Brief report

Double depression in older adult psychiatric outpatients: Hopelessness as a defining feature

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Abstract

Background: There is a paucity of research on the distinguishing features of double depression, particularly in older adults. Preliminary studies have revealed that individuals with double depression diagnoses tend to have more severe depression than individuals with major depression or dysthymia alone, but few other distinctions between the diagnostic categories have been found.

Method: We examined the possibility that hopelessness particularly characterizes double depression, by comparing older adults with double depression, dysthymia alone, or major depression alone, on hopelessness, as well as on internal and external locus of control. The sample included 54 older psychiatric outpatients who completed a battery of cognitive and symptom measures, and underwent structured clinical interviews.

Results: Double depressed patients showed high levels of hopelessness, whereas patients with either major depression or dysthymia alone showed more moderate levels of hopelessness. Low internal locus of control characterized both groups with a dysthymia diagnosis (dysthymia alone and double depression), and differentiated them from the group with major depression alone.

Limitations: The sample size was modest, and the results may not generalize to older adults with different demographic characteristics.

Conclusions: Hopelessness may be important in understanding the phenomenology of double depression in older adults, and may inform diagnostics and psychotherapeutics as well.

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Keywords: Double depression; Hopelessness; Older adults; Dysthymia; Major depression

1. Introduction

Despite considerable research on depression in older adults, limited attention has been given to the important nosological concept of double depression (dysthymia with superimposed major depression; [Keller and Shapiro, 1982]) in this group. In younger adults, studies comparing patients with double depression to patients with major depression alone (Klein et al., 1988; McCullough et al., 2000; Miller et al., 1986) have found that double depression was associated with more severe depression. Beyond symptom severity, which features might discriminate double depression from either major depression or dysthymia alone?

We reasoned that severity of hopelessness might be for three reasons. First, on rational grounds, it would not be surprising if acute deterioration (major depressive
episode) from a baseline of substantial distress and impairment (dysthymia) would be particularly associated with hopelessness (“things were persistently bad; now they’re acutely even worse”). Second, the hopelessness theory of depression asserts that as hopelessness becomes more serious, chronic and severe depressions become more likely (Abramson et al., 1989). Third, hopelessness is predictive of completed suicide (Brown et al., 2000). Because hopelessness is associated with the most pernicious complication of severe and chronic mood disorders (suicide), it may also characterize severe and chronic mood disorders themselves (and double depression is by definition chronic and relatively severe).

We examined the possibility that hopelessness particularly characterizes double depression by comparing older adults with double depression, dysthymia alone, or major depression alone. In addition to group comparisons on hopelessness, comparisons on locus of control were also made in order to assess whether hopelessness is a specific cognitive characteristic of double depression. We predicted that the double depression group would have more severe symptomatology and that severe hopelessness would differentiate patients with double depression from the dysthymia and major depression alone groups. In contrast, we expected that locus of control would not distinguish double depression from the two other diagnostic groups.

2. Methods

The data for this study were obtained as part of a comprehensive intake evaluation for older adult psychiatric outpatients at the Nova Southeastern University Community Clinic for Older Adults (NCCOA), a community-based psychiatric outpatient facility for non-psychotic adults aged 55 years and older. Overall, there were 244 consecutive admissions to the clinic between January 1995 and May 1997, 62% of whom agreed to participate in the larger project. We focus here on the 54 patients who met diagnostic criteria for major depression \((n=40)\), dysthymia \((n=6)\), or double depression \((n=8)\), and who had complete data on all study variables.

Of the 54 participants, 37 were women (69%), and the average age was 63.00, SD=7.22. Virtually all participants were Caucasian (93%). Patients’ social class was generally in the middle levels (85.7%), with 5.4% in the lowest socioeconomic status (SES) level and 8.9% in the highest (Hollingshead, 1975). Most patients were married (31.5%) or divorced (33.3%), with a significant minority widowed (20.4%) and the remainder never married (9.3%) or separated (5.6%).

