The influence of biography, life events and chronic difficulties on depressivity during the process of inpatient treatment of depressives

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Summary

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Background: The aim of the study is to complete the findings on life events in depression by investigating the influence of chronic stress in life and of biographical factors on the course of treatment of depressive subjects.

Methods: The data were assessed on 152 inpatients with the diagnosis of major depression (criteria of DSM-IV) diagnosed by SCID. Two thirds of the sample were females. The treatment was homogeneous for all patients participating in the study: antidepressive medication and "clinical management". The depressive status was documented at four points in time during the treatment (beginning, after one week of inpatient treatment, after three weeks of inpatient treatment and at the end of inpatient treatment) by the depression scale of v. Zerssen (1975). At the beginning of the treatment the patients had to answer questionnaires about biographic variables (BIFA-AL, Bühler and Bardeleben), stressful life events (ILE, Siegrist and Dittmann), chronic problems (CP, Siegrist), variables for coping with diseases (FKV, Muthny) and sociodemographic variables. The duration of the inpatient treatment was another indicator for the process of treatment.

Results: The mean duration of clinical treatment was 8 weeks and 2 days, at the maximum 29 weeks. Regarding the course of depression, there is a continuous and convincing decrease in the mean-scores of the depression scale. Contrary to common opinion the reporting of biographical data is not significantly influenced by depressive mood and depressive cognition, i.e. a significant change in mood had no significant influence on the recalling of events and memories of events. Critical life events, chronic difficulties, neuroticism, aim-relatedness and the overall subjective stress of life events significantly influence the depressive symptoms and the duration of clinical treatment and are suitable for predicting the clinical process. A statistically significant correlation exists between the biographic dimensions on the one hand and the stress due to chronic difficulties in life and the number of stressing life events on the other hand.

Conclusion: Our study explains the influence of life stress and biographic aspects on the process of inpatient treatment of depressive disorders and in addition shows a biographical predisposition for stress due to life circumstances and life events. The premorbid biography of an individual influences the sensitivity for stress and thus the risk of developing an affective disorder. The stress due to critical life events and chronic difficulties as well as biographic variables are suitable as predictors for the process of inpatient treatment of depressive disorders.

Clinical relevance: If the biographic risk profile is known, preventive psychotherapeutic intervention should be undertaken to avoid the genesis of a depressive disorder by critical life events. From our findings inferences can be drawn for the psychotherapeutic treatment of depressives. Besides cognitive "restructuring" psychodynamic therapy aims at reintegration of subjective experience and enables a structural change in the conception of biography.

Keywords: biography; personality; life events; depression

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Introduction

Paykel [1] has discussed the results of 23 studies on depressive patients under psychiatric treatment which showed for the most part a correlation between life stress and depression. Nevertheless,

the causal explanation of affective disorders by life events was disappointing. Life events could only explain a maximum of 10% of the variance [1, 2]. These results imply the assumption of moderating variables which have a positive or negative influence on the correlation between life stress and depression. In his prospective study Hautzinger [3] found a direct influence on depression of female sex, younger age, depressive disorders in the ancestors and one or more children under the age of six. Furthermore, he discovered that the variables marital status, satisfaction in marriage, frequency of pleasant activities and professional work had a moderating effect on depression. Wittchen [4] also assumed a multi-factorial model of causes for depression which takes into consideration, with regard to aetiology and the course of depressive disorders, not only external factors, like life events, but also internal characteristics, like the individual way of life or lifestyle, coping with disease and biological factors.

According to the multi-factorial model, the life event research and the biographical approach were combined. Comparing the biographical research to life event research, Wiedemann [5] stresses the importance of a biographical approach because the correlation between life stress, coping and social support is there assessed more completely. According to Wiedemann [5], critical life events always have to be classified in the context of the individual's overall situation.

Because modifying variables were ignored in previous research, the aim of this study is to investigate a correlation between the stress of life-changing events, chronic difficulties and biographical aspects on the one hand and the inpatient treatment of affective disorders on the other hand. As the assessment of the stress of life events cannot be separated from the specific biographical circumstances in which the individual lives, the second aim of this investigation is the correlation of the risk factors between each other. In this study we assume a causal correlation between a person's biography on the one hand and the experienced stress of critical life events and chronic stressors on the other.

