as a social stressor and contribute to the development of major depression because of the uncertainty about when the dispute will end and if it will end at all.
• A role dispute may also lead to the person feeling helpless if repeated efforts to resolve the dispute with the other person(s) are unsuccessful.

Role transitions:
• A role transition involves adjustment to a life change that requires a change in behaviour associated with an old role to enable a new role to be performed.
• A role transition can function as a social stressor and contribute to the development of major depression if the new role is placed on a person unexpectedly, the new role is
unwanted, the person is not psychologically or emotionally prepared for the new role or the old role is missed.

4

a What is co-rumination and how might it contribute to the development of major depression?

- Co-rumination occurs when individuals, usually friends, talk together and repeatedly discuss and revisit problems, speculating about them without acting to change them, and focus on negative thoughts and feelings associated with them.
- It is therefore a passive process in which little attention is given towards developing and enacting potential solutions to problems.
- Passively discussing and revisiting problems without enacting solutions could lead a person feeling helpless about ever resolving their problems and helplessness is known to be a contributing factor to the development of major depression.
- Furthermore, the repetitive nature of co-rumination could serve to reinforce a person’s negative cognitions (thoughts), which could lead them to develop negative thoughts about themselves, their world/environment and their future, which could, in turn, contribute to the development of major depression (see Box 15.7 p. 628).

b What is the essential difference between rumination and co-rumination?

- Rumination involves repeatedly thinking about or dwelling on undesirable thoughts and feelings, such as problems or moods, without acting to change them – by oneself
- Co-rumination occurs when individuals, usually friends, talk together and repeatedly discuss and revisit problems, speculating about them without acting to change them, and focus on negative thoughts and feelings associated with them

The essential difference between the two is therefore that rumination occurs by oneself whereas co-rumination occurs with someone else.

c What is your opinion of the hypothesis that adolescent girls tend to co-ruminate more than boys and that this may explain why adolescent girls are more likely to develop major depression?

Discuss student responses to clarify conceptual understanding.

5 Are socially isolated people more or less likely experience social stressors? Explain your answer.

Discuss student responses to clarify conceptual understanding, ensuring appropriate interpretation of social isolation and social stressor.

**Learning Activity 15.16 (p. 647)**

Data analysis

Consider the data in table 15.3 and complete the following tasks and questions.

1

a Which of the two depression scenarios is likely to be perceived by participants as the most severe case?

The scenario describing a person with major depression and suicidal thoughts
To what extent do differing perceptions appear to have influenced participant responses? Explain with reference to the data.

- differing perceptions of ‘severity’ do not appear to have influenced participant responses
- For the nine possible causes, percentages are roughly similar and in the same direction for both scenarios, e.g.
  - virus/infection—for both scenarios this is more likely to be endorsed as a possible cause by Australian than Japanese participants;
  - inherited/genetic—for both scenarios this is more likely to be endorsed as a possible cause by Australian than Japanese participants;
  - weakness of character—for both scenarios, this is more likely to be endorsed as a possible cause by Japanese people than Australians.

What cultural differences were there, if any, in relation to part (b)? Explain with reference to the data.

Answers should refer to differences between Australian and Japanese participants, e.g. note the differences for virus or infection as a suggested likely or very likely cause of both major depression variants, as well as allergy, inherited or genetic and weakness of character.

Classify the causal factors into psychological, biological and social domains.

- psychological
  - nervous person
  - weakness of character
- biological
  - virus or infection
  - allergy
  - inherited or genetic
- social
  - day-to-day problems
  - death of someone close
  - traumatic events
  - problems from childhood

Suggest a suitable type of graph for describing the data for a. above.

Bar graph or pie chart (but not a histogram or line graph)

What cultural differences in beliefs about contributory factors do the data suggest? Explain with reference to the data.

Scenario 1: major depression:
• The data suggest that Australian people more readily attribute biological factors to be a possible cause of major depression than Japanese people do, e.g.
  - of all of the nine possible causes, the cause with the most significant difference between Japanese and Australian people is virus or infection: only 6.2% of Japanese people attributed these as possible causes, whereas 50.5% of Australian people attributed these as possible causes, and
  - allergy: only 10.2% of Japanese people attributing this as a possible cause compared with 44.9% of Australian people, and
  - inherited or genetic causes: 34.6% of Japanese people compared with 68% of Australian people.

• The data suggest that Japanese people attribute psychological factors (within the individual) to be a possible cause of major depression more so than Australian people do:
  - nervous person: 81.4% vs. 67.9% respectively, and
  - weakness of character: 73.6% vs. 43% respectively.

• The data also suggest that both Australian and Japanese people attribute social factors to be a possible cause of major depression:
  - death of someone close: 96.3% vs. 79.8% respectively,
  - traumatic events: 93.9% vs. 82.6% respectively, and
  - problems from childhood: 91.3% vs. 81% respectively.

