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A qualitative study on vulnerability models of chronic depressive disorders

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ABSTRACT

The subject of this article was to qualitative analysis of vulnerability patterns in chronic depressive disorders. The aim includes a review of studies related to chronic depressive disorders which was eventually leaded to the expression of common elements in the development of chronic depression. The results show that; 1- In this disorder, there is resistance to treatment and include the following; 1) dysthymic disorder, 2)chronic major depressive disorder (MDD), 3)double depression (MDD superimposed on a dysthymic disorder) and 4)recurrent major depressive disorder with incomplete remission between the episodes. 2- In this disorder, involved a combination of biological, psychological and social and the disorder in the psychological field with these patterns: mental patterns (cognitive models, processing and memory-based models, Schema-based patterns and psychodynamic models), behavior patterns, social model cognitive and population patterns. 3- There are differences between acute and chronic depression of existing signs, and the aforementioned models often focus on major depression. 4- with previous studies, some common elements in chronic depressive disorders include; early loss, self- devaluation, disappointment in content of thought, lack of reassuring response to treatment, vulnerability information processing, early maladaptive schemas, the contradiction between ideal self and real self-representations, accidents and difficulties of life, marital, family, interpersonal, occupational problems, social segregation, difficulty in interpersonal skills, social avoidance, family history and socio-economic factors. Finally, in comparison with research conducted in major depressive disorder, backing research in psychotherapy for chronic depression is relatively young and lots of research is essential.

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1. Introduction

Always between 25 to 40 percent of patients get the admission to psychiatric clinics, people who show the cases of dysthymic. In compared with major depression, dysthymic associated with lower levels of compatibility, poorer prognosis, higher levels of melancholic and depressive personality traits. Also, in this group of people, there are Lots of family and career problems and also they are experiencing so many problems in their interpersonal relations (Klien et al., 1998) and do not change their depressed mood and sometimes this is their condition, takes 20 to 30 years or even more. So the duration average of the disorder in adults is approximately 5 years (Barlow and Durand, 2000). This problem, a disorder that is refractory to treatment and 40 percent of patients with this disorder do not respond to drug therapy (Snyder and Ingram, 2000) and often These patients feel incompetence onto others as a Working and are unable to enjoy life events (Halgin and Whitbourne, 2006).

There have been two main approaches to the definition of disorders characterized by the persistence of depressive symptoms. One is to consider simply the duration over which depressive symptoms have persisted. In this approach, someone is viewed as chronically depressed if they have suffered from depressive symptoms for a number of months or years with little evidence of relief. The alternative approach is to consider the degree to which attempts the treatment have been unsuccessful. In this approach, someone is viewed as persistently depressed if their symptoms have not been adequately alleviated by a course of treatment that might have been expected to be effective (Moore and Garland, 2004).

Anyway chronic depression, is a disorder resistant to treatment and based on the findings, many patients with this disorder often receive

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inappropriate treatment (Quitkin, 1985) and although depression is often considered to be a treatable condition, it is now clear that a sizeable minority of patients suffer chronic or persistent depressive symptoms (Moore and Garland, 2004). On the other hand, there is disagreement in relation to estimate the prevalence of chronic depression due to lack of agreement on the definition of persistent depression. The prevalence of persistent depressive disorder in the United States represented 1.4 percent of the total population, women (5 percent) and men (1/3 percent) (Uher, 2014). Furthermore, the prevalence approximately is 5.0 percent for persistent depressive disorder and 5/1 percent for chronic major depressive disorder in 12 months in the United States (American Psychiatric Association, 2013).

There are also numerous consequences of continuing depression. In research on the consequences of depression, it has become clear that it is difficult to separate antecedents of the consequences of depression. Many personal characteristics (e.g. low self-esteem) and social factors (such as lack of supportive relationships) can also be antecedents and consequences of persistent depression (Wells et al., 1989).

