

# Student writer winners

## JUDGES' REPORT

THIS is the first year of the Annual Student Writer Competition, sponsored by *The Psychologist*, the Professional Affairs Board and the Scientific Affairs Board. It was designed to publicise the fact that being able to communicate well is a key skill for all psychology graduates.

We are pleased to report an encouraging number of entries. These had to be in the form of a short article suitable for publication in *The Psychologist*.

We rated each entry on five criteria:

1. Quality of writing
2. Clarity of argument
3. Accessibility to *The Psychologist's* audience
4. Interest value
5. Relevance to audience

We then gave a global 'overall impression' rating.

Entries were judged blind. We rated them independently, before meeting to compare ratings and to make our decisions.

The entries were of variable quality. Writers for *The Psychologist* need to assume that the majority of readers will be non-specialist in the topic of their article. But this crucial criterion of accessibility posed a problem for a

number of entrants. Their articles were directed more towards fellow students or tutors who would be familiar with the subject area. It's easy to assume that more experienced Society members will all know at least as much as student members do, regardless of topic — this is not so.

In some cases, the writing was in 'traditional' academic journal style: overlong, convoluted sentences; passive rather than active voice; unexplained technical terms. All of these are inappropriate for communicating with, and engaging the interest of, a non-specialist audience.

However, several of the entries had met the criteria very well. We are delighted to publish here the two winners of this first competition — with our congratulations!

We would like to thank all the entrants for their interest and enthusiasm. We are sorry to disappoint those who were not successful this time; but we hope for lots more entries in the future.

Maryon Tysoe (*Editor, The Psychologist*)

Pam Maras (*Scientific Affairs Board*)

Tom Williams (*Professional Affairs Board*)

## Detecting depression in older adults

**D**EPRESSION has been labelled 'the most prevalent mental health problem of elderly people' (Mui, 1996, p.633). Indeed, depression in old age is almost twice as common as dementia (Pitt, 1982), with prevalence estimates ranging from 10 per cent to 20 per cent (Iliffe *et al.*, 1993). As such, detection and effective treatment are key issues.

Yet, depression in older adults is frequently 'under-diagnosed and under-treated in the primary care sector' (Garrard *et al.*, 1998, p.m92). This article shall consider the importance of early detection of depression in older people, possible factors underlying its under-diagnosis, and suggest methods for improving the situation.

Depression in the elderly DSM-IV (American Psychiatric Association, 1994) defines depression as a 'period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities'. Alongside this disposition, an individual needs to experience at least four additional symptoms which may include changes in appetite, decreased energy, feelings of worthlessness, difficulty in concentrating or recurrent thoughts of death.

Essentially, older depressives present

with similar symptoms to their younger counterparts, although there may be subtle differences (Gearing *et al.*, 1990). Lasser *et al.* (1998) explain that 'depression in the elderly often presents with more somatic or anxious features and less of the subjective sadness expressed by younger groups' (p.17).

Research suggests that depression levels may increase with increasing age. One longitudinal study examined changes in depressive symptoms in a sample of people aged 65 and over. They found significant increases in symptoms over time, especially among the very old (aged 85 and over) (Wallace & O'Hara, 1992).

Although not all studies replicate this finding (e.g. Myers *et al.*, 1984), the importance of medical professionals detecting and treating depression in older people as early as possible is highlighted.

Depression levels not only increase with age, but have important repercussions for other aspects of an individual's health.



*In her winning entry in the undergraduate*

*category, KATE LOTHIAN considers the detection and treatment of depression in older people.*

Hammen (1997) reports how depression appears to compromise the functioning of the immune system, thus making those with depression more susceptible to illness. Martin (1997) relates a 20-year study of 2000 middle-aged American men. Researchers discovered that participants who showed signs of depression had twice the risk of developing fatal cancer in later years, irrespective of other variables.

The fact that depression may increase susceptibility to physical illness is a cause for great concern. This is particularly the case when considering the elderly who tend to be already 'prone to ill-health' (Abercrombie *et al.*, 1995). As such, there is an obvious need for early detection and effective treatment of depression among older adults.

Further emphasising this point is the knowledge that depression is a strong predisposing factor to suicide, with an estimated 80 per cent of suicidal patients being significantly depressed (Rosenhan & Seligman, 1995). Furthermore, suicide rates are highest among the older population (McIntosh, 1992).