Method

The random sample consisted of 152 patients in inpatient treatment diagnosed major depression (criteria of DSM-IV) by SCID. Two thirds of the sample were females. The elderly (age >60 years) predominated with 28% of the total followed by the sixth decade (age 51–60 years) with 24%. The fifth decade (age 41–50 years) was represented by 22%. The number of persons between 31 and 40 years amounts to 16%. Below 30 years of age were 10% of the total. 63% of the total were married, 18% single, 13% widowed and 6% separated. 80% of all patients had children. 53% attended secondary modern school, 18% junior high school, 15% high school and 5% vocational college. The mean duration of inpatient treatment amounted to 8.3 weeks with a range from 2 to 29 weeks. 31% of the patients were diagnosed according to DSM IV as major depression, 16% as major depression subtype melancholia, 25% as recidivous major depression, 13% as recidivous major depression subtype melancholia and 7% major depression of bipolar disorder.

The treatment was homogeneous for all patients participating in the study: antidepressive medication and "clinical management", i.e. problem-oriented individual psychotherapy and group therapy two times a week supervised by the same senior psychiatrist. The depressive status was assessed at four points in time during the treatment (beginning, after one week of inpatient treatment, after three weeks of inpatient treatment and at the end of inpatient treatment) using the depression scale of von Zerssen [6]. At the beginning of the clinical treatment the patients had to answer questionnaires about biographical variables (BIOQUESTAL, Bühler and Bardeleben [7]), stressful life events (ILE, Siegrist and Dittmann [8]), chronic problems (CP, Siegrist & Dittmann [8]), variables for coping with diseases (FKV, Muthny [9]) as well as socio-demographic variables. The duration of the inpatient treatment was another indicator for the process of treatment.

The inferences drawn from the results of this study are limited because we did not compare the depressives with a different clinical sample. On the other hand, such a comparison is not easy to achieve because of the treatment schedule and the specificity of the medication.

Questionnaires

Biographic Questionnaire for Alcoholics (BIOQUESTAL, Bühler and Bardeleben 1994, 1996)

Because its biographic scale and its personality scales characterise it as a biographic questionnaire and a personality questionnaire as well and because it is constructed for a clinical population, the Biographic Questionnaire for Alcoholics (BIOQUESTAL, Bühler and Bardeleben 1994, 1996)

was applied in this study. This self-report questionnaire was originally designed for alcoholics and, by empirical evidence, is applicable, without loss of reliability, to other clinical populations, too. The questionnaire has three scales: Scale A (unipolar), named "Neuroticism", consists of 15 items and is a personality scale. This scale describes mainly depressive symptoms (depressive mood, rumination, instability of mood, emotional disturbances, despair, hopelessness, anxiety concerning the future, low self-esteem, impression of uselessness and social isolation). Scale B (bipolar), named "Unfavorable versus Favorable Primary Socialisation", consists of 12 items and is a genuine biographical scale. The positive pole is characterised by a disharmonious parental home with a strict type of upbringing and little support from parents or educators, the negative pole describes a harmonious home, trustworthiness of parents and educators. Scale C (unipolar), named "Aim-relatedness and Unspecific Motivation", consists of 11 items and is again a personality scale. It is characterised by conventional achievement motivation, unspecific motivation, purposefulness, resolution, orientation to the future, social contact or ability for cooperation, self-esteem, ego-strength and ego syntonia. The BIOQUESTAL scales reflect three fundamental dimensions of life which are important for clinical populations. These fundamental dimensions relate to personality (i.e. neuroticism), biography (i.e. primary socialisation) and motivation.

Inventory of Life-Changing Events (ILE, Siegrist and Dittmann, 1983)

To assess life events the Inventory of Life-Changing Events (ILE, Siegrist and Dittmann, 1983) was applied. This questionnaire is analogous to the "Social Readjustment Rating Scale" (SRRS) by Holmes and Rahe [10] and was completed by the subjective evaluation of distress, based on the stress-theoretical concept of the cumulation model. It combines an event list with respondent-based ratings covering the two years before the date of investigation. The patient by self-report answers a list of 32 potentially stressful events, e.g. divorce, death events, accidents, illnesses and two open categories. The number of life events (NLE) is an overall indicator for stress during the period in question. For every reported event 10 descriptive dimensions have to be completed by the respondent, namely predictability, controllability, situational vulnerability, subjective importance of an event, disruption of daily routines, active coping behaviour, two items of social support, "psychological costs" of event coping, previous experience with an event and the degree of event-related distress present at the time of interview. A "Mean Subjective Stress Index" (MSI) is computed by adding up the scores on a five point scale over all descriptive dimensions and all events weighted by the number of life events. The "Summarised Subjective Stress Index" (SSSI) is computed by adding up the scores on a five point scale over all descriptive dimensions and all events.

