Behavior

Bruce Bower reports from Dallas at the annual meeting of the American Psychiatric Association

Growing up with depression

The children of severely depressed parents appear to be vulnerable not only to recurrent depression but also to a variety of medical problems, according to Yale University investigators. But the role genetic and environmental factors play in their increased risk is not yet clear, says project director Myrna M. Weissman.

Weissman and her colleagues interviewed 56 children of depressed parents and 35 children of healthy parents six years after the parents entered the Yale study. The youngsters, whose mothers were also interviewed, ranged in age from 6 to 23. Compared with the children of healthy parents, the children of depressed parents had over three times the risk of developing severe depression. They also had significantly more colic in the first 10 months of life, head injuries, operations, poor peer relationships and weak or abnormal cries at birth. Their mothers reported more illness and medication use during pregnancy.

Higher rates of severe depression were reported by children about themselves than were reported by mothers about their children, notes Weissman. This suggests that the child might be the best source for detecting early signs of depression, she says.

The highest rates of depression were reported in late adolescence and early adulthood, adds Weissman. The contribution, if any, of increased stress in families with depressed parents, poor parenting of depressed mothers and heredity to a child's depression remains to be studied.

A closer look at 'bipolars'

A nationwide study involving five university medical centers and the National Institute of Mental Health (NIMH) is providing data that will help psychiatrists to revise the definition of manic depression, or "bipolar disorder" as it is called in their latest diagnostic manual.

"Bipolar patients are not gregarious, outgoing types as has sometimes been reported clinically," says Robert M.A. Hirschfeld of NIMH. He and his colleagues administered a battery of personality questionnaires to 194 subjects admitted to the study during either a manic or a depressive episode. The tests were given again one year later. Two comparison groups were also tested: 527 individuals with severe depression (no mania) and a control group of 3,200 relatives and spouses of the psychiatric patients, most of whom had no psychiatric disorder.

On many measures, the two groups of psychiatric patients were surprisingly similar, says Hirschfeld. For example, they both reported slightly more anxiety, stress and fear than the controls.

Both bipolar and depressed women were significantly more introverted compared with the controls, as were depressed men. Manic depressive men, however, were about as extroverted as the controls. All of the manic depressive patients reported substantially more dependency on one or more other people.

While this personality pattern applies to manic depressives in general, those patients who shifted from an excitable to a melancholic state, or vice versa, within the first eight weeks of the study had the worst prospects for recovery. Individuals who displayed only manic or depressive symptoms in that time period were up to three times more likely to recover one year later, says Martin B. Keller of Massachusetts General Hospital in Boston. Patients who were purely manic during the first eight weeks recovered faster than those who were depressed.

Patients who rapidly swung from mania to depression were also most likely to commit suicide, notes Jan Fawcett of Rush-Presbyterian-St. Luke's Medical Center in Chicago. Over four years, there were 45 suicides among manic depressives and pure depressives in the sample. A high proportion of these cases involved patients who had experienced both mania and depression within eight weeks of each other, says Fawcett.

Peeling the mask of facial pain

At times, depression is masked by pain in regions of the face and mouth which cannot be tracked to any organic cause. Individuals suffering from these symptoms are often viewed as a pain in the neck by physicians, who shuttle them from specialist to specialist and misdiagnose their underlying problem for years, says Stanley Lesse of the Neurological Institute of New York.

Lesse treated and studied 602 patients with troublesome facial pain between 1956 and 1978. In the vast majority of cases, he explains, the pain was a symptom of depression that had been overlooked by neurologists, dentists, otolaryngologists and ophthalmologists. Most of the patients were women between the ages of 36 and 59 who were ill for more than one year before being diagnosed correctly. Facial pain often began following simple dental procedures or minor surgery.

Psychiatric evaluations revealed that the patients usually had insomnia and problems with concentration. They lost interest in their surroundings and were socially isolated. Anorexia was a common problem, adds Lesse. Most had feelings of hopelessness; 18 had made suicide attempts, and 235 had contemplated or become preoccupied with suicide.

In general, these individuals are intelligent, hardworking and very aggressive, says Lesse. They are constantly fighting, however, against imagined feelings of worthlessness and inadequacy that get translated into facial pain.

When treated with psychotherapy and antidepressant drugs, these patients often showed marked improvement if their facial pain had been present for six months or less, reports Lesse. Only one-third to one-half of those who had facial pain for more than one year recovered with this treatment, he says.

Even those patients who responded to psychotherapy and antidepressants experienced a return of facial pain if they could not tolerate specific pressures in their lives. As with severe depression, "masked" depression is often recurrent.

Early diagnosis, rather than specialist-hopping for several years, is crucial when facial pain masks depression, concludes Lesse.

Emotional scars near Mount St. Helens

Mount St. Helens blew its top just over five years ago, and by press time it may have erupted again. But people living near the mountain are still suffering from the emotional fallout of the initial blast, report scientists at the Oregon Health Sciences University in Portland.

In two rural logging communities near Mount St. Helens, residents suffering significant property or personal loss were nearly 12 times more likely than others to experience a psychiatric disorder, says psychiatrist James H. Shore. This complements data showing increased mental disorders and stress responses among residents of a town coated by volcanic ash after the mountain exploded (SN: 4/7/84, p. 214). Their stress reactions lasted for at least seven months.

Shore and his co-workers evaluated more than 1,000 subjects from July to October 1983. The most common psychiatric disorders were anxiety, depression and post-traumatic stress. Among men who suffered severe property damage or the death of a relative, 11 percent developed a psychiatric disorder in the year following the eruption, compared with 1 percent of men who were unaffected by the blast. Rates of mental disorders among women experiencing substantial property or personal loss were about twice as high as those for men. According to the residents, the intensity of their emotional reactions decreased in the second and third years after the eruption.

"In the population we studied," notes Shore, "the major psychiatric impact was caused by the flood [instigated by the eruption], not volcanic ash."