Indeed, following a review of recent articles in medical literature, Martin *et al.* (1995) confirm that the 'development of depression in elderly subjects is associated with a higher risk of suicide than for any other age group' (p.999). Diagnosing and treating depressive symptoms early may minimise the risk of suicide among the elderly.

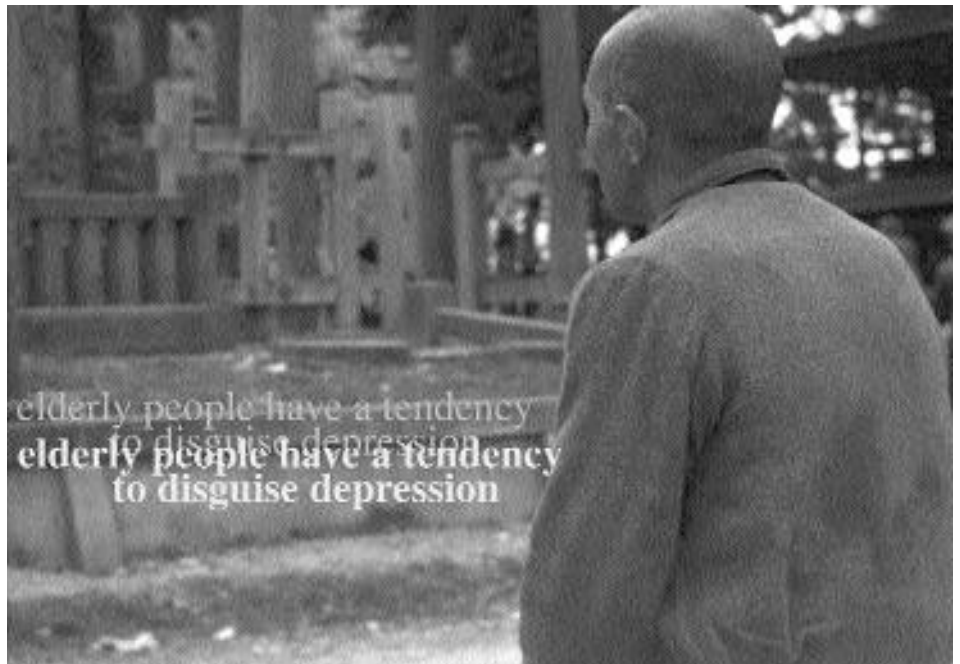
These considerations, along with the knowledge that 'the number and percentage of people who are elderly in our society are steadily increasing' (Comer, 1995, p.721), highlight just how important the issue of depression diagnosis and treatment in older adults is.

### Detecting depression

Despite the great need, research suggests that depression in the elderly goes largely undetected and, thus, untreated. Salzman (1997) writes: 'Early diagnosis and treatment of depression in the elderly remain challenging to the clinician.' (p.537.)

A community-based study conducted by Garrard *et al.* (1998) found that only half of older adults with self-reported indications of depression had documented clinical detection of depression by health providers. They found that recognition only improved when symptoms were severe.

One possible explanation for its underdetection is that elderly people have a tendency to, perhaps unwittingly, disguise



depression. Several authors comment on the frequency of elders regarding physical and mental malfunctions as the inevitable burden of old age (e.g. Rabins, 1996).

Steffens *et al.* (1997) found that this attitude was particularly likely among non-native ethnic groups whose culture may determine the attributions made. Furthermore, incorrect attributions may be reinforced by GPs. Lasser *et al.* (1998) claim that physicians collaborate with patients in deeming depression a 'normal' response to ageing and loss. Salzman (1997), however, explicitly states that '[l]ate-life depression must not be considered a natural part of the ageing process' (p.537).



Suicide rates are highest among the older population

Another explanation is put forward by McCullough (1991), who writes that the depressed elderly may present with 'unusual or atypical symptom patterns' (p.72). Thus, he claims, diagnosis is hindered. McCullough suggests that depression in the elderly may be masked as, among others, pseudodementia, somatisation or anxiety.

Certainly, difficulties may arise due to the tendency for depression to occur as one component of a pattern of co-morbidity. The relationship with coexisting conditions needs to be understood for effective treatment of the depressive symptoms.

