Social Factors in Depressive Illness

By Paul Bebbington *

INTRODUCTION

Sadness is part of normal human experience but from early times people found it useful to distinguish ordinary depressed mood from more severe forms which can be characterised as illnesses. Hippocrates coined the term melancholia. It was not clear that he associated this with depressed mood, but the other Hippocratics certainly did. The conception of depression as an illness was further elaborated by Griesinger in the Nineteenth century, and most of our ideas about the condition can be traced back to that period.

The deliberate setting apart of depressive illness from the ordinary human experience of sadness makes for considerable problems in its study. The word depression itself has come to be used in at least three senses. First, it is a term used by lay people to describe ordinary sadness, a *mood.* Secondly, it is a word used to describe a *symptom.* Depression as a symptom can be distinguished from ordinary sadness by its persistence, its pervasiveness, its uncontrollability, and the level of distress it causes. There is an arbitary element in drawing the line between ordinary sadness and depressed mood of pathological degree. I would say that depressed mood which is causing the subject considerable pain, which has lasted for perhaps five to seven days, which lasts most of the day, which is beyond the subject's capacity to control, and which responds only partially or fleetingly to the efforts of others to cheer the subject up is indeed pathological, whether there is an understandable cause or not.

The third sense in which the word depression is used is to describe a *syndrome.* When pathological depressed mood is defined as above, it tends to be associated with other features such as worry, tension, anxiety, loss of concentration, sleep disturbance, loss of interest, loss of libido and so on. Together these symptoms make up the depressive syndrome. In fact, people have found it useful to differentiate many depressive syndromes. However, in social epidemiology there has been a tendency to use only three. These are bipolar manic depressive illness, unipolar manic depressive illness and neurotic depression. Bipolar manic depressive illness is distinguished by the fact that the subject also has episodes of mania. Again the distinction between unipolar manic depressive illness and neurotic depression is arbitary, as it involves making a cut in what is essentially a continuum. This cut is certainly useful in deciding upon treatment; however its validity in social epidemiological terms is not clearly established.

The science of medicine is defined by a particular theoretical approach, which is the arrangement of medical phenomena in syndromes so that they can be studied better. Once a syndrome is established, it can be used in the pursuit of knowledge about aetiology, treatment and management. The requirement of a syndrome is that it should be useful. If it proves otherwise, it can be discarded and the phenomena grouped again in more useful forms. This is what the definitions of some types of sadness as depressive illness is about.

Macrosocial Factors in Depressive Illness

One may find out interesting things about the distribution of depressive illness and the possible reasons for it by studying relatively simple sociodemographic variables, such as sex, age, marital status, employment status and so on. Most of the findings which I will discuss here were established in Western industrialised cultures, and we know little of the distribution of depressive illness in other cultures, except to know it is still common [1].

One of the most consistent findings in psychiatric epidemiology is that depression is commoner in women. In Western societies the prevalence of depression in community surveys has ranged be-

* MRC Social Psychiatry Unit
Institute of Psychiatry
De Crespigny Park
London SE5 8AF

tween 2½ to 5% in men and between 5 and 10% in women [2]. In most studies the ratio is a little over 2:1 (F:M). This finding emerges in studies of severe depressive illness among psychiatric inpatients and is seen throughout the range to the mildest condition, although it is possible that the female preponderance is less in the more severe conditions [3].

The extreme consistency of this finding has led people to postulate that it arises because of a biological difference between the sexes. However, when the population is broken down into different sociodemographic groupings, it is found that the ratio varies, this is turn raising the possibility that the difference arises from social causes [4].

One condition which affects the sex ratio for depressive illness is that of marriage. In Western societies, post-marital groups, that is, those who are divorced, widowed or separated, have very high rates of depression in both sexes. Interestingly, the F:M sex ratio is reduced in the post-marital group. However, the most striking effect of marriage can be seen by contrasting the married and single in the two sexes. It is invariably found that married men have a lower rate of depression than their single brothers. This can be seen as a protective effect of marriage. Findings for women do vary, but in general are considerably different. In some studies, married women have higher rates for depression than their single sisters, while in other studies it can just be said that the protective effect is much less in women. The findings in men could be explained in terms of the selection effect: the more normal men get married, leaving a residuum of men among whom some may be particularly prone to depression. However, no selection effect seems likely to account for much of the *increased* rate in married women. It seems much more likely that marriage itself has an effect in raising the risk of depression amongst women. If so, this goes some way towards explaining the overall higher rates in women. It does suggest that the female preponderance is due to social causes.

However, some authors have recently claimed that the increase in depression amongst married women is brought about by the fact that they have children. In one study it appeared that having borne children raised the risk of depression ever afterwards amongst women, the speculation being that this arose because of some unspecified biological change [5].

If marriage does indeed raise the risk of depression amongst women how does it do so? One possibility is because of the involvement of married women in child care. A number of studies from the cities of the Western World suggest that being involved in child care increases the risk of depression amongst women. In our own study [6] we were able to show that the increased rate of depression in married women was brought about because having children prevented them going out to work, and that it is really employment that protects women from depression. However, Mediterranean studies and a study from rural New Zealand both suggest that involvement in child care actually protects women from depression [7, 8, 9]. Clearly the relationship is likely to be greatly modified by the varying status and burdens of the role of mother in different societies.

The instance of depression illness changes with age in a way that is interesting, since it serves to distinguish neurotic from unipolar manic depressive illness. The incidence of severe depression increases with age, whereas the instance of neurotic illness peaks in early to middle adult life and then declines [3]. This finding is quite consistent, but has never been adequately explained. My own speculation is that age actually exerts a releasing effect on severe affective disturbance, operating through neurobiological changes. On the other hand, the neurotic form of depressive illness is associated more with the social environment, and the peak incidence reflects the time of peak readjustment for the individuals concerned. The increase of severe affective disorders with age is a sort of default option, for there are social influences which obliterate this relationship, but they are those of the most extreme kind. This can be shown by examining the age incidence curve for those in the post-marital group. The divorced, widowed and separated show a reversal of the usual curve: it is the youngest people in this group that have the highest incidence of severe depressive illness whereas by old age incidence has fallen to that of the married population. In contrast the early peak seen in neurotic depressive illness is exaggerated in the post marital.

In the Western World, unemployment is strongly associated with an increase in neurotic depressive illness, although it is not clear whether it increases the rate of severe depressive illness. This increase in