List of Chronic Problems (CP, Siegrist and Dittmann, 1983)

The List of Chronic Problems (CP, Siegrist and Dittmann, 1983) assesses chronically difficult life circumstances that were experienced as distressing during the last five years. It consists of 14 items such as the atmosphere at home, the quality of social relationship, chronic diseases, financial difficulties and so on.

Depression Scale (D-S, von Zerssen 1975)

For an exact evaluation of severity of depression the Depression Scale by von Zerssen (D-S, 1975) was applied. This standardised self-rating questionnaire consisting of 16 items was presented to the subjects four times during inpatient treatment to assess the severity of depression and is a process parameter of the treatment.

Furthermore, several sociodemographical variables were documented, e.g. age, sex, marital status, the situation of living, education and questions concerning partnership and friendship.

The procedures of SPSS (1991) were applied for the statistical analysis of the data.

Results

The mean duration of clinical treatment (DT) was 8 weeks and 2 days, the maximum 29 weeks. At 66.4%, the sex ratio was predominantly female. The less than 30-year-old persons were represented by 9.9%, the 41–50-year-old by 21.7% and the 51–60-year-old by 23.7%. 63.2% of the persons of the sample were married, 17.8% single, 6% separated or divorced and 13.2% widowed. 79.3% of the subjects had children. Almost half of the patients (47.7%) lived in villages with less than 2000 inhabitants, 27.1% in towns with 2000–10 000

Table 1 Correlation between depressivity (DS 1–4) and duration of inpatient treatment (DT) and BIOQUESTAL scales A, B and C (* p <0.05; ** p <0.01; *** p <0.001), r = correlation factor.

n = 152	BIOQUESTAL-A r	BIOQUESTAL-B r	BIOQUESTAL-C R
DS 1	0.421**	0.174	–0.203
DS 2	0.522***	0.199*	–0.486***
DS 3	0.501***	0.203*	–0.481***
DS 4	0.464***	0.164	–0.394***
DT	0.299***	–0.011	–0.283***

Table 2 Correlation between depressivity (DS 1–4) and duration of inpatient treatment (DT) and the stress variables (NLE = number of life events, MSI = mean subjective stress index, SSSI = summarised subjective stress index) and chronic problems (CP), r = correlation coefficient (* p <0.05; ** p <0.01; *** p <0.001).

n = 152	NLE r	MSI r	SSSI R	CP R
DS 1	0.424**	0.234	0.391**	0.420**
DS 2	0.233**	–0.110	0.177*	0.300***
DS 3	0.236**	–0.170*	0.175*	0.315***
DS 4	0.298***	–0.010	0.264**	0.334***
DT	0.167*	–0.101	0.128	0.234**

inhabitants, 25.2% in towns with more than 10 000 inhabitants.

Regarding education, the majority of the patients (52.6%) had high school graduation, 17.8% secondary modern school education, 5.3% technical college graduation and 15.1% university education. Regarding job training, 27% of the sample had no qualification, i.e. were employed as semi-skilled workers or as trainees without qualification, 48% completed apprenticeship, 9% passed an examination for master craftman's diploma, 7% passed technical college and 9% university.

To assess the memory bias of depressivity for biographical data, the mean scores of BIOQUESTAL scales, NLE, MSI and CP as well as the correlations of the six variables before and after inpatient treatment of depressive subjects were analysed [11].

