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Perceptions of Depression Among Recovered-Depressed and Never-Depressed Individuals

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Abstract

Research on lay beliefs about depression has shown that recovered-depressed people evaluate their own depressive experiences as more distressing than do those who have never experienced major depression. This study tested whether history of depression would influence beliefs about others' experiences of depression. Recovered-depressed ($n = 63$) and Never-Depressed ($n = 64$) adults completed the Self-Appraisal Questionnaire (R-SAQ; Coyne & Calarco, 1995), revised to address perceptions of others' experiences of depression. History of depression was not associated with R-SAQ scores. In supplementary analyses, self-reported depression proneness was also uncorrelated with perceptions of others' depression. People without a history of major depression were just as likely to recognize the highly debilitating nature of depression for others. Although nondepressed people frequently fail to convey empathy to friends or relatives who are depressed, this failure probably does not reflect lack of knowledge that depression is incapacitating.

Keywords

depression; lay theories; interpersonal theories; rejection effect; empathy; perceived effects of depression

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Lay beliefs about the nature, causes, and consequences of depression may vary as a function of one's own experiences with depression. For example, in previous research people with a history of depression considered interpersonal difficulties more important in the onset of depression than did those who had never been depressed (Furnham & Kuyken, 1991). People who had experienced major depression rate their experiences of depression as having affected their lives in more distressing and debilitating ways than did those whose depressive experiences did not reach clinical levels (Coyne, Gallo, Klinkman, & Calarco, 1998). This difference holds true even with formerly depressed patients who had completely recovered from the most recent depressive episode (Kirk, Haaga, Solomon, & Brody, 2000), suggesting that their perceptions of the nature of depressive experience were affected by depression history, not current symptoms.

Although these results are important in helping us understand how people perceive that their lives have been changed by depression, they do not address the possible impact of the presence or absence of a history of depression on perceptions of and reactions to other people's

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depression. Anecdotal evidence from a focus-group study suggested that never-depressed people may not understand how distressing and debilitating depression can be for others (Coyne & Calarco, 1995). If never-depressed people believe that Major Depression is no different phenomenologically from transient sadness, then this perception may influence the way that they respond to others who are depressed. Coyne's interpersonal theory of depression (1976) proposes that depression often elicits rejection as a response (via mechanisms including excessive reassurance-seeking on the part of the depressed person and negative mood induction in the responder). If never-depressed people underestimate the impact of depression, they may not, for example, provide the empathy that their depressed family members and friends require, which would be consistent with findings that prior experience with a particular need may facilitate empathy for others with that need (Batson et al., 1996). They may also be more likely to reject people with depression, a well-documented response consistent with Coyne's interpersonal theory (Segrin & Dillard, 1992). We examined this issue in the context of a study of depression vulnerability and coping among cigarette smokers.

Method

Participants

Participants were 127 adults (63 men and 64 women) who responded to advertisements for a study of how smoking relates to coping and negative feelings. The mean age was 38.75 years ($SD = 11.28$). Forty-seven participants were Caucasian, 77 African American, and 3 of other or mixed races. All participants met the following inclusion criteria: (a) age 18 or over, (b) not currently depressed, (c) no major depressive episode or treatment for depression within the past two months, (d) no current suicidality, (e) regularly smoking at least 10 cigarettes a day, a requirement of the larger project in which this study was included (Haaga, Thorndike, Friedman-Wheeler, Pearlman, & Wernicke, 2004). Participants were classified as "Recovered-Depressed" (RD, $N = 63$, 51% female and 49% male; 48% African American and 52% Caucasian) or "Never-Depressed" (ND, $N = 64$, 50% female and 50% male, 73% African American, 22% Caucasian, 5% other races) on the basis of a structured clinical interview, with never-depressed participants failing to meet criteria for a history of major depressive disorder and recovered-depressed participants meeting DSM-IV criteria for past major depressive disorder (American Psychiatric Association, 1994).

Measures

Eligibility and Diagnosis—Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979). The BDI is a 21-item self-report measure of current depressive symptom severity with extensive evidence of high reliability and convergent validity (Beck, Steer, & Garbin, 1988). Participants with BDI scores ranging from 0–14 were accepted as eligible for this study.

Structured Clinical Interview for Diagnostic and Statistical Manual-IV (SCID-I/NP; First, Gibbon, Spitzer, & Williams, 1995). Portions of the SCID were administered to ascertain lifetime major depression and current major depression. Interviewers were clinical psychology doctoral students under the supervision of a licensed clinical psychologist. All diagnostic interviews were audiotaped for later evaluation of interrater agreement. A subset of SCID audiotapes (10% of total sample, $n = 8$ RD, $n = 4$ ND) was randomly selected for an independent diagnostic evaluation conducted by the supervising psychologist who was unaware of the original diagnosis. There was 100% agreement between the diagnoses.

Depression Proneness Inventory (Alloy, Hartlage, Metalsky, & Abramson, 1987). The DPI is a 10-item self-report measure of vulnerability to depression in response to stress. Participants respond to face-valid items (e.g., "Are you the type of person who easily becomes very depressed, sad, blue, or down in the dumps?") on a 1–7 Likert scale. The DPI has been shown

to have high test-retest reliability after one month ($r = .88$) and high internal consistency ($\alpha = .90$; Alloy et al., 1987). It was used in this study to supplement depression history. A continuous-variable rating of depression proneness may provide a more sensitive measure of current depression vulnerability, given that some never-depressed participants are highly vulnerable, while some formerly-depressed participants could be at low risk of recurrence after successful treatment (Just, Abramson, & Alloy, 2001).

