

**AN EXPLORATION OF DIFFERENCES IN STRESS AND DEPRESSION  
AS PERCEIVED BY THERAPISTS IN ONE CLINICAL SETTING**

by

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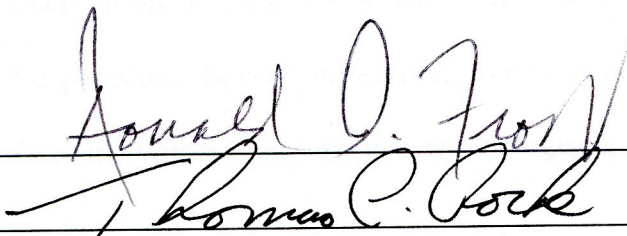
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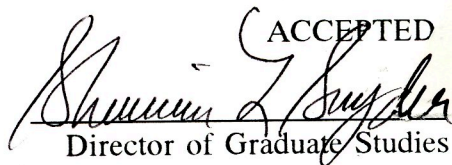
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# ABSTRACT

The purpose of the study was to describe how therapists differentiate between stress and depression when diagnosing and treating patients. The study investigated whether or not there is a consensus of opinion on the optimum therapies as perceived by mental health practitioners.

Selected literature was reviewed concerning the history of psychology, stress, anxiety and depression as well as accepted treatments for each condition. The study combines empirical and intuitive data collected from mental health professionals through observation and participation in treating anxious, stressed and depressed patients.

A descriptive approach was used to examine the opinions and attitudes of some clinical practitioners in one clinical setting who diagnose and treat patients suffering from stress and depression. Several differences were observed between the responses given by the two social workers and the two psychologists.

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# CHAPTER 1

## THE PROBLEM

### Introduction to the Study

Ordinary stress can lead to anxiety, mild depression or severe depression. Symptoms of depression and symptoms of stress are often so similar that only a well-trained therapist is able to determine the exact nature of the problem and therefore recommend a treatment modality. This research was a descriptive study of therapists who must diagnose and distinguish between stress and depression in their patients.

### Background

The researcher has observed the results of stress and depression which afflict patients who are being treated for mental disorders and physical disease. Therapists who treat these conditions often have difficulty in determining the primary cause of the disorder.

### Purpose of the Study

The purpose of the study was to describe how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients.

## **Statement of the Problem**

Stress and depression can be considered serious disorders which may strike anyone and affect every facet of a person's life. The symptoms and effects of stress and depression are very closely related (Kaplan & Sadock, 1991). This relationship between the two and their differences must be understood in order to treat stress and depression as separate manifestations (Kaplan & Sadock, 1991). A therapist must be knowledgeable about what triggers depression in a stressed person by understanding the differences between stress and depression.

## **Theoretical Basis**

The basis for this research is techniques used by therapists to clearly differentiate between depression and stress. Distinctions in depressive states are not clear-cut, and may not be useful in determining treatment for a depressed patient; however, depression triggered by life events are treatable by physical methods (Klein & Wender, 1993). Beck (1991) believes that nonspecific stress may contribute to the development of depression and Burns (1990) indicates that clinicians diagnose several types of depression. Therapists must be able to consistently diagnose stress and/or depression in order to determine the appropriate treatment.

## **Significance of the Study**

This study examined how some therapists discriminate among the symptoms of stress and depression and how those therapists select appropriate treatment modalities

for their patients. The results of the study may be important to therapists who diagnose and treat stress and depression in their practices. This knowledge may also be valuable in developing consistent training programs for both psychologists and social workers.

### **Operational Definition of Terms**

**Anxiety Disorders:** Disorders in which debilitating anxiety is a central feature. The anxiety comes on as sudden panic attacks or is the result of a phobia, an obsession, or a compulsion. Anxiety symptoms are frequently associated with depression (DePaulo and Ablow, 1989, p. 178).

**Affective Disorders:** Mental experiences that include moods, emotions, and motivations. Affective experiences are often distinguished from cognitive abilities such as intelligence, memory, and reasoning (DePaulo and Ablow, 1989, p. 177).

**Atypical Depression:** A moderately severe form of affective illness that combines long periods of depression with short intervals of relief. Sleep and appetite are often increased. The onset of atypical depression may seem closely timed to distressing life events. Its victims frequently come to suffer from prominent anxiety symptoms and abnormal behaviors such as eating disorders (DePaulo and Ablow, 1989, p. 178).

**Behavioral Therapy:** Psychotherapy that attempts to extinguish abnormal behaviors by changing the consequences of those behaviors (DePaulo and Ablow, 1989, p. 179).

**Cognitive Therapy:** Psychotherapy, which when used for depression, is designed to confront and correct what is seen as an inappropriately dismal self-image and view of the world. Through techniques including discussion, role playing and demonstration of success in assigned simple tasks at home, the therapist attempts to expose the distortions in the patient's negative mind-set (DePaulo and Ablow, 1989, p. 179).

**Major Depression:** The affective illness marked by decreased self-esteem, inability to concentrate, and lack of energy (DePaulo and Ablow, 1989, p. 184).

**Stress:** A physical or emotional reaction to unpleasant stimulus (Peterson, 1990).

**Therapist:** A professional counselor, psychologist, social worker, or psychiatrist, who is qualified to diagnose and/or treat stressed and/or depressed patients.



## **Assumptions and Limitations**

It is assumed that the therapists surveyed correctly identified stress or depression in their patients through standardized criteria. It is further assumed that the four participants responded freely and honestly. Also assumed is that the questionnaire accurately addressed the issues of the study.

The study was limited by a small sample size. The small sample implies a lack of predictability for the population as a whole. The study is further limited in that the manner, severity, and timing of the onset of stress or depression varies with each person so that the therapist may have problems in correctly identifying the disorder.

## **Organization of the Remainder of the Study**

The remainder of the study is organized into four chapters. Chapter Two reviews selected literature concerning stress, depression, the relationship between the two disorders, and accepted treatments for the two conditions.

Chapter Three reviews the purpose of the study, describes the methodology and outlines the design of the study. The source of the data and kinds of data collected is also presented. The format for presenting the data and method of analyzing the collected data is discussed.