Rabins (1996), however, suggests that we replace the view that late-life depression presents atypically with the appreciation that the phenomenology of the depressive disorder varies across the life span. He states that the criteria for diagnosing major depression were developed in younger individuals and may not be valid when considering older generations.

Tylee & Katona (1996) comment that the primary care setting is ideal for detecting depression and, therefore, remain surprised that 'only a small minority of the elderly depressed are identified or treated' (p.207). Indeed, the opportunities provided via surgery attendees and the mandatory annual over-75 health checks (introduced in the 1990 GP contract (Department of Health, 1989)) do make such high levels of undetected depression rather startling.

Glasser and Graval'd's (1997) study unearthed some possible underlying factors. They collected findings of a self-administered survey from 141 family



There is a need for systematic screening for depression amongst older adults

practitioners. They discovered that 66.7 per cent did not use a standard test to screen for depression, 29 per cent reported that depressed elderly patients frustrated them, and 24.2 per cent admitted that they were too pressured for time to routinely investigate depression in the elderly.

### Systematic screening for depression

The evidence provided in this article clearly indicates the high prevalence of elderly depression and the importance of symptoms being detected early and

effectively treated. The findings of Glasser and Gravdal indicate that clinicians with their current resources cannot be relied upon to complete this task.

As such, there seems to be a need for systematic screening for depression in the aged, a sentiment echoed by Koenig *et al.* (1995). The over-75 health check provides the perfect opportunity for such routine screening, either by the GP or a practice nurse (Mann *et al.*, 1998; Chew *et al.*, 1994). Still required, though, is a brief and user-friendly assessment instrument that will reliably detect depression in older adults.

Recently, an assessment schedule that fits these requirements has been produced. The Elderly Assessment System (EASY) (Philp, 1997) is a 25-item schedule for the rapid assessment of an older person's physical, mental and social well-being.

One inclusion, taken from the Mental Health Inventory-5 (Berwick *et al.*, 1991), is specifically intended to detect depression. Work is currently under way in the Sheffield region to validate this assessment question within the context of the EASY schedule. If it proves to be a reliable and valid indicator of depression, one would hope that the system will be widely adopted as a means of screening older adults.

EASY is, of course, not the only means of detecting depression. The Geriatric Depression Scale (GDS) (Yesavage *et al.*, 1983) was designed to emphasise the psychological aspects of depression and asks patients to report whether each of the 30 statements, such as 'I tend to avoid people at social gatherings', is true or false.

Another screening device, the Beck Depression Inventory (BDI) (Beck *et al.*, 1961), is a 21-item schedule assessing, amongst others, sadness, sleep problems, appetite, energy level and self-evaluation. Assessment tools that focus on depression measurement alone, such as the GDS and BDI, may be appropriate to use following a positive outcome on the EASY depression question.

Detection of depression in older adults is, of course, only the first hurdle. Having been screened positive for depression,

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follow-up care is necessary. Two years after its introduction, Iliffe *et al.* (1991) evaluated screening for depression in those aged over 75 in two general practices.

Iliffe concluded that use of a chosen screening instrument doubled GP recognition of depression but that it had no impact on treatment offered. This is clearly cause for concern and highlights that, alongside improved depression detection, there is a need for improved follow-up. Work currently under way in Sheffield and other areas is tackling this issue.

This article, then, has highlighted two key issues. Firstly, depression in older people is commonly underdetected and, thus, systematic screening is necessary. Secondly, depression in the elderly, even when detected, may be inadequately treated and, as such, a comprehensive follow-up programme is required.

The development of EASY, and similar screening devices, along with research into effective treatment programmes, go part-way to addressing these issues. There is, however, a long way to go before elderly depression is consistently and effectively detected and treated in primary care settings.

■ *Kate Lothian was, when her article was written, an undergraduate student in the Department of Psychology at the University of Sheffield. By the time of publication, she expects to have completed her degree and to be employed at the university's Centre for Ageing and Rehabilitation.*

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# Somewhere over the rainbow

**A**LTHOUGH we know intuitively what stress is, it is a surprisingly nebulous concept to try to define. Both the World Health Organization and the diagnostic criteria (DSM-IV) issued by the American Psychiatric Association (1994) confine their definitions to acute stress disorder, and post-traumatic stress disorder (PTSD).