Existing literature on depression risk factors, that lead to recurrence or survival of symptoms and the causes of chronic depression, are limited. However, these factors are very widely expressed about depression and they have taken different approaches to psychology. According to the bio-psycho-social model (Engel, 1997), study of human behavior, in addition to psychological aspects, requires other sciences. Depression of risk factors can be divided into three major categories: Biological, psychological and social factors. However, the factors mentioned in the literature, can not necessarily find the same expression in chronic depression, that this can lead to incorrect diagnosis and inappropriate treatment. Also, often in chronic depression, symptoms of depression may be created as a result of inappropriate treatment or be created due to initial incorrect diagnosis result and apply the inappropriate processes (Moore and Garland, 2004). In DSM5, chronic disorder, by eliminating chronic major depression and dysthymic disorders, apparent in persistent depressive disorder (dysthymia). So, they created a new disorder that this disorder is created by a combination of dysthymic disorder and chronic major depressive disorder (America Psychiatric Association, 2013). But, despite the high prevalence and importance of this disorder, results are not available for this disorder. Also, pay attention to this disorder, as an independent disorder, in the process of identifying the factors, which has particular importance for treatment. Because these vulnerability factors can be different from major depression, so should be paid to other factors that have led to the sustainability and continuity of their symptoms. Understanding these factors and explain patterns in chronic depressive disorders, can be added to improve treatment and create a new view that would be just and reasonable. So, in this article, will be presented the concept of chronic depressive disorders and will be presented to previous patterns associated with this disorder.

2. Concept

Approximately 20% of all depressed individuals develop a chronic course (Arnow and Constantino, 2003; Gilmer et al., 2005). This implies that 2.5e6% of the adult population in the community suffers from chronic depression (Kessler et al., 2005, 1994). Chronic depression is associated with increased functional impairment (Klein et al., 2000; Klein et al., 2006; Wells et al., 1992), higher levels of health care utilization, hospitalization and economic costs (Berndt et al., 2000; Gilmer et al., 2005; Howland, 1993; Klein et al., 2000; Smit et al., 2006) compared with non-chronic forms of depression.

Four types of chronic depression are usually distinguished in the literature: 1) dysthymic disorder, 2) chronic major depressive disorder (MDD), 3) double depression (MDD superimposed on a dysthymic disorder) and 4) recurrent major depressive disorder with incomplete remission between the episodes (Torpey and Klein, 2008). There are consistent findings supporting the idea that the various manifestations of chronic depression do not represent distinct disorders (Cuijpers et al., 2010; Klein et al., 2004; Klein et al., 2006; McCullough et al., 2003, 2000). The DSM-5 (American Psychiatric Association, 2013) diagnosis of persistent depressive disorder (dysthymia) includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia.

It is suggested that the determinants of chronic depression do not necessarily differ qualitatively, but only quantitatively from those of acute depression, with involvement of increased levels of these determinants in chronic forms (Riso et al., 2002). Among the several possible determinants of chronic depression that have been investigated so far, the strongest support has been found for the role of developmental antecedents and early adversity (Bifulco et al., 1997; Brown et al., 2008; Brown et al., 2007; Brown et al., 1994; Brown and Moran, 1994; Klein et al., 2009; Lizardi et al., 1995; Riso et al., 2002).

A more chronic form of depression, persistent depressive disorder (dysthymia), can be diagnosed when the mood disturbance continues for at least 2 years in adults or 1 year in children. This diagnosis, new in DSM-5, includes both the DSM-IV diagnostic categories of chronic major depression and dysthymia. Also in this disorder, these symptoms are: 1. Poor appetite or overeating, 2. Insomnia or hypersomnia, 3. Low energy or fatigue, 4. Low self-esteem, 5. Poor concentration or difficulty making decisions, 6. Feelings of hopelessness (American Psychiatric Association, 2013).

3. Patterns of chronic depression

In this disorder, are involved three biological, psychological and social. But it's still not clear influence of these factors and what role directly or indirectly they have in persistent chronic depressive disorder. Also the Previous models often focus on major depression. Findings of Tsuang et al. (2004) have shown that depression is the result of influences is multiple genetic and environmental and other factors. In any case the patterns that have been proposed to explain depression include:

3.1. Mental patterns

3.1.1. Cognitive models

There are several issues in mental model. The cognitive model by Beck (1967), assumes that early loss is leads to stable cognitive structures that person vulnerable to depression following the next events of his life. As a result, core beliefs, people are ready for depression (Fennel et al., 2004).

Three aspects of the cognition to create and maintain depression are important which include: cognitive vulnerability Such as content and process of negative thinking and so on. The early loss, self-devaluation and hopelessness of their influence on the content of thought depressed people. Beck's cognitive triad (Indicates a negative point of view and damaged about themselves, of the world and about the future) there are core characteristics of this content. This opinion plays an important role in maintaining depression. A system of mutual feedback (interaction) appeared Where the system, negative thinking causes in people who are severely depressed mood and physical problems, loss of motivation due to low mood leads to a decrease in involvement in Activities satisfactory (Fennel et al., 2004). Thus the process of thinking depression is characterized by their widespread bias. This process may cause a person did not remember the positive experiences in the past and the present (Fennel, et al., 2004).