Chapter Four presents the data and the results of the analysis. The findings of the study are presented in terms of the results of the questionnaires returned by participants of the study.

Chapter Five contains a summary of the study problem, the findings and the conclusions of the study. General recommendations and recommendations for future study are also presented.



## CHAPTER 2

### LITERATURE REVIEW

#### **Introduction**

The purpose of the study was to describe how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients. This chapter reviews selected literature concerning stress and depression and accepted treatments for each condition to answer whether the techniques used by therapists to identify depression and stress are appropriate to clearly differentiate between the two conditions. There appears to remain little doubt that mental disorders are caused by a combination of biological and environmental factors. Successful treatment depends on the ability of a mental health practitioner to distinguish between stress and depression.

#### **Definition and Physiological Effects of Stress**

Nathan (1987) cites the American Academy of Family Physicians estimate that sixty percent of the problems brought to physicians in this country are stress-related. Stress is necessary to the health and well-being of the human body and is desirable in many situations because people require the stimulation generated by mental and physical stress (Peterson, 1990). A certain level of stress may help an athlete

perform better during a race or a give a manager an edge while making a presentation to a large audience. Stress may be defined as anything that triggers the body's adaptive mechanisms and affects people not only physically, but also emotionally (Peterson, 1990). The emotional reactions to stress may lead to depression, irritation, fatigue, forgetfulness, confusion, anger, and fear and too much stress may lead to paranoia, delusions, and other psychoses (Peterson, 1990) and has come to be perceived as the cause for almost any psychological problem.

Stress is the body's reaction to an unpleasant stimulus. When the body's adaptive mechanisms are triggered by a loud noise, vibration, or physical threat (Peterson, 1990), the body activates its defense mechanisms. Physiological defense mechanisms prepare the body to take action to deal with a stressful situation when fight or flight are appropriate responses to a physically threatening predicament. Peterson (1990) lists the natural responses to danger, including a release of hormones such as cortisone, thyroid, and endorphins and the reduction of other hormones, such as testosterone and progesterone. The digestive tract shuts down; sugar and insulin are released into the bloodstream and the amount of cholesterol from the liver is increased. The heartbeat races, air supply is increased by deeper breathing, and the blood thickens.

Peterson (1990) points out that a symbolic threat can also trigger a stress response even if the threat is not to one's life, but to one's ego, and physical action is not necessary. The body may respond to criticism the same way it responds to a physical threat but it would be inappropriate to run away or attempt to fight.

The physical preparation for defense activates natural responses, which take a significant toll on the body if not used for physical action. The physical response that takes only a few minutes to start can take hours to end, causing damaging effects to the body's systems (Peterson, 1990). Peterson (1990) lists the damaging effects: The cortisone that was released to protect against an allergic reaction to dust destroys resistance to cancer and other illnesses; the thyroid hormone designed to speed up the body's metabolism and provide extra energy results in shaky nerves, exhaustion, jumpiness and insomnia; endorphins are a pain killer that can ease the discomfort of physical injury but can also aggravate migraines, backaches, and arthritis.

Systems that shut down during stress also have negative consequences. A reduction of sex hormones, testosterone and progesterone, decrease fertility, and can cause anxiety, frustration and irritation; and shutting down the digestive tract diverts the blood supply to muscles, but also causes dry mouth, bloating, diarrhea, and cramps (Peterson, 1990). Peterson (1990) lists how normal systems activities are increased by stress and can have adverse side affects, such as sugar and insulin released into the blood stream provide a quick energy supply, but contributes to diabetes and hypoglycemia; cholesterol increases long distance energy but causes coronary and heart problems; and the racing heartbeat and thickened blood for muscles and lungs becomes high blood pressure and can cause strokes and heart attacks.



## **Causes of Stress**

The stimulus causing the stress reaction is called the stressor. Peterson (1990) categorized stressors as psychosocial, involving adaptation, frustration, overload, and deprivation; bioecological such as biorythms, nutrition, and noise; personality stressors involving self-perception, behavioral patterns and anxiety; and environmental events or conditions that have the potential to induce stress, such as extreme heat or cold, isolation, or the presence of hostile people. Stressors are a part of daily life which cannot be avoided, however, some people are physically able to handle more difficult work, some are physiologically stronger and can stand more environmental stress, some are psychologically stronger and can handle more psychological stress (Peterson, 1990). The ill effects of stress are reduced if there is a fit between the person and the environment, social support, and the person's response to a situation (Peterson, 1990).

## **Effects of Stress**

As the number of stressors increase, so does the number of stress-related illnesses. There are three categories of disease, organic diseases, conversion reactions, and psychosomatic diseases (Peterson, 1990) that may be brought on by unsuccessful coping with stress. Stress does not cause disease, but can cause psychogenic psychosomatic disorders resulting from emotional stress such as backaches, skin reactions, peptic ulcers, migraine headaches and some respiratory disorders (Peterson, 1990). Somatogenic psychosomatic disorders occur when

emotional disturbances such as anxiety, anger, fear, and frustration increase the body's susceptibility to organic disease and hinder the body's defenses against organic disease (Peterson, 1990). The list of physical illnesses that can result from excessive stress grows longer each year including illnesses in categories such as diseases of the cardiovascular system, digestive system, immunological system and skeletal-muscular system (Peterson, 1990).

Stress related diseases affect a person's relationships with spouse, children, friends, colleagues, and at work through psychological consequences which can include emotional disturbances, insomnia, personality disorganization, paranoia, schizophrenia, thought and perceptive disorders, behavior disruptions and alcoholism (Peterson, 1990).

In certain individuals, nonspecific stress, whether caused by a single incident or a series of traumatic events, may contribute to the development of depression (Beck, 1991) which seems to reinforce the environmental causes of stress. However, several studies of heavily stressed rats showed a difference between different strains, leading to a conclusion that there is a genetic distinction implying that a predisposition to depression could be inherited (Dowling, 1993). Also, according to Kaplan and Sadock: "Repeated attacks of fear. . . provide the chronic stress to produce intense and long-lasting autonomic neuroendocrine reactivity, accompanied at the psychological level by conflict. This pattern results in chronic anxiety" (1991, p. 390). Thus, stress is considered a strong factor in the development of anxiety and phobic neuroses as well as mood disorders characterized by depressive states.