Scenario 2: major depression with suicidal thoughts:

• The data suggest that Australian people more readily attribute biological factors to be a possible cause of major depression with suicidal thoughts than Japanese people do, e.g.
  - of all of the nine possible causes, the cause with the most significant difference between Japanese and Australian people is virus or infection: only 6.6% of Japanese people attributed these as possible causes, whereas 41.4% of Australian people attributed these as possible causes, and
  - allergy: only 11.4% of Japanese people attributing this as a possible cause compared with 37.6% of Australian people, and
  - inherited or genetic causes: 34% of Japanese people compared with 68.4% of Australian people.

• The data suggest that Japanese people attribute psychological factors (within the individual) to be a possible cause of major depression with suicidal thoughts more so than Australian people do:
  - nervous person: 77.4% vs. 66.6% respectively, and
  - weakness of character: 69.2% vs. 46.1% respectively.

• The data also suggest that both Australian and Japanese people attribute social factors to be a possible cause of major depression with suicidal thoughts:
  - death of someone close: 94.8% vs. 81.4% respectively, and
Chapter 15: Mood disorder: major depression

- traumatic events: 92.7% vs. 79.6% respectively), and
- problems from childhood: 95% vs. 82% respectively.

3 Which of the causal factor(s) do you believe are inaccurate? Explain your answer(s).

Discuss student responses to clarify conceptual understanding.

4 On the basis of the data, write a tentative conclusion about similarities and differences of Japanese and Australians on causes of major depression (with or without suicidal thoughts).

On the basis of the data it could tentatively be concluded that:

- In both Japan and Australia, the public has a predominant belief in social causes in the development of major depression. These causes include day-to-day problems, death of someone close, traumatic events, and problems from childhood.
- However, there are also some major differences between the two countries: Australians had stronger beliefs in infections, allergies and genetics as possible causes, while Japanese had stronger beliefs in being a 'nervous person' and 'weakness of character'.

5 a How might the beliefs individuals hold about the cause(s) of a mental disorder influence the type of assistance they seek to cope with it? Explain your answer.

- If an individual believes a mental disorder is caused by biological factors, they might be more likely to seek assistance from a medical professional.
- If an individual believes a mental disorder is caused by psychological factors, they might be more likely to seek assistance from a psychologist, psychotherapist or counsellor or it may reduce the likelihood of them seeking assistance at all, e.g. the belief in 'weakness of character' is of concern because this is quite a 'stigmatising' explanation (the implication is that the disorder is the person's fault) and could make people less likely to disclose that they are experiencing a mental disorder and to seek professional help.

b Assuming perceived cause influences choice of treatment, what type of treatment might Japanese people prefer? Australians? Explain with reference to the data.

- Australians had stronger beliefs in infections, allergies and genetics as possible causes, while Japanese had stronger beliefs in being a 'nervous person' and 'weakness of character'.
- Therefore, Australians may prefer treatment in the form of medical interventions, e.g. anti-depressant medication, whereas Japanese may prefer treatment that will result in an increase in 'will power' and 'mental toughness'.
- However, it is important to note that both Australian and Japanese participants attributed social causes to the development of major depression therefore they may both acknowledge the importance reducing the impact of social factors, e.g. stress management, social support etc.

Learning Activity 15.17 (p. 648)

Media response
Read the newspaper article on ‘Why chatting too long on Facebook can get a girl down’, then answer the following questions.

1. Construct a simple flow chart to summarise the procedure (or research method) of the study reported in the article.
   Example: see next page.

   - Eighty-three girls aged around 13 years tested for depressive symptoms and interviewed (in the presence of a parent)
   - At the interview they were asked:
     1. how much time they spent talking to friends about their problems
     2. how much they encouraged each other to do so
     3. their tendency to revisit the same problems

   Contacted 12 months later...

   - The same 33 girls (now aged about 14) again tested for depressive symptoms and interviewed.
   - At the interview they were asked about romantic experiences considered normal for early teenagers, e.g. having been asked on a date, having been kissed

   Results
   - Higher levels of discussing problems with friends significantly linked with higher levels of depression
   - More romantic experiences linked both to excessive

2. What cause–effect relationship is suggested by the article in relation to major depression?
   The cause–effect implied is that of co-rumination and depression, i.e. the higher the level of discussing problems with friends, the higher the levels of major depression and vice versa.

3. To what extent is the suggested relationship consistent with theory described in the text.
   Explain your answer with reference to the article and the text.
   - The findings of the Davila and Star (2009) study described in the article are consistent with the findings of the Rose (2002) study described in the text
   - Rose (2002) also found that co-rumination is a risk factor in the development of major depression. Rose also found that girls co-ruminate more than boys and that this becomes more pronounced in adolescence.
4 According to the article, what is a possible contributory role to major depression of Facebook and similar social networking sites?