Other cognitive processes that are involved in the persistence of depression, including: Many different types of logic errors, like; overgeneralization (overall conclusions to all events: specific and detailed), selective attention(Note the only negative aspects to the external experiences), all or nothing thinking (Fennel et al., 2004), ruminative response style, generalized memory (inability to process certain memories, especially positive memories) (Williams et al., 2006), reduction of metacognitive awareness (inability to seeing thoughts as thoughts and as a result, seeing them as fact), lack of problem-solving and lack of concentration and sloth in mental processes (Teasdale et al., 2000).

Also, according to Beck's cognitive model, early developmental experiences, how to interact with parents and important people in life, form assumptions or schemas about the self, the world and other people that Based on them, in depression, created dysfunctional assumptions and are negative self-thoughts and signs created such as behavioral symptoms (reduced activity and resignation), motivational features (apathy and lethargy), emotional symptoms (anxiety and guilt), symptoms of cognitive (difficulty concentrating, lack of decision-making power) and physical symptoms (anorexia and insomnia) and a vicious circle is formed that activates both the second level (Presuppositions) and a deeper level (Schema) (Dowd, 2004).

In the interactive model of cognitive subsystems of Teasdale and Barnard (1993), mood-dependent biases in cognitive processes, reflect changes in the model schemas Which serve to interpret experiences and the switch from non-depressed to depressed mood, are associated with changes in schematic mental models Which serve to interpret experiences (Teasdale et al., 2000). In The cognitive model of depression, Moor and Garland (2004), the avoidance beliefs and strategies as important factors in vulnerable patients are considered at the persistence of low mood and environmental and psychological consequences. So avoidance strategies in a long time are important in strengthening and maintaining low mood. In addition, the absence of reassuring response to treatment, perpetuates negative beliefs that are central to depression intensifies and a vicious circle is created by environmental implications avoidance and depression (Moore and Garland, 2004).

3.1.2. Information processing and memory-based models

Beevers (2005) in a study suggests dual process models offer powerful accounts of cognitive phenomena in social and personality psychology but they have not been widely adapted to clinical phenomena. This review presents a dual process model of cognitive vulnerability to unipolar depression. According to dual process theories, humans possess two modes of information processing. An associative mode involves quick, effortless processing that rests on well-learned associations. A reflective mode involves slow, effortful processing that rests on symbolic rule-based inferences. Whereas the associative mode occurs automatically, the reflective mode operates when expectancies are violated and sufficient cognitive resources are available to respond. A cognitive vulnerability to depression is observed when negatively biased associative processing is uncorrected by reflective processing. The circumstances when this is likely to occur are reviewed. New insights and implications for assessment, etiology, and treatment of cognitive vulnerability to depression are discussed.

Williams and Moulds (2010), conducted a study to the impact of ruminative processing on the experience of self-referent intrusive memories in dysphoria. This study of findings align with the suggestion that depressed individuals may get caught up in a ruminative cycle that, due to the documented effects of analytical self-focus,

exacerbate the emotional response elicited by intrusions and perpetuate biased attentional focus on them.

Also, Hermans et al. (2008) in their study stated that two decades of research have shown that depressed patients experience significant difficulties retrieving specific autobiographical memories. Importantly, reduced autobiographical memory (AM) specificity is a known vulnerability factor for depression and is predictive of a more chronic course. One of the models that have been put forward to explain the origin of this reduced specificity is the affect-regulation model, which assumes that being less specific might help to prevent negative or painful emotions by recalling events in a less specific way. This avoidant memory style might have beneficial effects in the short run (less emotional impact of stressful events) but is detrimental in the long run.