## Depression Defined

Anxiety is a feeling of fear that some disaster will strike in the future, while depression is a feeling of loss because the disaster has already happened (Burns, 1990). Depression is characterized by a loss of self-esteem, goes on and on, results in unrealistic distorted thoughts and an inability to function productively (Burns, 1990).

A category of mental dysfunction, mood disorders, have been noted since the beginnings of recorded history although the term used was melancholia and the feelings of hopelessness and despondency were often attributed to spells cast by a wicked force (Cammer, 1971). Today, mood refers to a prolonged emotion that colors the whole psychic life. Depression, according to Diagnostic and Statistical Manual of Mental Disorders (APA, 1987) is a disturbance of mood, that is not due to any other physical or mental disorder.

According to Beck, depression may be defined in terms of the following attributes:

1. A specific alteration in mood: sadness, loneliness, apathy.
2. A negative self-concept associated with self-reproach and self-blame.
3. Regressive and self-punitive wishes: desires to escape, hide, or die.
4. Vegetative changes: anorexia, insomnia, loss of libido.
5. Change in activity level: retardation or agitation. (Beck, 1991, p. 6).



## Signs and Symptoms of Depression

According to Burns (1990), Depression may be the cause when a patient reports any of the following signs:

1. Poor appetite and significant weight loss, or increased appetite and significant weight gain.
2. Insomnia, or increased sleep.
3. Agitation, or retardation, of movement and thought.
4. Loss of interest or pleasure in usual activities or decrease in sexual drive.
5. Fatigue and loss of energy.
6. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
7. Diminished ability to think or concentrate, or indecisiveness.
8. Recurrent thoughts of death or suicide, or suicide attempts.

Depression is an uncomfortable mental state that may be characterized by such adjectives as blue, dejected, or discouraged (Burns, 1990). In ordinary usage, the word refers to a mood state that in medicine is called dystymia, as contrasted with the normal state of euthymia and the opposite state of elation (Burns, 1990).

Normal human responses to situations may include transient depression. Mourning the loss of a loved one is usually accompanied by a depressed mood, but this is not considered to be anything other than an expected response to the loss. Burns (1990) discusses the difference between healthy sadness and depression.

1. Depression involves a loss of self-esteem.



2. Depression goes on and on.
3. People who are depressed may not function productively.
4. Depression is not realistic, and always results from distorted thoughts.
5. Depression is an illness.
6. Depression feels hopeless, even though the prognosis is excellent.  
(Burns, 1990, p. 39)

Not all of these characteristics occur in each individual who becomes depressed. For purposes of psychiatric treatment, a person is considered to have experienced a major depressive episode if he or she exhibits a loss of interest or pleasure in all or almost all usual activities and shows at least four of the above symptoms nearly every day for at least two weeks, otherwise, professional treatment would not be considered essential (Burns, 1990).

Major depression is estimated to occur in ten to twenty-five percent of the world's population in the course of a lifetime with women more often affected than men by a ratio of one and a half to one (Greist & Jefferson, 1992). At least five percent of the population can be diagnosed with major depression at any point in time (Greist & Jefferson, 1992). Theories have been advanced that make cultural and social rather than biological factors primarily accountable for this difference between the sexes in the occurrence of depression (Greist & Jefferson, 1992). Relatives of patients with major depression seem to be at some higher risk of becoming depressed and about two percent of the population may have a chronic disorder known as depressive personality (Greist & Jefferson, 1992).

Beck (1991) lists emotional, cognitive, motivational, vegetative and physical manifestations and delusions as indicators of depression. Emotional manifestations include a dejected mood, self-dislike, loss of gratification, loss of attachments, crying spells and loss of humor. Cognitive manifestations include low self-evaluation, negative expectations, self-blame and self-criticism, indecisiveness, distorted self-image, loss of motivation, and suicidal wishes. Beck (1991) lists three major cognitive patterns found in depressed persons:

1. Experiences are construed in a negative way, interpreted by the patient as representing defeat, deprivation, or disparagement. The patient sees his or her life as filled with burdens, obstacles or traumatic situations.
2. The patient views him or herself in a negative way, regarding himself or herself as deficient, inadequate or unworthy and tending to attribute unpleasant experiences as a result of a personal defect.
3. The patient views the future in a negative way, anticipating that current difficulties or suffering will continue indefinitely as a life of unremitting hardship, frustration and deprivation. (p. 255)

Motivational manifestations are characterized by a paralysis of will and increased dependency on others for help, guidance or direction (Beck, 1991).

Physical manifestations include fatigue, loss of sleep, loss of appetite, and a loss of libido Beck, 1991). Depressed individuals may have delusions and hallucinations that include feelings of worthlessness, a delusion of having committed an unpardonable sin, punishment, death, illness and body decay, and poverty.

According to Burns (1990), clinicians diagnose several types of depression. These include major depressive episodes, dysthymic disorder, bipolar disorder, and

cyclothymic disorder. Distinctions are based on severity and duration of the symptoms.

### **Categories of Depression**

**Major depressive episode.** In a major depressive episode, a person feels sad or experiences loss of interest in pleasurable activities for at least a two to four week period. Symptoms may also include loss of appetite or eating too much, trouble sleeping at night or sleeping too much, feeling agitated, and extremely restless, or feeling dull, fatigued and slowed down, feelings of worthlessness or guilt, difficulties concentrating, and thoughts of death. Twice as many women as men have major depressive episodes (APA, 1987, p. 228).

**Dysthymic disorder.** Dysthymic Disorder is a milder form of depression which lasts for two years or more, where the person is chronically unhappy and pessimistic but the depression is not severe enough to qualify as a major depressive episode. It begins between childhood and young adulthood and is more common among women. Sometimes called depressive personality or depressive neurosis (APA, 1987, p. 230).

**Bipolar disorder.** Recurrent depressions are sometimes called unipolar depressions. Bipolar persons go into a deep depression and then suddenly develop an abnormal and potentially dangerous mood elevation. Also called manic depressive (APA, 1987, p. 225).