There were no significant differences in scale B (Primary Socialisation) of BIOQUESTAL, in the number of life events, the mean subjective stress index and the global score of chronic problems, whereas the differences of mean scores in scale A (Neuroticism) and scale C (Aim-relatedness) of BIOQUESTAL were statistically significant. The scores of scale B of BIOQUESTAL ($r = 0.50$; $p < 0.001$) and scale C of BIOQUESTAL ($r = 0.37$; $p < 0.01$), the number of life events ($r = 0.83$; $p < 0.001$) and the global score of chronic problems ($r = 0.78$; $p < 0.001$) correlated significantly in a positive way before and after inpatient treatment whereas there was no significant correlation for scale A of BIOQUESTAL and the Mean Subjective Stress Index before and after inpatient treatment. Summing up, there was no significant memory-bias of depressive mood for biographical data (scale B of BIOQUESTAL, NLE, MSI and CP).

Regarding the course of depression, there is a continuous and convincing decrease in the mean-scores of the depression scale. Initially, there is a mean depression score of 23.02, at the end of inpatient treatment this score has dropped to 9.7, but is still higher than normal. According to von Zerssen [6] healthy subjects show a score less than 10 items.

All process parameters (DS 1 to DS 4, DT, except DS 1) and the BIOQUESTAL scale A correlated significantly positively and BIOQUESTAL scale C correlated significantly negatively (table 1).

Significant correlations also existed between the number of life events and stress due to chronic problems and all depression scores. Stress due to chronic problems correlated significantly with the duration of inpatient treatment (table 2).

In order to find causal relations between the variables, multiple regressions were computed, with the parameters for process of treatment

(DS 1 to DS 4, DT) as dependent variables and the BIOQUESTAL scales as well as the stress variables (NLE, MSI, SSSI, CP) as independent variables (table 3). BIOQUESTAL scale A and stress due to chronic problems cause significantly more depressive symptoms at the beginning of inpatient treatment (DS 1), whereas the BIOQUESTAL scales A positively and C negatively are significant predictors for DS 2 and DS 4. BIOQUESTAL scale A is a predictor for duration of inpatient treatment. All BIOQUESTAL scales as well as MSI cause significantly depressive symptoms at DS 3.

Another aim of this study was to analyse and explain the stress variables (NLE, MSI, SSI, CP) as dependent variables by the biographical dimensions "Neuroticism" (BIOQUESTAL-A), "Primary Socialisation" (BIOQUESTAL-B) and "Aim-Relatedness" (BIOQUESTAL-C) as independent variables (table 4). The scales BIOQUESTAL-B and BIOQUESTAL-C (with a negative correlation) are significant predictors in the multiple regression for the number of life events. Both explain 14.1% of the variance. Regarding the MSI as a dependent variable BIOQUESTAL-B is a significant predictor. Similar

Table 3 Stepwise multiple regression with stress variables (BIOQUESTAL scales, NLE, MSI, SSSI, CP) as independent variables and treatment variables (DS 1 – DS 4, DT) as dependent variables, with Beta-weight, Adj. R-Square = explained variance, Multiple R = multiple correlation coefficient, R-Square = multiple determination coefficient, F = F-Test, Sig. F = significance of F.

n = 152	DS 1		DS 2		DS 3		DS 4		DT	
Adj. R-Square	0.208		0.376		0.409		0.227		0.040	
Multiple R	0.476		0.621		0.653		0.490		0.217	
R-Square	0.227		0.385		0.426		0.240		0.047	
F	12.298		42.305		24.680		18.637		6.740	
Sig. F	0.001		0.000		0.000		0.000		0.011	
	Beta	**P**	**Beta**	**P**	**Beta**	**P**	**Beta**	**P**	**Beta**	**P**
BIOQUESTAL-A	0.331	0.025	0.480	0.000	0.387	0.000	0.351	0.000	0.217	0.011
BIOQUESTAL-B					0.176	0.013				
BIOQUESTAL-C			–0.234	0.003	–0.261	0.001	–0.201	0.038		
NLE										
MSI					–0.151	0.027				
SSSI										
CP	0.340	0.021								

Table 4 Stepwise multiple regression with BIOQUESTAL scales as independent variables and stress variables as dependent variables, Beta-weight, Adj. R-Square = explained variance, Multiple R = multiple correlation coefficient, R-Square = multiple determination coefficient, F = F-Test, Sig. F = significance of F.