3.1.3. Schema-based patterns

Montazeri et al. (2013) concluded that in their study, depressive symptoms increase the students with higher scores the schemas of loneliness, vulnerability, abuse/mistrust, defectiveness/shame, failure to achieve, unrelenting standards and merit. Results also indicated that the schemes (schemas, loneliness, vulnerability, abuse/mistrust, defectiveness/shame, failure to achieve, unrelenting standards and merit) are able to predict depression. Also Shahamat (2011) concluded that in this study, there was a significant relationship between early maladaptive schemas and symptoms, somatization, anxiety and depression. Meanwhile, the above symptoms were predicted by the defectiveness/Shame schema predicted to be significant. Also, Halvorsen et al. (2010) studied depressed and non-depressed individuals; as a result, there were significant differences between the two groups in their early maladaptive schemas. In this study, regression model, schemas of self-control/ inadequate and constraints hampered, were significant predictor of depressive symptoms. Reinecke and Simons (2005) were the findings that early maladaptive schemas associated with low social skills are important factors in increasing vulnerability to depression in adolescents. Those in the study of a range of factors associated with depression such; early traumatic experiences, child-parent interaction patterns, biological factors and life events to be concluded that these factors, associated with failure to develop efficient schemas and social skills in depression. Harris (2002) also showed that the Schema play the role of mediator in relationship between perceived parenting styles with depressive symptoms. The four schemas that had the greatest variance were: defectiveness / shame, Self-control/ inadequate, vulnerability and dependence / incompetence. Calvete et al. (2005) also emphasized the clinical relevance of these early maladaptive schemas with emotional symptoms of depression and anxiety disorders. Cecero et al. (2004) showed in a study, positive significant relationship existed between early maladaptive schemas and feeling of pleasure.

3.1.4. Psychodynamic model

Taubner (2013) in a study suggests in psychoanalytic theory, mental disorders like depression are seen as rooted in the individual past of a patient: that is, either as a residuum of early experience or as the expression of primitive modes of psychic functioning. Repeated (early) attachment experiences form internal working models (IWMs) of attachment that serve as generalized expectations and organizing intrapsychic structures. Insecure and especially disorganized IWMs are seen as vulnerabilities for the development of mental illnesses. Bowlby (1988) claimed that increases in depressive symptoms should most likely occur when vulnerable individuals experience stressors that test and strain their relationships. Such experiences can increase depressive symptoms by enhancing negative beliefs about the self and about others. The objectives of psychodynamic psychotherapy with depressed patients are to work toward a stable modification of social expectations and affect regulation strategies related to the depressive pathology by reactivating IWMs within the therapeutic relationship.

3.2. Behavior patterns

In explaining the behavioral factors that lead to depression, there are referring these cases; excessive alcohol or drug consumption, avoiding social contact, refer high-risk behavior and rumination (Morris et al., 2009). Based on Forrester (1973), two behavior patterns seen in depressed patients:

1. Low frequency of positive social behaviors that these behaviors are reinforced receives, such as eye contact and verbal communication.
2. High frequency of avoidance and escape behaviors, such as complaining, help-seeking, and suicidal behaviors, feelings of sadness, interpersonal disturbing events.

In the model proposed by Levenson (1973), low rates of positive reinforcement related to the response, leading to depression and low rates of this type of reinforcement, resulting in decreased social behavior and other behavioral. Raes et al. (2010) in a study stated that; depression can cause major behavioral problems in the sub-scales: Activity / avoidance, rumination, loss of employment / education and social damage. Also, Raes et al. (2010) in a study stated that; depression can cause major behavioral problems in the sub-scales: Activity / avoidance, rumination, loss of employment / education and social damage. Also Parhoun et al. (2013) showed the effects of depression on quality of life and the role of behavioral therapy in improving it. Finding of this study was shown that the results of Bigdeli and Rahimian Booghar (2011) have been confirmed.

3.3. Social model

In social model and life events on depression, one of the models explaining depression by Williams (2001), which in this model are important life events and problems in terms of land, for Depressed patients. In this model, high social support is regarded as an important factor against negative life events, (Morris et al., 2009). Emotion caused by long periods dealing with unreasonable expectations, criticisms and Hostilities others, the conflicting relations that their predisposition to depression. It is also possible, a supporting mental, is more important than the actual existence of support in prevention of depression, (Harris et al., 1999). In cognitive behavioral interventions for depression, factors such as; marital problems, family, interpersonal, occupational, legal, financial and social segregation as social factors are involved in causing depression (Morris et al., 2009).

Based on other studies, risk factors increase the incidence of the disorder, includes the following components; physical factors, parental death during childhood, age, sex, celibacy, divorce and separation, low socioeconomic levels, special life style, family history of depression (Dowd, 2004).

Daily performance with depression is changes in many areas of life, such as location of work, leisure, marriage and family. Most patients with depression with return periods and considered to be the return of the disease, factors such as low levels of social support, inconsistency, lack of leisure time, poor quality of their relationships (Stefos et al., 1996). Thus, defects in social functioning negatively occur in the treatment prognosis finally, the patient would be excluded from the social sphere (Paddock and Nowicki, 1986) or increases the rate of recurrence.