**Cyclothymic disorder.** Mild mood swings from overly negative, pessimistic and discouraged to mild elation. oscillating back and forth for at least two years. Most modern theorists agree that both biological and psychological factors play a role in causing depression (APA, 1987, p. 226).

Klein and Wender (1993) state that "The majority of cases of depressive and manic-depressive illness appear to be genetically transmitted and chemically produced" (p. 87). In other words, the disorder appears to be caused by a tendency toward abnormal chemical functioning in the brain (Klein & Wender, 1993). Mood disorders such as depression and manic depressive illness seem to run in families with children of a depressed parent having a 20% to 25% higher risk of depressive type illness. Geneticists who study psychiatric illnesses have developed tests to determine the extent to which depression may be inherited by analyzing the complex relationship between nature and nurture and found that a genetic predisposition towards depressive illness did not mean that other factors did not play a role Klein & Wender, 1993).

Psychiatrists formerly classified some depressions as reactive, that is, produced by life events in a person predisposed because of psychological maladjustment to unfortunate life experiences and believed to be curable by psychotherapy (Klein & Wender, 1993).

Other depressions were classified as endogenous, or those produced within the suffer for no identifiable reason but was probably caused by abnormal biological functioning in the brain (Klein and Wender, 1993). The predominant chemical, or biological, theory of depression is called amine hypothesis and is based on an

observation that depression can be caused by drugs that deplete the brain of chemicals called biogenic amines (Klein & Wender, 1993). Endogenous depression was believed to be treatable by physical methods such as drugs and electroconvulsive treatment.

Distinctions in depressive states are not clear-cut, and may not be useful in determining treatment for a depressed patient, however, increasing evidence is that biological depression and manic-depression triggered by life events are nonetheless treatable by physical methods (Klein & Wender, 1993).

### **Treatment Modalities**

The time to seek treatment is any time a mood problem is chronic or severe, or interferes with normal functioning (Burns, 1990). Therapies for stress and depression include emotional and cognitive therapies, pharmacotherapies, and electroconvulsive sessions, or any combination as prescribed by the therapist based on the severity and nature of the symptoms.

**Psychotherapy.** Greist & Jefferson (1992) refer to psychotherapy as "talk" therapy. Patients and their doctors talk about the experiences that have had and are having, important relationships and future goals, and feelings, thoughts and behaviors. Psychotherapy is usually most helpful for less severe depression, but less effective for more severe depressions although it can help all patients in improving relationships, thinking patterns or behaviors that may have led to depression. There are several variations of psychotherapeutic methods.

In supportive therapy, a therapist helps the patient shore up defenses, utilize strengths by empathizing with the patient's distress, explaining the course of depression, monitoring changes, and reassuring the patient that improvement will occur (Greist & Jefferson, 1992).

In dynamic therapy, generally following psychoanalytic theory, the therapist helps the patient seek to understand unresolved unconscious conflicts that led to depression and help the patient uncover, understand, and deal with angry feelings that may lead to recovery using dream interpretation, free association and exploration of the past. (Greist & Jefferson, 1992).

Short term therapy is conducted in ten to twenty sessions which focus on the present rather than the past in an active collaboration between patient and therapist. Patients are encouraged to present their view of the problems and the therapist explores alternative explanations. The therapist helps the patient define concrete and measurable targets, achievable goals, and identifying and correcting obvious deficiencies in coping skills (Greist & Jefferson, 1992).

Interpersonal therapy uses supportive and dynamic psychotherapeutic techniques with an emphasis on understanding and improving relationship skills (Greist & Jefferson, 1992).

Cognitive therapy is based on the idea that distorted and unrealistic thoughts lead to unhealthy negative emotions like depression and anxiety. The cognitive therapy approach emphasizes learning to think about problems in a more positive and realistic way to change feeling. (Burns, 1990)



Behavior therapy attempts to alleviate depression by returning behavior patterns toward normal by helping patients increase the number of normal and nondepressed behaviors so that they will receive the positive reinforcements from thought and feelings associated with more normal behavior patterns (Greist & Jefferson, 1992).

Cognitive-behavioral therapy combines cognitive and behavioral therapy to help the patient focus on negative thoughts and uses educational, cognitive and behavioral techniques to first change behavior to counteract the negative thoughts and behaviors that result from negative thinking (Greist & Jefferson, 1992).

**Pharmacotherapy.** Pharmacotherapy makes use of antidepressants such as tricyclic drugs and MAO inhibitors (Beck, 1991), tranquilizers, such as Valium, lithium for severe manic depression, barbiturates, and antihistamines (Burns, 1990). Generally, patients who benefit from medication in addition to psychotherapy are those who are out of touch with reality and delusional, so severely depressed or anxious that they are unable to function, those who are suicidal, or those who have not made progress with psychotherapeutic treatment alone (Burns, 1990).

**Electroconvulsive therapy.** When depression is extremely severe, electroconvulsive therapy (ECT) may be recommended. "ECT produces a seizure in the brain under safe, medically controlled conditions which is more effective than other treatments and has been refined in recent years" (Dowling, 1993, p. 192). Kaplan and Sadock (1991) report that most clinicians find that ECT results in more



rapid improvement as standard pharmacotherapy for both major depression and bipolar disorder.

## **Summary**

Psychiatrists, psychologists, professional counselors and social workers all offer treatment for stress and depression. Correctly diagnosing whether a patient suffers from stress, an anxiety disorder, or a mood disorders such as depression is an extremely complex undertaking. Compounding the problem is the need to determine whether the cause is biological, psychological or environmental. Different mental health disciplines receive education and training which emphasize different aspects in diagnosis and treatment modalities.

## CHAPTER 3

### METHODOLOGY

#### **Introduction**

The purpose of the study was to describe how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients.

#### **Research Methodology**

The methodology used for the study was descriptive research. Descriptive research was selected to explore the opinions and attitudes of clinical practitioners in one clinical setting who diagnose and treat patients suffering from stress and depression. The methodology permitted the researcher to survey a small group of therapists to explore the causes for the differences and similarities in treatment based on the variation in disciplines, i.e., psychologist or social worker. As noted by Merriam and Simpson (1989), descriptive research provided the researcher with the ability to collect accurate and representative data from the sample and study similarities and differences among social workers and psychologists in a real-life clinical setting.