But neither of these definitions includes the everyday stress with which we are all familiar, and which is so common today. Added to this, in the literature and in common usage, there is a great deal of crossover and overlap between the use of the words anxiety and stress.

Yet in the everyday world, most stressed people know perfectly well that they are stressed, but would strongly resist the suggestion that they have anything in common with those suffering from an anxiety disorder. There is clearly room for clarification here.

Moving on to the treatment of stress and anxiety disorders, there is a great deal of evidence (Shapiro & Shapiro, 1982; Power *et al.*, 1990; Butler *et al.*, 1991; Reynolds *et al.*, 1993; Wilson & Bostock, 1993) to suggest that a wide range of effective treatments already exist. These include cognitive therapy, medication, behaviour therapy, counselling, relaxation, or combinations of these. And yet all of these approaches have limited effectiveness, with a sizeable minority of individuals not significantly helped by them. Why should this be so?

Lastly, attempts to diagnose and categorise the anxiety disorders have been criticised for becoming more and more complex. This categorisation is commonly done using complicated check-lists of defining symptoms such as those detailed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) produced by the American Psychiatric Association.

These symptoms include agoraphobia without panic, panic with or without agoraphobia, generalised anxiety, social anxiety disorder, anxiety disorder not otherwise specified, mixed anxiety–depression, and so on. Could there be a simpler method of categorising such common difficulties?



Alice Muir, the winner in the

postgraduate category, takes a new look at stress and anxiety.

This article will attempt to address these and other current issues in the very broad field of stress and anxiety.

## The stressor spectrum

My first and most basic suggestion is that all anxiety is part of the human response to one or more stressors.

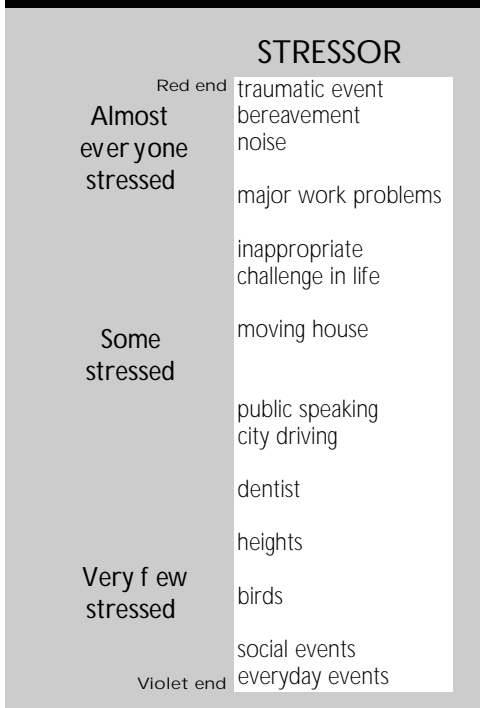
To elaborate on this, imagine the most common stressors were to be arranged in a spectrum, from traumatic experiences such as a road accident or disaster at one extreme, to 'normal' everyday life experiences at the other.

Such a spectrum could range generally from situations at one extreme, which almost everyone would find stressful (e.g. traumatic experiences, bereavement), to those in a middle area which moderate numbers of people find stressful (e.g. speaking in public, city driving), to those at the opposite extreme which only a small minority find stressful (e.g. social situations, everyday events). But all of these situations could produce anxiety in the individual for whom it was a stressor.

This spectrum could be likened to the spectrum (or rainbow of colours) in physics, which is a spectrum of different wavelengths of light, from red to violet. Figure 1 gives a flavour of how such a spectrum of stressors might appear — the number of stressors could be anything from 50 to 100 or more.

Holmes and Rahe (1967) produced a scale of the stress ratings for a wide range of changes which can occur in people's lives. What we are doing here is taking that idea much further, by looking not just at life's changes, but at life itself. It also begins to take into account individual

FIGURE 1 The stressor spectrum



vulnerability to a wide range of life events and situations.