Lynch (2001) in a study stated that; people with depression are lack of interpersonal skills, self-regulation and distress tolerance. And Brockmeyer et al. (2015) showed on, in patients with chronic depression, avoid, was more than the control group. Also avoid the social and emotional behavior (in the form of emotional expression limited to others) has been reported in patients with chronic depression rather than depression period. In addition, to avoid the feelings of the public and avoid social behavior had a positive relationship with the level of depression in chronically depressed patients. So much attention to maladaptive avoidance processes is effective in the treatment of chronic depression.

3.4. Demographic patterns

At the same time, the provisions of the persistence of depression, special attention must be factors related to the treatment of chronic depression and social/demographic factors and individual patient factors. Some studies have shown that continuation of depression was higher in older patients (Kocsis et al., 2000) and women (Berti Ceroni et al., 1984). Also, the occurrence of negative life events after the onset of a period of depression associated with chronic (Scott, 1988). Of negative life events are more common marital and interpersonal problems, especially in patients with chronic depression. And dismissal from work is common, especially in men with chronic depression. There is some debate about the issue is whether such events are part of the continuing depression or have been the consequences of this disease (Gotlib and Hammen, 1995). The patient's individual factors, it is known that some factors related to the patient's history, Personality before his illness and depressive symptoms, are being as important predictors of chronic. There is also a greater number of previous periods of illness and family history of depression; both have predicted the persistence of depression (Scott, 1988). Hosseini and Ashrafi (2011) showed the rate of depression in women, single students and unemployed students was more of the same category with them. Amanat et al. (2006) research showed that socio-economic factors can have a significant role in the development of depression in women. Also Gharedinge et al. (2011) showed in the rate of depression, there is a significant difference between Single and married women, employed and unemployed women, women in various age and educational levels.

4. Discussion and conclusion

It is important that there are some differences in the symptoms between acute and chronic depression. However, psychologically, patients with persistent depression, helpless and desperate are immutable (Thase, 1994). For many patients, lack of motivation and pleasure is more intense than acute negative mood states. Patients usually experience their symptoms so that, are totally out of their control: They feel they do not have the power to change the sustainability context of their low mood and they may experience "for no reason" peak intensity at various unpleasant emotions. This lack of control often leads to paralysis and inaction. Therefore, many patients desist from their important roles or functions or put them in precarious conditions. Despite this lack of perceived control, Patients often blame themselves, because of depression and also for external problems and they feel guilty (Keller et al., 1995). Also, it seems in chronic depression, is common complaints related to energy and fatigue in people and is more debilitating than other signs. This combination of despair, depressed mood, uncontrollable, fatigue and lack of response to previous treatment, can also enthusiastic therapists are depressed. Brockmeyer et al. (2015) showed that avoiding social and emotional behavior has been reported in patients with chronic depression than people with recurring depression. In recent research, family problems, anxiety and low self-esteem in childhood and early adulthood problems associated with chronic depression (Angst et al., 2011). The results of an analysis report that abuse in childhood is associated with an increased risk of chronic depression and lack of response

during treatment (Nanni et al., 2012). Also, there is a relationship between chronic depression and personality disorders second axis (Riso et al., 2002). Agosti (2014) study showed that the presence of panic disorder, generalized anxiety disorder, personality disorders (class B) and a history of physical abuse were associated with reducing improvement in chronic depression. At the same time, it should be noted that most of these models have been focusing on major depression and according to research, it seems, has not made explanation model for chronic depression. However, with previous studies, some common elements in chronic depressive disorders include:

1. Early loss, self- devaluation, disappointment at the content of thought, the errors: included over-generalization, selective attention, thinking of all or nothing, ruminative responses styles, generalized memory, reduced cognitive self-awareness and failure problem solving, difficulty focusing and slow mental processes, beliefs avoidance.
2. Lack of reassuring response to treatment.
3. Vulnerability information processing.
4. Early maladaptive schemas; loneliness, failure, unrelenting standards and entitlements, obey / self-control, defectiveness / shame, Inadequate self-control, vulnerability and dependence / incompetence.
5. The contradiction between ideal self and real self-representations.
6. Accidents and difficulties of life, marital, family, occupational problems.
7. Social segregation.
8. Difficulty in interpersonal skills.
9. Social Avoidance.
10. Family history and socio-economic factors.

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