## **Design of the Study**

The study was designed as a small sample survey of the diagnosis and treatment of depression as conducted by clinical practitioners at a mental health facility in Glendale, Arizona.

## **Sample and Population**

The population was mental health personnel who have diagnosed and treated or are currently treating people for depression, anxiety or stress and other related diseases. The participants were drawn from a pool of fifteen practitioners at the mental health facility in Glendale, Arizona.

## **Instrumentation**

The instrument used to collect data for this study was a questionnaire devised by the researcher presented as Appendix A. The questions were developed by the researcher to elicit information from the participants sample concerning diagnosis and treatment of stress and depression. The researcher provided assurances of confidentiality to the respondents.

Part I, questions 1 through 8 of the questionnaire, asked for information on the respondent's practice and background. Item 9 stated that the respondent would be willing to participate in a personal interview. Part II, items 10 through 24 of the questionnaire, used a Likert scale to assess the level of agreement with statements concerning the diagnosis and treatment of depression and stress. Item 25 requested

the respondent to record perceptions of the differences between stress and depression as seen through causes, symptoms, diagnosis, treatment, and description. Item 26 provided space for comments or clarification.

The questionnaire was considered to have face validity in that the items related specifically to the impressions and opinions of the sample on topics of depression and stress (Babbie, 1991). The researcher assumed the questionnaire's reliability in that the instrument was designed for a sample population with specialized knowledge of the subject of depression and stress treatment modalities.

### **Data Collection Procedures**

Data were collected by the researcher from practitioners who responded to the questionnaire. During the month of October, 1994, the researcher mailed or handed out questionnaires to fifteen practitioners and provided a self-addressed stamped envelope for ease of return. Five responses were returned by the end of October. One of these five was incomplete due to the respondent's retirement from active practice.

### **Presentation of the Data**

The data are presented in Chapter Four. Table 1 summarizes the respondents' demographic data. Table 2 compares items numbered 10 through 24 for differences and similarities among the respondents on these items.

## **Data Analysis**

Data were analyzed by the researcher by comparing the differences in response between the social workers and the psychologists on items 10 through 24. Comments in items 25 and 26 were reviewed for insight into determining how causes and symptoms led to diagnosis and recommended treatment. Some respondents described how they distinguish between depression and stress. The small number of respondents made statistical analysis impractical.



## CHAPTER 4

### PRESENTATION AND ANALYSIS OF THE DATA

#### Findings

This chapter presents the data collected by the researcher through the survey instrument described in Chapter 3 and reproduced as Appendix A. The purpose of the study was to describe how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients. The researcher provided a survey to fifteen people selected for the sample population. Five responses were received, and one of the five declined to answer because he was no longer in active practice. The remaining four responses are the basis for the findings and results. Findings and results of the survey are presented in two tables and a transcription of comments provided by the respondents.

Table 1 displays the responses to the nine items in Part I of the survey, Your Practice. The data identifies the four respondents by a pseudonym. The demographic data requested in this section was limited to type of practice, age range, sex, education, years of practice, number of cases, number of patients with signs of depression, and number of patients with signs of stress. Item 9, "I would be willing to participate in a personal interview" was not used. Table 2 compares data collected in Part II of the survey, Stress and Depression. Level of agreement to items 10

through 24 is listed by respondent. Each respondent provided comments as requested in items 25 and 26.

### Part I - Your Practice

All respondents, three women and one man, were in the 45 to 54 age range, however two respondents had from one to five years of practice, one had from six to ten years, and one had eleven to fifteen years of practice. The two respondents who held doctorates had a psychological practice. Two respondents were social workers, one with a master's degree, and the other with a master's degree plus additional graduate hours. The case load for the respondents' ranged from a low of one to five, to a high of twenty-one to fifty. Each respondent indicated the same number of cases of patients with signs of depression and signs of stress as their total case load.

Table 1  
Questionnaire Part I - Your Practice

Part I - Your Practice Responses	Sue	Joe	Pam	Amy
Type of Practice	Psychology	Social Work	Psychology	Social Work
Age Range	45-54	45-54	45-54	45-54
Sex	Female	Male	Female	Female
Education	Doctorate	Master's	Doctorate	Master's plus
Years of Practice	11 - 15	1 - 5	1 - 5	6 - 10
Number of Cases	21 - 50	6 - 10	1 - 5	6 - 10
Patients with signs of Depression	21 - 50	6 - 10	1 - 5	6 - 10
Patients with signs of Stress	21 - 50	6 - 10	1 - 5	6 - 10



## Part II - Stress and Depression

Part II asked the respondents about how they diagnose and treat stress or depression. The respondents circled the number corresponding to the level of agreement they felt with fifteen statements. Choices for level of agreement included strongly agree, agree, undecided, disagree, and strongly disagree. The four respondents levels of agreement are shown in Table 2.

Table 2  
Questionnaire Part II - Stress and Depression

SA = 5 Strongly Agree A = 4 Agree U = 3 Undecided D = 2 Disagree SD = 1 Strongly Disagree

Part II - Stress and Depression Responses	Sue	Joe	Pam	Amy
10. It is easy to differentiate between stress and depression.	2	4	2	4
11. Stress is a less serious condition than depression.	2	2	2	4
12. No one seems to know how to distinguish between stress and depression.	2	2	2	2
13. Stress leads to depression.	4	2	4	2
14. The DSM-III-R clearly defines the differences between stress and depression.	2	2	2	2
15. Stress causes depression.	2	2	3	2
16. Anxiety and stress are normal.	4	4	4	4
17. External forces or internal perceptions of external forces lead to stress.	4	4	4	4
18. There is a genetic predisposition that causes depression.	4	4	4	4
19. Stress causes diseases and mental disorders.	4	4	5	4
20. Depression can be cured with medication.	4	2	4	4
21. Stress can be relieved by lifestyle changes.	5	5	4	4
22. Stress is a symptom indicating other serious conditions.	4	2	2	2
23. Psychotherapy is the best treatment for depression.	3	2	3	2
24. Psychotherapy is the best treatment for stress.	3	2	4	2

One respondent, Joe, disagreed strongly enough about item 11, "depression can be cured with medication" that he wrote "cured, no." on the form.

