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The Social Problem of Depression: A Multi-theoretical Analysis

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The purpose of this paper is to discuss the social problem of depression from a multi-theoretical perspective. It explores depression through the lens of two psychologically based theories of human behavior, existential theory and cognitive theory, as well as through the vehicle of two sociological theories, Marxist theory and the theory of oppression. By understanding how each of these theories explains depression, social workers may be helped to see the complexity of treating the problem. It is the belief of the authors that social work literature, which is often dominated by reductionist, quantitatively-based research studies, has increasingly ignored theoretical explorations of key social problems such as depression, to the detriment of the profession and the disciplines which inform it.

Introduction

The purpose of this paper is to discuss the social problem of depression from a multi-theoretical. This work has been undertaken for several reasons. First, each of the four theories presented in this article form a piece of the puzzle for understanding depression as a psychosocial phenomenon. By understanding how each of these theories explains depression, social workers may be helped to see the complexity of treating the problem. Second, the increasing hegemony of psychiatry and privatization in the United States, through the vehicle of managed care, has led to the medicalization of many problems that often have psychosocial etiologies. Thus, other explanations to depression have received little recent interest or articulation. Third, it is the belief of these

authors that social work literature, which is often dominated by reductionist, quantitatively-based research studies, has increasingly ignored theoretical explorations of key social problems. This is lamentable, as theoretical scholarship has had an important place in the building of a social work knowledge base.

The problem of depression

Depression is so prevalent that it has been referred to as the "common cold" of mental illness (Turnbull, 1991). However, unlike the common cold, depression can be fatal, and has been referred to as the world's number one public health problem (Burns, 1980). Social awareness and concern regarding depression can be evidenced by the proliferation of self-help books written on the subject over the past decade (Carrigan, 1997; Greenberger & Padesky, 1995; Larsen, 1989; Katzenstein, 1998; Kramer, 1993; Rosen & Amador, 1996). Since depression is so prevalent, all social workers, regardless of their practice setting and specialization, must be familiar with various aspects of the syndrome.

Depression has been a social problem throughout history. The biblical tale of King Saul, and Homer's suicidal character of Ajax depict examples of major depressive disorders (Kaplan & Sadock, 1998). Depression is seen throughout history in literary and medical arenas (Goodwin & Guze, 1996).

Freud's conception of depression prevailed for the first half of the twentieth century. While the psychoanalytic view of depression is far more complex and detailed than can be presented here, the perspective stresses unresolved conflicts from the past, locked away in the unconscious, as the main determinant of the disorder. Social workers working from this perspective, the diagnostic school, sought to treat depression by helping their clients uncover and resolve repressed conflicts.

The work of Jesse Taft (1933) and the functional school of social work represented a major shift in how depressive moods and other emotional experiences were seen. Taft and the functionalists rejected the notion that emotional problems were the result of unresolved conflicts and intrapsychic pathology. For Taft (1939), emotions were to be accepted and experienced, not changed or blunted. In Taft's conception of maturity and health, the highly functioning individual is able to tolerate a high degree

of emotion without reactivity, without the need to “act them out.” Ideally, emotions are to be tolerated and processed through our consciousness prior to any action.

Challenging the dominance of the diagnostic and the functional schools in the interpretation of depression was the developing medical model. With the advent of modern psychiatric medication, depression began to be seen as a medical disease. Today, the medical model stands as the dominant model for understanding and treating depression. Psychopharmacological developments, through the study of antidepressant medications and their effects on depressive symptoms, have supported the biomedical view of depression and other mental disorders. Medical research has sought to demonstrate that depression is caused by fluctuations in levels of neurotransmitters, which lead to the subjective experience of depression. The medical model seeks to increase levels of these neurotransmitters in an effort to decrease depressive mood. (Kaplan & Sadock, 1998).

For the general United States population, Boyd and Weissman (1983) report that at some point in their lives, 8–12 percent of men and 20–24 percent of women will meet the diagnostic criteria for major depression. Prevalence of depression varies greatly within the population however. Egeland & Hostetter (1993) found the incidence for all types of depression within the Amish community to be less than 1 percent. This variance across populations points to the importance of social and cultural influences in the definition and expression of depression.

Kaelber, Moul & Farmer (1995) compared epidemiological research on depression in dozens of countries and geographic regions. They note that incidence rates for depression range from as low as 1.1 percent in Italy to 12.4 percent in Africa. While depression and other affective disorders are universally shared, their expression varies. Geertz (1973) observes that emotions are indeed “cultural artifacts.”

Existential and cognitive theory: Explanations for depression

Existential theory

Existentialism is a tradition with deep and ancient philosophical roots, shaped by the hopelessness and despair of post-

WWII Europe (Mullan, 1992). Mullan (1992) comments that at the core of existentialism is man's "quest for a reason for existing without recourse to religion or outside authority" (p.554). Man is born into a state of nothingness, out of which he/she creates meaning. Existentialists contend that ideas, including the notion of God, are creations of man's existence (Sartre, 1957).