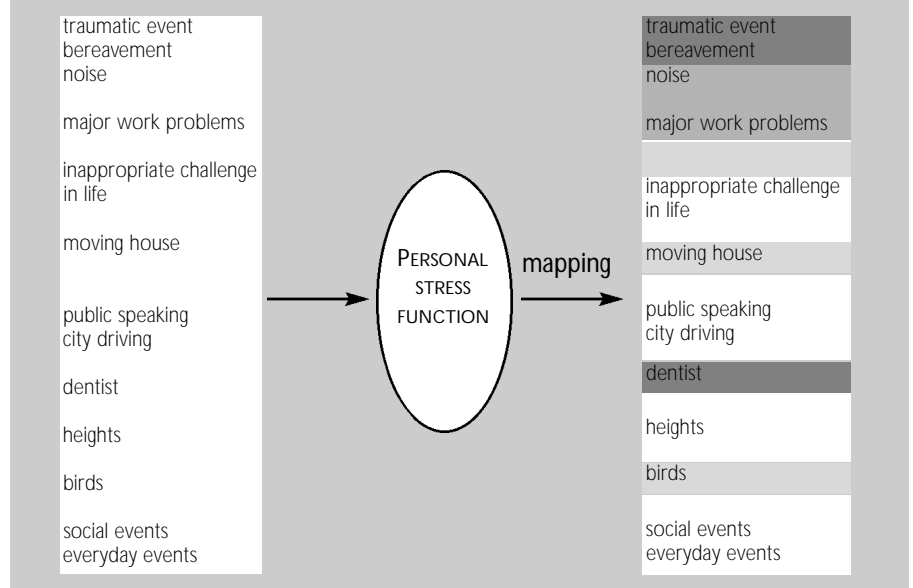
So why does a particular situation come to arouse stress in one individual but not in another? It is clear that almost everyone will experience stress and therefore anxiety in the face of a traumatic event or a bereavement. But as we move along the spectrum, the effects of how the individual reacts to or appraises an event come into play more and more, with the stress associated with an event or situation increasingly affected by individual differences.

Much theorising has gone on in this area. Howarth (1978) suggests that for each individual, a range of biological, developmental, social and phenomenological factors will determine whether a situation is perceived as stressful or not. So these factors might include personality characteristics, genetic predisposition, lability of autonomic nervous system, social skills, previous learning, and many more.

Baron and Kenny (1986) would describe such factors as mediators and moderators variously affecting the outcome of any stressor, whilst Cox and Mackay (1976) would term this overall process as a 'transaction' between the individual and their environment.

Another way of looking at this process might be to see all those factors which affect the outcome of a stressor on an

FIGURE 2 Stressor spectrum mapping through personal stress function to produce personal anxiety spectrum



individual as 'variables'. Now, using the terms 'function' and 'variable' in their mathematical sense, an individual's 'personal stress function' could be envisaged as a function of all these variables. So for any stressor, this 'personal stress function' would yield the corresponding level of stress or anxiety for that individual.

This idea can now be taken further to arrive at an individual's 'personal anxiety spectrum'. Just as every chemical element has its own fingerprint 'spectrum' of light when vaporised, every individual will at

any moment in time have their own unique 'anxiety spectrum'. This will be the unique outcome of the stressor spectrum being mapped through their 'personal stress function' to produce their 'personal anxiety spectrum'.

To give a visual picture to this process, those items able to induce anxiety in a particular individual at a particular time could be shaded in on the personal anxiety spectrum, with the magnitude of the anxiety caused by each factor denoted by the strength of black/white shading in that area (rather than the colour or strength of