### **Perceived Differences Between Stress and Depression**

Item 25 requested the respondents to give their perceptions of the differences between stress and depression related to causes, symptoms, diagnosis, treatment, and description.

**Sue.** is a female between the ages of 45 and 54 with a psychological practice, and doctorate degree. She has practiced between 11 and 15 years and has a current caseload of between 21 and 50 patients, all of whom she feels show symptoms of depression and/or stress. The following is her verbatim response to the question, "What are your perceptions of the differences between stress and depression as seen through the following:"

**Causes:** Stress is usually attributed to external factors (job, tough boss, financial problems, collectors calling) and depression is a response to loss (including a response to stress if options appear to be limited).

**Symptoms:** Symptoms of stress: somatic complaints (headaches, fatigue, GI distress, increased blood pressure) anger, passive resistance toward stressor (if a person). Symptoms of depression: decreased eating, sleeping (waking early), vegetative symptoms (can't get dressed or shower), tearful, hopelessness, thoughts of death.

**Diagnosis:** If symptoms of depression are present (eating, sleeping disturbance, uncontrollable tears, thoughts of suicide or death), then Dx = depression. If not present, but patient feels angry, pressured or upset by job, boss, bills, overtime, too many commitments, etc., then Dx = stress.

**Treatment:** Depression: medication, grieving loss, psychotherapy, exercise. Stress: change in lifestyle, including exercise, diet, time and money management.

**Description:** Stress is described as emotional and physical response to external factors (although most people say "my problem is stress" rather than "my problem is how I respond to stressful circumstances." Often physical (headaches, GI distress, etc.). Depression is described as an internal emotional state of grieving, loss, hopelessness, helplessness with behavioral correlates of: loss of appetite, sleep disturbance, thoughts of death. Both can result in fatigue, irritability, frustration.

Sue used item 26 to expand on her answers, included here by item number and level of agreement.

4. Stress leads to depression. (Disagree)

Comment: *Stress can lead to depression if untreated and ignored.*

6. Stress causes depression. (Agree)



Comment: *Stress itself does not cause depression, but depression can result if an individual does not have the skills to cope with stress.*

9. There is a genetic predisposition that causes depression. (Agree)

Comment: *Sometimes. other times, depression cannot be accounted for by genetic predisposition, but is a product of learning.*

10. Stress causes diseases and mental disorders. (Agree)

Comment: *If an individual does not possess the ability (skills) to cope with stress or change environmental factors, then such stress can lead to disease and/or mental disorders.*

11. Depression can be cured with medication. (Agree)

Comment: *I dislike the word "cure". Depression may sometimes be decreased or successfully treated with medication.*

14. Psychotherapy is the best treatment for depression. (Undecided)

Comment: *Sometimes it is. Sometimes medication or other factors such as exercise can best treat depression.*

15. Psychotherapy is the best treatment for stress. (Undecided)

Comment: *Sometimes it is. Sometimes, lifestyle changes, education, etc. are the best treatment for stress.*

**Joe.** Joe, the sole male respondent, is a social worker with a masters degree.

He has practiced for more than 21 years and has a current caseload of between one and five patients, all of whom he feels show symptoms of depression and/or stress.



The following is his verbatim response to the question, "What are your perceptions of the differences between stress and depression as seen through the following:"

**Causes:** I don't know what the causes are. I know how to respond to both and I know some things that are related/correlated to stress and depression.

**Symptoms:** There are a number of symptoms common to both, some are different. Treatment is usually different.

**Diagnosis:** I'm not terribly impressed with diagnoses. Both are in part very psychosocially related although depression can be largely biological.

**Treatment:** I use hypnosis, relaxation, lifestyle changes and thinking changes for stress. I prefer medication and supportive therapy for depression.

**Description:** Stress is more related to tension, such as discomfort, distress; whereas depression is more related to a sense of hopelessness, nothing works, etc.

As a final comment in item 26, Joe said:

Many of my clients don't know if there is a difference. Most of the time if they experience one they experience the other.

**Pam.** Pam, the third respondent, is a female between the ages of 45 and 54 with a psychological practice, and doctorate degree. She has practiced between one

and five years and has a current caseload of between one and five patients, all of whom she feels show symptoms of depression and/or stress. The following is her verbatim response to the question, "What are your perceptions of the differences between stress and depression as seen through the following:"

**Causes:** A certain amount of stress is normal and to be expected in a given lifestyle. Depression is a result of several factors including a bio-disposition, chemical imbalance, major stressor or on-going daily hassles.

**Symptoms:** Symptoms of the both are closely intertwined and may be difficult to separate clinically. However, depressive symptoms are strongly behaviorally categorized while stress can be nearly anything.

**Diagnosis:** In my opinion, depression is a clinically defined diagnosis while stress is contributing external factors.

**Treatment:** The treatment for depression is probably most enhanced by combined psychotherapy and psychopharmacology (although no in all cases). Treatment for coping with stress is an integral part of depression treatment.

**Description:** I view depression as a clinical diagnosis arising from behavioral, somatic and psychological factors--mainly internal in description. Stress arises from external factors or situations that exacerbate a deeper depressive symptom.

As a final comment in item 26, Pam said:

Psychotherapy for depression or stress must entail both sources of distress in a person's life in order for improvement in daily functioning to occur.

**Amy.** Amy, the fourth respondent, is a female between the ages of 45 and 54 with a social work practice, a masters degree and graduate hours. She has practiced more than 21 years and has a current caseload of between six and ten patients, all of whom she feels show symptoms of depression and/or stress. The following is her verbatim response to the question, "What are your perceptions of the differences between stress and depression as seen through the following:"

**Causes:** A genetic predisposition toward depression can be assessed by tri-generational examination of mood disorders/substance usage.

Situational trauma can certainly precede adjustment disorder with depression. Stress is plus and minus, depending on precipitive event.