n = 152	NLE		MSI		SSSI		CP	
Adj. R-Square	0.141		0.046		0.136		0.245	
Multiple R	0.384		0.222		0.384		0.510	
R-Square	0.148		0.049		0.148		0.260	
F	22.524		13.120		12.472		17.465	
Sig. F	0.000		0.000		0.000		0.000	
	Beta	**P**	**Beta**	**P**	**Beta**	**P**	**Beta**	**P**
BIOQUESTAL-A					0.180	0.026	0.233	0.008
BIOQUESTAL-B	0.352	0.000	0.222	0.000	0.292	0.000	0.225	0.003
BIOQUESTAL-C	–0.123	0.000					–0.221	0.010

results exist with BIOQUESTAL-A and BIOQUESTAL-B as independent variables and SSSI as dependent variable. BIOQUESTAL-A and BIOQUESTAL-B significantly cause the SSSI and explain 13.6% of the variance. There is also a significant connection between BIOQUESTAL and stress due to chronic problems. All three BIOQUESTAL scales as independent variables (predictors) significantly cause chronic problems as dependent variables and explain 24.5% of the variance. BIOQUESTAL-C has a negative causal relation (table 4).

Discussion

Contrary to common opinion the reporting of biographical data is not significantly influenced by depressive mood and depressive cognition, i.e. a significant change in mood had no significant influence on the recalling of events and memories of events.

In previous research on life events, the influence of life events on the genesis of affective disorders was shown [1, 3, 4]. Our study convincingly verified that the effect of life-stress before inpatient treatment significantly influences the process and course of inpatient treatment.

These results confirm the findings of Bartelstone and Trull [12] who suppose that the degree of depression depends on the interaction between personality traits and the occurrence of negatively evaluated life events. Kendler et al. [13] found a strong association between stressful life events and depressive onsets. The depressiogenic effect was strongly predicted by contextual threat level. Mazure et al. [14] scrutinised the interactive effects of life events and personality factors regarding the predictability of the incidence of a major depression and its course in therapy. According to their findings, certain personality traits cause a vulnerability for depression. Furthermore, it was shown that a life event which is congruent with the personality also increases the risk of depression.

In our study a significant correlation was also shown between all depression scores and the stress due to chronic difficulties which corresponds to the results of Wittchen [4] and Cooper [15] who verified the effect of chronic difficulties on the genesis of a depression.

The presumed positive correlation between the number of life events as well as the summed up experienced subjective stress (SSSI) with the scores of severity of depression (DS 1 to DS 4) was significant. The duration of inpatient treatment, therefore, can be equated with a delayed therapeutic improvement. Chronic difficulties, too, showed a highly significant correlation with all scores of severity of depression (DS 1 to DS 4). These findings correspond to the results of Wittchen [4] and Cooper [15] proving a causal impact of chronic difficulties on the genesis of depression.

Furthermore, our study verified the influence of biographic variables on the process and course of inpatient treatment of affective disorders and also confirmed their prognostic effects. Surtees [16] found similar results and emphasises that the vulnerability of becoming depressive is determined by personality variables, too. According to Kendler et al. [17], genetic factors influence the probability of becoming depressive by increasing the sensitivity for depression-inducing life stress and in this way for example predispose individuals for risky environments.

Fergusson and Horwood [18] already discussed that there are direct correlations between the occurrence of life events and personality and that a certain social environment increases the risk of life events. Corresponding to those findings the investigation of Alloy and Abramson [19] compares the cognitive model of Beck [20] with the concept of learnt helplessness and concludes that both theories imply the hypothesis that a certain cognitive lifestyle increases the vulnerability of an individual for a depressive episode if critical life events occur additionally.

In our study the prognostic effect of all biographic factors on life stress was confirmed: unfavourable primary socialisation (BIOQUESTAL-B) causes a higher number of critical life events as well as a higher experienced subjective stress. There is a significant correlation between the biographic dimensions and the stress due to chronic problems. Scale BIOQUESTAL-C, however, is a protective variable. Our results correspond to the "key and lock" hypotheses by Parker et al. [21]. According to these analyses, negative events which are experienced during childhood (keys) increase the risk of a depression if similar life events recur during adulthood (lock).