Perceptions of the Experience of Depression—Revised Self-Appraisal

Questionnaire (R-SAQ; Coyne & Calarco, 1995; Coyne et al., 1998). The SAQ assesses beliefs about one's personal experience of depression. It includes seven subscales (with Cronbach's alphas as reported in Coyne et al., 1998): Need for Balance ($\alpha = .86$), Lack of Energy ($\alpha = .88$), Imposition of Limits ($\alpha = .91$), Management of Burden ($\alpha = .89$), Relationship Concerns ($\alpha = .92$), Found Strength in Depression ($\alpha = .80$), and Sense of Stigma ($\alpha = .71$). The SAQ was revised for this study to assess participants' beliefs about the experience of Major Depression in others. For example, an item on the original SAQ that reads, "When I am depressed, I feel totally drained of energy," was changed to read, "When people are depressed, they feel totally drained of energy". Coefficient alphas for the revised SAQ scales in the current sample were as follows: Need for Balance ($\alpha = .83$), Lack of Energy ($\alpha = .59$), Imposition of Limits ($\alpha = .75$), Management of Burden ($\alpha = .81$), Relationship Concerns ($\alpha = .81$), Found Strength in Depression ($\alpha = .68$), and Sense of Stigma ($\alpha = .54$). Although fairly high in most cases, the internal consistency of the revised SAQ subscales was lower than for the original subscales.

Procedure

Participants first completed informed consent, then the BDI. Those scoring ≤ 14 on the BDI were eligible to continue and completed the main components of the study in random order: SCID, other measures needed for the larger study of which this is a part, and questionnaires (the RSAQ and other measures).

Results and Discussion

As reflected in Table 1, the recovered-depressed (RD) and never-depressed (ND) groups did not differ significantly on any of the subscales of the RSAQ measure of perceptions of others' experience of depression. Likewise, none of the RSAQ subscales correlated significantly with depression vulnerability measured as a continuous variable with the Depression Proneness Inventory (DPI). The correlations were all negative, nonsignificant, and very small, ranging from $r = -.01$ (with Sense of Stigma subscale) to $r = -.18$ (with Need for Balance subscale).

Because the depression history groups differed significantly by race (ND being 73% African American, compared to 48% of RD group), $X^2(3, N = 127) = 14.28, p < .01$, we conducted a series of hierarchical regressions predicting RSAQ subscale scores from depression history and demographic variables. The race X depression history interaction was never significant, indicating that the differing racial composition of the groups did not confound the main results. Consistent with the depression history results, African American participants reported lower depression proneness (DPI $M = 24.52, SD = 9.48$) than did Caucasian participants and those of other races ($M = 31.35, SD = 9.70$), $t(116) = 3.82, p < .0001$. As with depression history, there were no significant race X depression proneness interactions in predicting RSAQ subscale scores.

Previous research investigating the perceptions that lay people have about their own experiences with depression indicated that people with a history of major depression believe that their experiences were more distressing and incapacitating than do people without such a history (Coyne et al., 1998; Kirk et al., 2000). However, in the present study, no significant

differences emerged between RD and ND groups on any of the Revised SAQ (RSAQ) scales. Likewise, there was no significant correlation of depression proneness with any of the RSAQ scales.

The current study has several potential limitations. First, the RSAQ scales showed lower internal consistency compared to the original SAQ subscales (Coyne et al., 1998). This pattern may suggest that it is difficult for anyone (regardless of depression history) to clearly imagine what depression is like for another person. Second, because we recruited specifically for cigarette smokers, we may have attracted a sample that was less interested in depression status and depression beliefs than if we had recruited solely based on depression criteria. Although this sampling procedure may have limited the generalizability of the results, it could also have conferred an advantage by limiting the extent to which participants reported reactions in line with what they think would be expected of a recovered-depressed person or a never-depressed person.

If our results prove replicable in studies using different recruitment strategies, one possible explanation could be that recovered-depressed individuals feel differently about their own experiences of depression than they do about the experience of depression in others. That is, they might judge others' experiences to be less negative than their own. It is also possible, however, that our results mean that never-depressed individuals are able to recognize that the depressive experiences of others can have severe negative consequences, qualitatively different from their own less severe dysphoric experiences. Future studies should incorporate both the original SAQ [referencing one's own experiences of depression] and our revised SAQ [referencing others' experiences of depression] in order to help distinguish these potential explanations of the findings.

If it is true that never depressed people appreciate that the experience and consequences of Major Depression are markedly different from those associated with periods of transient sadness, then the question remains why they commonly reject depressed people (Segrin & Dillard, 1992) and respond to them in ways perceived by depressed people as highly insensitive (Coyne & Calarco, 1995). There may well be a breakdown in the relation between abstract understanding of the experience of depression and the ability to convey empathy. Such a breakdown might be explained by other individual differences in personality or experience, such as trait empathy or frequency and duration of exposure to friends and family members with depression.

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Table 1
Revised Self-Appraisal Questionnaire Scale Scores

Scale	RD (n = 62) M (SD)	ND (n = 60) M (SD)	t (p)
Lack of Energy	18.62 (3.17)	19.03 (3.41)	.69 (.49)
Imposition of Limits	19.99 (4.34)	21.07 (4.46)	1.35 (.18)
Management of Burden	17.45 (4.28)	17.68 (3.93)	.30 (.77)
Found Strength	12.45 (3.18)	12.73 (3.12)	.50 (.62)
Need for Balance	15.81 (4.17)	17.33 (4.80)	1.88 (.06)
Relationship Concerns	19.56 (4.73)	20.39 (4.72)	.97 (.34)
Sense of Stigma	10.47 (2.48)	10.42 (2.70)	-.11 (.91)

Note. RD = Recovered-Depressed; ND = Never-Depressed.