All patients received a psychological assessment battery that was completed within an initial evaluation time of two weeks, prior to the initiation of treatment. The battery included the Hopelessness Scale (Beck et al., 1974), the Beck Depression Inventory (BDI; Beck and Steer, 1987), the Beck Anxiety Inventory (BAI; Beck et al., 1988), and the Locus of Control Scale (Levenson, 1974). The Locus of Control Scale measures the generalized expectancy that outcomes are contingent upon one’s own actions (internal control) versus the expectancy that outcomes are determined by forces beyond one’s control such as powerful others or chance (external control), and yields a separate score for each type of control. These measures are all self-report questionnaires and were used to assess the severity of

### Table 1

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<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>1. Hopelessness</td>
<td>11.31 (5.38)</td>
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<td></td>
<td></td>
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<tr>
<td>2. Internal locus</td>
<td>0.01 (6.29)</td>
<td>23.22</td>
<td></td>
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<tr>
<td>3. External locus</td>
<td>–0.24* (14.07)</td>
<td>–0.21</td>
<td>57.37</td>
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<tr>
<td>4. BDI</td>
<td>0.62*</td>
<td>0.08</td>
<td>–0.17</td>
<td>23.98 (9.24)</td>
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<td>5. BAI</td>
<td>0.35*</td>
<td>0.05</td>
<td>–0.13</td>
<td>0.65* (14.33)</td>
<td>20.15</td>
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<tr>
<td>6. Age</td>
<td>–0.10</td>
<td>–0.22</td>
<td>–0.09</td>
<td>–0.12</td>
<td>–0.04 (7.22)</td>
<td>63.00</td>
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<tr>
<td>7. Sex</td>
<td>0.25*</td>
<td>0.09</td>
<td>0.17</td>
<td>0.16</td>
<td>0.11</td>
<td>–0.02 (–)</td>
<td>–</td>
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Note. Means on diagonal; standard deviations in parentheses. BDI=Beck Depression Inventory. BAI=Beck Anxiety Inventory. For sex, 0=male; 1=female. *p<0.05; †p<0.10.
Table 2
Means and standard deviations of hopelessness and internal locus of control variables in double depressed, major depressed, and dysthymic patients

<table>
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<tr>
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<th>Double Depressed</th>
<th>Major Depressed</th>
<th>Dysthymic</th>
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<tr>
<td>Hopelessness</td>
<td>15.05° (SD=6.38)</td>
<td>10.68° (SD=5.88)</td>
<td>10.56° (SD=3.89)</td>
</tr>
<tr>
<td>Internal locus</td>
<td>24.76° (SD=4.92)</td>
<td>22.19° (SD=6.19)</td>
<td>28.08° (SD=6.98)</td>
</tr>
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Note. Per each row, means bearing different superscripts differ significantly. Regarding internal locus of control, the combined group of dysthymic patients (double depressed+dysthymic alone) showed lower locus of control than major depression patients.

various types of patient symptoms. Master’s-level clinicians conducted the diagnostic evaluation with the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (patient edition with psychotic screen; SCID-IV-P; American Psychiatric Press, 1994), a structured interview to determine diagnoses. All assessment tools possess adequate reliability and validity, and most have been successfully used with older populations (Gallagher et al., 1983; Hill et al., 1988; Kabacoff et al., 1997; Levenson, 1974; Segal et al., 1995).

3. Results

Means, standard deviations, and intercorrelations for all variables are presented in Table 1. Initial analyses showed that there was no relation between group status (double depressed vs. major depressed vs. dysthymic) and each of the following variables: age (F[2, 51]=2.15, two-tailed p>0.10), SES (F[2, 51]=0.02, two-tailed p>0.10), sex (chi-square, df=2, χ²=0.76, two-tailed p>0.10), depression symptoms (F[2, 51]=0.42, two-tailed p>0.10) and anxiety symptoms (F[2, 51]=0.28, two-tailed p>0.10). Regarding both depression and anxiety symptoms, means for the double depression group were higher than those for the major depression group, which in turn, were higher than those for the dysthymia group (but again, symptom mean differences were non-significant). Because of the relatively small groups of dysthymic and double depressed, power may not have been sufficient to detect differences in symptom severity.