An example of the modifying influence of certain types of personality on the perception of the stress of life events is the melancholic type (typus melancholicus) of Tellenbach [22]. Tellenbach defines the situation, a person is living in, as constituted by typical features of the personality of that person. The individual constitutes his or her situation in a way that the situation has a pathogenic influence back on the constituting person. However, the melancholic type should not be conceived statically but dynamically, i.e. biographic influences should also be considered as constitutive

for that type. The conception of Tellenbach has clinical consequences because in the clinical realm it may be possible to show the individuals the problematic aspects of their attitudes by psychotherapeutic intervention and to modify them. In accordance with the conception of the melancholic type [22], i.e. that this type is highly vulnerable to the influence of stressing events because of its limited coping possibilities, our investigation also shows strong evidence of the influence of premorbid biography on depression and its inpatient treatment.

Like Parker et al. [23] we pursued a diathesis stress model suggesting that unfavourable primary socialisation (anomalous parenting) predisposes persons to a dysfunctional attitude style which then prompts depression by a significant or relevant stressor. In this model we have to distinguish mood-dependent factors from mood-independent ones concerning the number of life events and their subjective stress (MSI, SSI) [24]. Such mood-dependent factors are scale A and scale C of BIOQUESTAL, whereas scale B is a mood-independent factor. The last one may presumably cause a linear causal process leading to a specific effect, in our case a life event or its subjective stress, whereas mood-dependent factors are part of a cyclic causal process, i.e. they may be influenced, for example, by a depressive process which as such may be influenced by life events which may in turn be influenced by mood-dependent factors and so on. So mood-dependent factors are not really suitable for confirming our basic assumption of causal effects of personality factors on the number of life events and their subjective stress but only to confirm a vicious circle as part of a depressive process. Linear causal processes deriving from mood-independent factors (e.g. biographical factors, vulnerability) may be the beginning of cyclic causal processes, i.e. vicious circles between life events on the one hand and mood-dependent factors (e.g. personality variables) on the other and therefore preventive psychotherapeutic intervention is necessary to avoid the genesis of harmful life events. Psychohygienic measures, systematic desensibilisation of the subjective stress due to life events and relaxation techniques as for example autogenic training are necessary to break the noxious influence of life events. If the mood-dependent factor is too strong, then the cyclic process has to be broken by drug therapy and even inpatient treatment.

Our study explains the influence of life stress and biographic aspects on the process of inpatient treatment of depressive disorders and in addition shows a biographical predisposition for the stress due to life circumstances and life events. So with relatively easily assessable predictor variables it is possible to determine a significant prognostic effect for depressive symptoms during inpatient treatment. Paykel considers the benefit of the life event research especially in the prevention of patients with such a risk profile.

From our findings inferences can be drawn for the psychotherapeutic treatment of depressives. A part of the features of the neuroticism factor, for example the psychovegetative lability, being conditioned by the biological disposition indeed cannot be influenced immediately by psychotherapeutic interventions but indirectly by relaxation techniques, for example by autogenic training. To decrease the harmful influence of life events psychohygienic procedures, systematic desensibilisation of subjective stress of life events, autogenic training or meditative procedures should be introduced in the therapy of depressives. Another part of the features of the neuroticism factor, however, for example the cognitive attitudes, may be changed directly. In this case the cognitive therapy of depressives attempts to change these attitudes by cognitive "restructuring". We propose training practices for fantasies that are in contrast to the dreary reality of life of the depressives. For this purpose in each single case the concrete reality of the life of a concrete patient must be grasped in the psychotherapeutic treatment and on that basis a "contrasting world" should be projected into which the respective person penetrates.

In a sense, the events of biography are comparable with that part of the neuroticism factor which cannot immediately be influenced by psychotherapeutic interventions because these occurred in the past and therefore they escape a direct psychotherapeutic influence. They cannot be changed as such because they have taken place and vanished in the past already. However, the attitude of the individuals towards such biographical facts can be changed by cognitive and emotional deconstruction. These events can presumably be estranged in fantasy and the attitudes of the respective persons to their particular past can psychotherapeutically be influenced. This estrangement of the past in the sense of a cognitive "restructuring" can be increased by fictitious reconstruction of biography so far that the biography gets a new and fictitious form so the life of the respective person could in fantasy have happened "very differently". Bühler and König [25] reported that depressive patients in their fantasy are able to set themselves free from their depressive attitudes. Besides cognitive "restructuring" psychodynamic therapy aims at reintegration of subjective expe-

rience and enables a structural change in the conception of biography.

Last but not least, counselling seems to be a further and important procedure to decrease the impact of life events on depressive patients.

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