FIGURE 3 The personal anxiety spectrum of three very different individuals

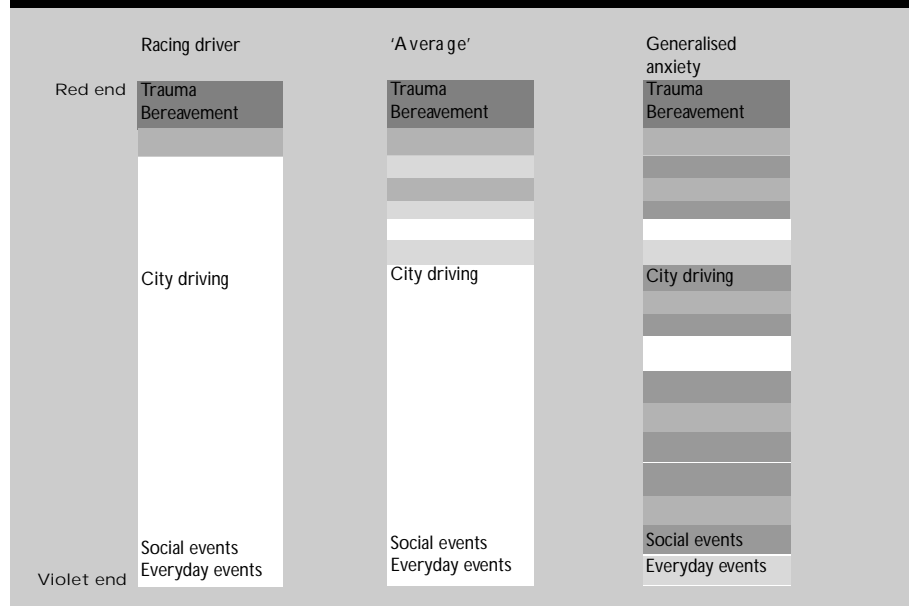
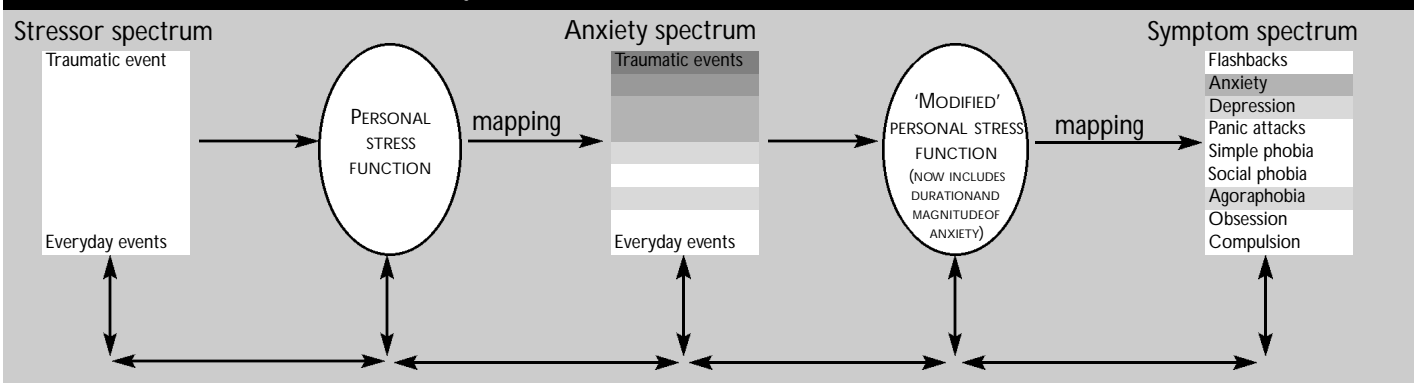


FIGURE 4 A new look at stress and anxiety



the colour in chemistry), as shown in Figure 2.

So, in very general terms, an ‘average’ person would have an anxiety spectrum, heavily concentrated at the ‘trauma’ or ‘red end’ of the spectrum, and with some spread towards the centre. A Formula 1 racing driver who finds little in life stresses him or her might have a very short spectrum concentrated almost entirely at the red end. A patient with generalised anxiety disorder would have a very full spectrum, also shaded at the red end, but also probably shaded throughout its length, with very few gaps (Figure 3).

It should be relatively easy to compile a package of standard or specially written assessments, to create this visual picture of an individual’s current anxiety. Computer software capable of doing this should be relatively easy to produce.

**Labelling — stress or anxiety?**  
Those whose spectrum is concentrated at the red end, will probably experience little anxiety in their lifetime, and if they do, are likely to label themselves, and be labelled by others, as ‘stressed’.

Those who have a fuller spectrum, extending to the ‘violet end’, are very likely to suffer chronically, and also since there is no ‘obvious’ or generally accepted source of stress, be labelled by others and label themselves as nervous or anxious

rather than stressed. Currently the former is less socially acceptable than the latter, but there is really no tangible difference between the two.

**Stress, anxiety and the symptom spectrum**

Not everyone who experiences anxiety goes on to develop an anxiety disorder. For any individual, what happens after the initial experience of anxiety seems to me to be dependent on the duration and magnitude of that anxiety, and once again, on the personal stress function (see Figure 4).