We thus conducted a one-way (double depressed vs. major depressed vs. dysthymic) Multivariate Analysis of Covariance (MANCOVA), with hopelessness and the locus of control variables as the dependent variables, and age, SES, sex, and depression and anxiety symptoms as covariates. Results were virtually identical whether covariates were included or not. The results of the analysis are reported in terms of Wilks’ lambda, an exact multivariate F statistic. The MANCOVA produced a significant multivariate effect for group (Wilks’ lambda=0.76; F[6, 88]=2.21, two-tailed p<0.05). The univariate effect of group on external locus of control did not approach significance (F[2, 46]=1.33, two-tailed p>0.10). Results for the two other univariate effects were as follows: Hopelessness (F[2, 46]=2.76, two-tailed p=0.074); Internal locus of control (F[2, 46]=2.66, two-tailed p=0.081).

Follow-up analyses indicated that double depressed patients were more hopeless than patients in the two other groups (F[1, 47]=5.63, two-tailed p<0.05); the two other groups (major depression alone and dysthymia alone) did not significantly differ from each other (F[1, 39]=0.00, two-tailed p>0.10). Regarding internal locus of control, follow-up analyses indicated that patients with dysthymia (whether double depressed or not) displayed lower internal locus of control than patients with major depression (F[1, 47]=4.38, two-tailed p<0.05); the two dysthymia groups (double depression and dysthymia alone) did not significantly differ from each other (F[1, 7]=1.08, two-tailed p>0.10). Means from these follow-up analyses are presented in Table 2.

Double depression patients, by definition, carried two diagnoses, whereas only a proportion of other patients did; raising the possibility that double depression patients experienced more hopelessness than others simply as a function of higher number of diagnoses among double depression patients. To address this issue, analyses were repeated, including all double depression patients, and only including major depression and dysthymia patients who also carried a second, non-depressive diagnosis. Here, as before, double depressed patients were more hopeless than patients in the two other groups (F[1, 36]=5.94, two-tailed p<0.05); the two other groups did not significantly differ from each other (F[1, 28]=0.76, two-tailed p>0.10). Significantly higher levels of hopelessness thus appeared to specifically characterize the double depression group, and this finding was not explained by differing rates of multiple diagnoses across the three groups.

4. Discussion

We predicted that hopelessness may specifically characterize double depression patients, and results were consistent with this prediction. Double depressed patients had
high levels of hopelessness, whereas patients with either major depression or dysthymia alone showed more moderate levels of hopelessness. Three cognitive variables were examined (internal and external locus of control and hopelessness), and only hopelessness appeared to specifically relate to double depression status, suggesting that it may be a specific cognitive feature of double depression. In addition, we found that low internal locus of control characterized both groups with a dysthymia diagnosis (dysthymia alone and double depression), and differentiated them from the group with major depression alone. Finally, in contrast to past studies on young adults, we did not find significant symptom severity differences between patients with double depression and other patients. It is possible that severity differences exist, but that we did not have adequate statistical power to detect them. Or, perhaps older adults with major depression alone or dysthymia alone show more severe symptom pictures, to the point that they approach symptom levels of those with double depression.

Our results may have modest clinical implications. Diagnostically, even though hopelessness is a diagnostic criterion for dysthymia and not for major depression, our findings suggest that it may not discriminate very well between the two syndromes. It did, however, differentiate those with double depression from those with dysthymia or major depression alone in the current study. Therapeutically, our findings are consistent with recent theorizing and empirical results on the importance of cognitive therapy (combined with antidepressant medicines) for chronic depressions in general (Keller et al., 2000) and for depression in older people (Thompson et al., 2001). The natural emphasis of cognitive therapy on low internal locus of control (which our results suggest may be a particular issue for dysthymia patients in general) and hopelessness (which our results suggest may be a particular issue for double depression patients) fits well with our findings.

The findings must be interpreted in light of the study’s limitations. The sample was modest in size and may not be representative of older populations in general. While we urge that this issue be considered in interpreting our findings, we note that it cannot fully explain away our findings. The strength of the relationship between double depressed diagnostic status and hopelessness exceeded conventional levels of statistical significance despite, not because of, reduced statistical power due to small sample size. We hope that our preliminary findings serve as a springboard for future studies investigating the phenomenon of double depression.

References