**Symptoms:** Depression - sleep, eating irregularly/difficulties concentrating, focusing/difficulty finding pleasure or sexual interest, tearfulness. Stress - physical symptoms which can be exciting or apprehensive, increase heart/lung activity, tightness of muscles, etc.

**Diagnosis:** Varies.

**Treatment:** Depression - psychotherapy, cognitive psychotherapy, meds. Stress - lifestyle increase/decrease depending on plus or minus.

**Description:** ?

## CHAPTER 5

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### Summary

The purpose of the study was to describe how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients. Descriptive research was selected to explore the opinions and attitudes of clinical practitioners in one clinical setting who diagnose and treat patients suffering from stress and depression using a 26 item questionnaire to survey a small group of therapists to explore the causes for the differences and similarities in treatment based on the variation in disciplines, i.e., psychologist or social worker.

The data collected by the researcher through the survey instrument were presented in Chapter 4 and described how some therapists in a clinical setting differentiate between stress and depression when diagnosing and treating patients. Statistical comparisons were not computed due to the small number of respondents.

The results of Part II of the questionnaire revealed differences in perceptions between Sue and Pam, both psychologists, and Joe and Amy, both social workers. Each question is listed below with a narrative analysis of what the responses imply.



**11. It is easy to differentiate between stress and depression.**

The responses to the statement diverged as shown in Table 2. Both psychologists agreed, both social workers disagreed. The implication may be that even mental health professionals disagree on the seriousness of stress and that psychologists may have better training in identifying the distinctions between stress and depression.

**12. Stress is a less serious condition than depression.**

The two psychologists and one social worker, agreed that stress is less serious while the other social worker disagreed. The implication is that stress and depression are distinguished with proper diagnostic training through formal education and an understanding of the Diagnostic Statistical Manual III Revised.

**13. No one seems to know how to distinguish between stress and depression.**

All four respondents disagreed. The implication is that stress and depression are distinguishable.

**14. Stress leads to depression.**

The responses to the statement were different according to discipline. Both psychologists agreed, while both social workers disagreed. The implication of the varied responses may be that psychologists feel that stress diagnosed and treated early would avoid the patient suffering from depression, as noted in Sue's comment that

"stress can lead to depression if untreated and ignored." The social workers, in disagreeing, seemed to distinguish between the two conditions.

**15. The DSM-III-R clearly defines the differences between stress and depression.**

All agreed that the DSM-III-R definitions were adequate in distinguishing between stress and depression. The implication here is that the DSM-III-R clearly defines both stress and depression and places them in their proper categories.

**16. Stress causes depression.**

Three respondents disagree that stress causes depression. Sue commented that "Stress itself does not cause depression, but depression can result if an individual does not have the skills to cope with stress." One respondent was undecided as to whether stress causes depression. The implication here is that stress does not in itself cause depression. Inadequate coping skills and mechanisms will allow stress to cause depression. The opinion that stress causes depression varies among professionals.

**17. Anxiety and stress are normal.**

All respondents agree that anxiety and stress are normal. The implication here is that stress and anxiety are a normal part of an individual's life.

**18. External forces or internal perceptions of external forces lead to stress.**

All respondents agree that stress is caused by external forces. The implication is that stress is caused by external forces such a lack of daily living skills, employment issues, family and environmental factors, and health, among other stressors.

**19. There is a genetic predisposition that causes depression.**

All respondents agree that a genetic predisposition may exist that causes depression. Sue qualified her response: "Sometimes. Other times, depression cannot be accounted for by genetic predisposition, but is a product of learning." Her implication is that although genetically predisposed, external factors may also play a part in the onset of depression. Every human carries in the gene pool a gene, that when triggered, predisposes a person to depression. This gene can be triggered by both external factors and internal factors.

**20. Stress causes diseases and mental disorders.**

Three agreed and one strongly agreed that disease and mental disorders can be caused by stress. Sue expanded her answer by stating that "If an individual does not possess the ability (skills) to cope with stress or change environmental factors, then such stress can lead to disease and/or mental disorders." The implication here is that if one does not remove himself or herself from a stressful environment, it is more likely that stress will lead to a diseases or mental disorder.

**21. Depression can be cured with medication.**

Although three of the four respondents agreed with the statement, Sue qualified her response by stating, "I dislike the word 'cure.' Depression may sometimes be decreased or successfully treated with medication." Joe disagreed, and wrote, "cured, no." by the statement. The implication was that patients suffering from depression at one point in their lives are more likely to suffer depression later if not monitored after initial treatment. Although a person may appear to have overcome depression under medication, medication is only one way to control depression and retard it from getting worse. Depression is controllable, not curable.

**22. Stress can be relieved by lifestyle changes.**

All respondents agreed or strongly agreed. It may be implied that a lifestyle change to combat normal stress would reduce the possibility of more severe stress and thus reduce the likelihood of depression. Further, the implication is that any change, not matter how insignificant, if it reduces stress, it will reduce the likelihood of depression for the individual.

**23. Stress is a symptom indicating other serious conditions.**

One psychologist agreed that stress is a symptom, while the other three disagreed. The response of the three is surprising in that all agreed that stress causes diseases and mental disorders as stated in item 20. The implication is that more



serious conditions may be ignored if the therapists do not seek the underlying causes of the stress.

**24. Psychotherapy is the best treatment for depression.**

It is interesting that the two psychologists were undecided about psychotherapy as the best treatment for depression while the two social workers disagreed. In expanding on her response, Sue notes that "Sometimes it is. Sometimes medication or other factors such as exercise can best treat depression." In recommending exercise as a treatment for depression, it may be implied that a strong element of stress remains as an indicator of depression. Further, research indicates that a combination of psychotherapy, exercise, diet and medication is the best treatment for depression. The implication is that there may be a different emphasis placed on treatments depending on whether one is trained in social work or psychology.

**25. Psychotherapy is the best treatment for stress.**

The responses were mixed on this item. One psychologist, Sue, was undecided and remarked that, "Sometimes it is. Sometimes, lifestyle changes, education, etc. are the best treatment for stress." The other psychologist agreed with the statement, but the two social workers disagreed. As in item 24, the implication is that there may be a different emphasis placed on treatments depending on whether one is trained in social work or psychology.