According to the article, Facebook and other similar social networking sites can possibly play a contributory role in the development of major depression because:

- they provide teenagers with more opportunities to share problems and talk over and over again about the same emotional difficulties;
- frequently discussing the same problem can intensify into an unhealthy activity for those who use Facebook and other electronic means to obsess about it;
- they make it very easy for adolescents to become even more anxious, which can lead to depression.

5 Suggest a potential confounding variable of relevance to the reported research and its findings.

- A confounding variable is a variable other than the independent variable that has an unwanted effect on the dependent variable, making it impossible to determine which of the variables produces the change in the dependent variable.
- In this study the DV is level of depression/number of depressive symptoms.
- An example of a variable other than the IVs that could have influenced the development of depressive symptoms in the adolescent girls is social factors (e.g. the presence of negative life events) that the teenagers could have experienced in the intervening 12 months of the study.

6 In what way might social networking sites reduce the incidence of major depression

a among adolescent girls?

Ways may include:

- reducing social isolation/feelings of loneliness;
- reducing stress;
- increasing access to social support;
- providing aid in finding and receiving mental health information, which may include techniques for preventing or dealing with symptoms.

b the wider community?

Ways may include:

- reducing social isolation/feelings of loneliness;
- increasing access to social support;
- providing aid in finding and receiving mental health information which may include techniques for preventing or dealing with symptoms.

Learning Activity 14.18 (p. 651)

Media response
Select and view one of the television advertisements about major depression from the following website: www.youthbeyondblue.co/tvads. These advertisements were produced by youth beyondblue.

Write a 200-250 word commentary about how a person’s family and social network can play a role in preventing the development of major depression. Ensure you refer to examples in the advertisement you viewed and key symptoms of major depression described in the text.

Student’s commentaries will vary.

Learning Activity 15.19 (p. 654)

1 Outline three ways in which a family can support someone with major depression.

Ways may include:

- encouraging the depressed family member to ‘stick with’ their treatment until their symptoms go away (this could take several weeks);
- monitoring whether they are taking their prescribed anti-depressant medication;
- making themselves available by talking to the person, asking them how they are feeling or spend time with them, just to let them know someone cares and understands them;
- making plans to do something with them (e.g. go for a walk, to see a movie, to a coffee shop);
- educating themselves about major depression (contributory factors, how it affects people and how it can be managed);

2

a What is a social network?

A social network is the various individuals or groups who maintain relationships with an individual in different aspects of their lives.

b What are two key characteristics of a social network?

Key characteristics include:

- that people in a person’s social network usually have some kind of significance or importance to the individual, such as those with relatives, close and other friends, neighbours, work colleagues, teachers, acquaintances, family doctor, hairdresser, priest and so on;
- that some people within the network know each other and therefore have some kind of connection with each other, as well as with the individual.

c Construct a diagram that shows several individuals and groups in your social network, and identifies connections between people in your network and a different social network.

Discuss student answers and clarify conceptual understanding.

d Give three examples of how the social network of someone with major depression can provide support.

Examples may refer to:
• appraisal support: having access to someone with whom to talk and obtain feedback about feelings;
• tangible assistance: the provision of material support, such as services, financial assistance or goods (gifts), doing a job or chore, giving food to someone who may not have the energy to cook a nutritious meal for themselves;
• information support: the provision of information or advice and giving feedback about how a person is doing, e.g. explain where to get help, showing how to do something, giving feedback as to one’s appearance, behaviour etc.
• emotional support: provision of reassurance, care, and being able to rely on and confide in a person, which contributes to the feeling that one is loved and cared about, e.g. hugs or pats on the back as well as listening and empathising without passing judgement.

3

a What is a recovery group?
A recovery group is a not-for-profit support group run by and for people who interact in some way on the basis of common interests or experiences to support one another.

b What is a common goal of recovery groups for major depression?
A common goal of recovery groups for major depression is to draw on other group members’ experiences to develop problem-solving skills for self-care and management of symptoms in the gradual step-by-step restoration of mental health. The goal is therefore not necessarily the absence of major depression and its symptoms.

c Give three examples of how a recovery group can provide support for someone with major depression.
Examples may include:
• helping people with major depression feel less lonely and isolated;
• providing a means of connecting and sharing with others who truly understand what each member is going through because virtually all members have ‘been there’ or ‘are there’, i.e. ‘are in the same boat’;
• providing opportunities to talk openly and honestly about feelings, to share personal experiences (e.g. what worked and what didn’t) and gain a clearer understanding of what to expect in their situation;
• providing opportunities for members to assist each other in developing problem-solving skills for self-care and management of symptoms and to develop and maintain healthy lifestyle habits.