For example, long-lasting moderate levels of anxiety are most likely to produce consequences such as phobic or obsessive behaviour, whereas acute short-lived anxiety experienced during trauma is most likely to result in symptoms of PTSD.

Although the DSM defines discrete categories of anxiety disorder, most people with these disorders actually experience a wide variety of symptoms which can include aspects of anxiety, depression, panic, agoraphobia, phobias and obsessions.

It would seem to make better sense to think of these symptoms as a spectrum too, rather than as a set of discrete disorders (Figure 4). As before, standard assessments could define the depth of shading and indicate severity of a particular condition,

giving a comprehensive and visual picture of the difficulties of any individual.

Figure 5 again gives a flavour of how such a spectrum might look for three individuals with very different conditions, and could offer a simple solution to describing and categorising anxiety disorders.

**Current treatment options**

Most current options for treating anxiety will tackle one or more aspects of the overall process shown in Figure 4, usually producing a positive but limited effect (e.g. medication and behaviour therapy mainly tackle symptoms, cognitive therapy and counselling tackle part of the personal stress function).

The problem with this is that for any individual, not all appropriate aspects of their individual anxiety process might be dealt with, nor will there be sufficient depth and concentration of treatment applied in the required areas.

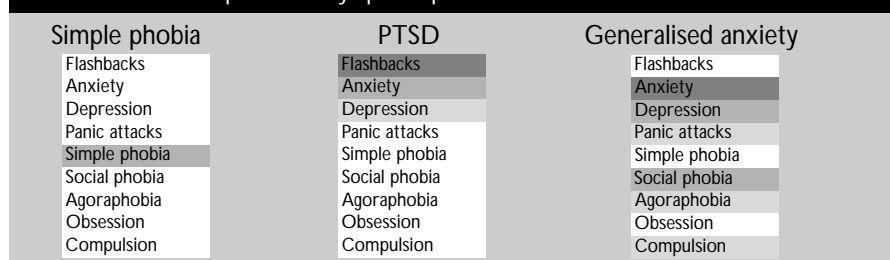
For example, if an individual’s anxiety arises mainly from a serious lack of assertiveness in relationships, then medication or behaviour therapy will produce a limited improvement, by dealing with the symptoms, but they will not address the root cause. But combining these therapies with counselling and an assertiveness course may prove much more beneficial.

**Summary**

This article has taken another look at how stress and the anxiety disorders might be assessed, categorised and conceptualised, and offered suggestions as to how an eclectic approach might bear greater fruit as a treatment option, rather than seeking out the ‘best’ treatment option for all, which a great deal of research currently does.

There is already much support for eclecticism in treating patients (Austen, 1997;

FIGURE 5 Examples of the symptom spectra for three individuals



Dryden, 1992; Garfield, 1995). From this perspective, a package of straightforward questionnaires, standard psychological assessments and some physiological measures could be used to gain a global picture of the personal stress function, and anxiety and symptom spectra for any individual.

From this detailed and comprehensive assessment, a tailor-made package of

treatment could be quickly determined for each individual, ensuring that treatment is more likely to be highly effective and that improvement should be maintained.

■ *Alice Muir is a postgraduate student at the Anxiety and Stress Research Centre, Department of Psychology, University of Stirling.*

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## BOOK AWARD 2000

The Scientific Affairs Board in votes nominations

**Award** — £500 annual award. The cheque and commemorative certificate will normally be presented at the London Conference at which the winner(s) will be invited to deliver a lecture.

**Eligibility**— Books published after 1 January 1996 that make a significant contribution to the advancement of psychology may be nominated, and the author or at least one co-author should be resident in the UK. Edited collections of papers are not eligible, nor are books published by the Society.

**Nominations**— Nominations should include:

- a letter giving the title of the book, name(s) of the author(s), publisher and date of publication
- a short statement (not more than one side of A4) explaining why the author(s) should receive the award
- copies of at least two published reviews of the book
- supporting statements by up to three additional referees with expertise in that field, plus a copy of the book, whenever possible. Nominators may be individuals, authors, publishers or their agents.

Nominations should be sent to the Chair of the Scientific Affairs Board at the Society's office, to arrive no later than

**Monday 6 December 1999**

Further details from Lisa Morrison at the Society's office (e-mail: [lismor@bps.org.uk](mailto:lismor@bps.org.uk)).