## Conclusions

Conclusions may be drawn from the results of the survey despite the limited number of respondents. There were several distinctions between the responses given by the two social workers and the two psychologists.

The results of comments in item 26 of the questionnaire study point toward differentiating between stress and depression in part by differentiating between internal and external causes.

The results of the research indicated that therapeutic disciplines may be inconsistent in teaching therapists how to determine whether a patient suffers normal stress that could lead to depression.

The results also indicated that therapeutic disciplines view stress and depression differently due to education and training. There are several statements where education and training played a role in the perceptions of depression and stress depending on whether the respondent was a psychologist or a social worker. The two social workers, both with master's level education, felt that differentiating between stress and depression was easy as opposed to the psychologists, both of whom held doctorates.

The statement "stress leads to depression" was another area where there was divergence by social worker or psychologist. The two psychologists both felt that stress leads to depression, while the two social workers disagreed.

Agreement that psychotherapy was the best treatment for stress and depression also varied by discipline. Both psychologists were either undecided or agreed, while both social workers believed that psychotherapy was not the best treatment.

Stress was perceived as being caused by external factors found in a patient's lifestyle, such as work and home life problems. Lifestyle changes in diet, amount of exercise, behavioral modification, etc. are recommended to reduce the stress. Depression is perceived as an internal problem whose cause may be biochemical or genetic. Treatments recommended include medication and psychotherapy, but psychotherapy alone was not seen as the sole treatment.

## **Recommendations**

General recommendations are addressed to the mental health facility which provided the population for the research.

1. The practitioners employed by the facility should investigate ways to communicate their views on diagnosis and treatment of stress and depression to each other. Improved communication among practitioners would lead to more consistent treatment for patients.
2. The differences in responses by discipline at this facility indicated that a more comprehensive study with an expanded sample might reveal additional areas where psychiatrists, psychologists, professional counselors and social workers differ in their opinions as to the best way to diagnose stress and depression. This facility

should investigate interdisciplinary training and education to seek agreement on diagnosis, treatment and the role of stress in depression.

3. Future study would might reveal that more emphasis should be placed on educating mental health professionals on the symptoms and treatments for both stress and depression.



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# APPENDIX A

## DIAGNOSING STRESS AND DEPRESSION

## DIAGNOSING STRESS AND DEPRESSION

The following questionnaire is designed to determine your opinions about stress or depression. The answers you provide will be strictly confidential.

Please answer the following by putting a check mark or X in the appropriate blank and return this questionnaire in the enclosed envelope. Thank you for your cooperation.

### PART I - Your Practice

1. Circle Type of Practice:

Psychiatric    Psychological    Counseling    Social Work    Other \_\_\_\_\_

2. Circle Your Age Range:

20-24            25-34            35-44            45-54            55 and over

3. Sex:            Female            Male

4. Education: Indicate your highest level of education:

\_\_\_ B.A. or B.S. degree    \_\_\_ Doctorate  
 \_\_\_ Master's or equivalent    \_\_\_ Post Doctoral  
 \_\_\_ Master's plus grad hours

5. Experience: Circle the number of years you have practiced:

1-5            6-10            11-15            16-20            21 or more

6. Circle Approximate Number of Current Cases:

1-5            6-10            11-20            21-50            51 or more

7. Approximate number of patients with symptoms of depression:

1-5            6-10            11-20            21-50            51 or more

8. Approximate number of patients showing signs of stress

1-5            6-10            11-20            21-50            51 or more

9. I would be willing to participate in a personal interview: Yes No



## PART II - Stress and Depression

The following section asks about how you diagnose and treat stress or depression. Please circle the response that best matches your opinion.

SA = Strongly Agree   A = Agree   U = Undecided   D = Disagree   SD = Strongly Disagree  
Level of Agreement

		SA	A	U	D	SD
10.	It is easy to differentiate between stress and depression.	5	4	3	2	1
11.	Stress is a less serious condition than depression.	5	4	3	2	1
12.	No one seems to know how to distinguish between stress and depression.	5	4	3	2	1
13.	Stress leads to depression.	5	4	3	2	1
14.	The DSM-III-R clearly defines the differences between stress and depression.	5	4	3	2	1
15.	Stress causes depression.	5	4	3	2	1
16.	Anxiety and stress are normal.	5	4	3	2	1
17.	External forces or internal perceptions of external forces lead to stress.	5	4	3	2	1
18.	There is a genetic predisposition that causes depression.	5	4	3	2	1
19.	Stress causes diseases and mental disorders.	5	4	3	2	1
20.	Depression can be cured with medication.	5	4	3	2	1
21.	Stress can be relieved by lifestyle changes.	5	4	3	2	1
22.	Stress is a symptom indicating other serious conditions.	5	4	3	2	1
23.	Psychotherapy is the best treatment for depression.	5	4	3	2	1
24.	Psychotherapy is the best treatment for stress.	5	4	3	2	1

25. What are your perceptions of the differences between stress and depression as seen through the following:  
(Use separate sheet of paper or reverse if needed)

a. Causes:

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b. Symptoms:

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c. Diagnosis:

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d. Treatment:

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e. Description:

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## BIOGRAPHICAL SKETCH

Kevin Burkart was born in Phoenix, Arizona. He attended Coronado High School in Scottsdale, Arizona and after graduation, attended Scottsdale Community College where he received an A.A. degree in psychology. The following year, he moved to Flagstaff for a year's study at Northern Arizona University, followed by study at Arizona State University, where he completed a bachelor's degree in Psychology. With degree in hand, he began work in the corrections field for two years. He accepted a position with McDonnell-Douglas as a government security specialist for six years. He next worked for Smith-Kline Medical Labs as a specimen processor for three years. In 1992, he began the master's program at Ottawa University while working for Developmental Behavioral Consultants, Inc. as a resident treatment specialist. Currently, he works for Westbridge Treatment Centers as a psychiatric technician. With the master's degree, he plans to work under the psychologist while pursuing a Ph.D. and opening his own practice.



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