Sartre (1957) comments that this supposition often leads critics and layman alike to view existentialism as pessimistic in its conception of human nature. However, existentialists contend that just the opposite is true. Sartre (1965) calls this the first principle of existentialism: "Man is nothing else but what he makes of himself"(p. 15). The "authentic man," comes to grips with the reality of his/her existence; he/she chooses to define him/herself and creates him/herself in every action; develops meaning and purpose for him/herself. Existential novels depict characters as finding meaning and purpose in spite of the pain and suffering that surrounds them. Thus, human beings are free to seek meaning and joy in spite of difficult and even oppressive circumstances.

The notion of meaning is central to the existential conception of depression. To Camus (1955), the sense of feeling lost, characteristic of depression, is inherent in the human dilemma; because we are meaning seeking creatures in a world with no meaning, man's position is ultimately "absurd" and can lead to instability. Sartre (1957) believes that man is forlorn due to his/her being "condemned to freedom." That is, without a God that bestows upon us a prior meaning, we are totally and utterly responsible for our own meaning and joy; a painful realization which each human being needs to come to grips with, or escape, through addiction, self-destruction or anti-social acts. Yalom (1980) calls the work of Victor Frankl the most important on the existential notion of meaning. Frankl (1963) observed that those who did not find meaning in concentration camps rarely survived. They gave up hope, were forlorn, and displayed vegetative and dysphoric systems of depression.

Yalom (1980) posits that depression is more a function of an individual's lack of acceptance for personal responsibility in life. He attributes this sense of responsibility to the concept of locus of control. That is, one who accepts responsibly for

creating meaning in his/her life and for his/her own actions can be said to possess a high degree of internal locus of control. Conversely, an external locus of control is a sign of "bad faith," or rejection of responsibility for one's behavior and affect. In his review of empirical research, the author found significant support for the hypothesis that depression and external locus of control are positively correlated.

Cognitive Theory

The earliest roots of cognitive theory can be traced to the Roman and Greek Stoic philosophers. Stoic philosophy can best be summarized by Epictatus (Ellis, 1962) when he proclaimed, "Men are not influenced by events, but by the views they take of events." The Stoics believed that man's rational thinking could be used to overcome the uncertainties of emotions and various problems of existence. This notion lies at the very heart of cognitive theory.

Modern cognitive theory developed along several separate epistemological tracks. This is noteworthy, as cognitive theory is actually a meta-theory incorporating many different theories, each well defined and distinct in its own right (Werner, 1986). The binding thread of each is the centrality of conscious thought in the shaping of human behavior, emotion, and change. Additionally, each of these schools have de-emphasized a positivist perspective in favor of a constructivist view, focusing on the importance of each person's perception in the construction of his/her own reality and psychopathology (Payne, 1991).

Cognitive theory, as with existentialism, eschews the ridged determinism of psychoanalytic and behaviorist schools of thought in favor of a conception of men and women as actors in the drama of their own lives.

Albert Ellis's (1958) Rational Emotive Theory (RET) marks a seminal occurrence in the development of cognitive theory. Ellis's theory holds that people's emotional disturbances are caused by idiosyncratic philosophies and constructed beliefs that lead clients to unhappiness and pain.

Another pioneer in the development of cognitive theory, Aaron Beck (1979), provides one of the most comprehensive yet simple definitions stating that cognitive theory:

consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals. The emphasis on thinking, however, would not obscure the importance of the emotional reactions which are generally the immediate source of depression. It simply means that we get to the person's emotions through his cognitions. By correcting erroneous beliefs, we can damp down or alter excessive, inappropriate emotional reactions. (p. 214).

While both existential and cognitive theories provide much insight into the nature and treatment of depression, cognitive theory's literature is far more extensive. In fact, cognitive based therapies are often considered the treatment of choice for many kinds of depression (Turnbull, 1979).

Beck (1972 & 1976) concludes that the central element of depression is the experience of loss. The depressed individual regards him/herself as missing something that is necessary for his/her happiness. For Ellis (1973), depression is largely caused by irrational beliefs that lead to the experience of worthlessness. Irrational beliefs are those that are both untrue in nature and which lead to feelings that are not helpful to an individual's well-being and survival. The core irrational beliefs that lead to depression are "global evaluations of worth" and "awfulizing." A "global evaluation of worth" is a belief that people can be rated. According to Wallen et al. (1980) people become depressed as they rate themselves as being less than, or no good, based on some of their behaviors, or on their inability to achieve certain goals. Thus, instead of sometimes failing, one becomes a failure. Each successive failure becomes proof of the depressed person's inherent inadequacy.

"Awfulizing" cognitions also result in depression. "Awfulizing" refers to beliefs that exaggerate the "badness" or severity of a situation. For example, an inconvenience or a mild problem becomes a catastrophe. Both of these irrational beliefs can work together in creating/supporting depression. For instance, if someone exaggerates a problem that he/she created, he/she may then evaluate themselves as being a complete and total failure.

While irrational beliefs help us understand how cognitive content can make people depressed, the cognitive view holds that certain cognitive structures or processes can contribute to depres-

sion as well. People who are depressed tend to make the cognitive distortions of selective abstraction (viewing only negative aspects of their behavior), dichotomous thinking (seeing themselves in good and bad terms), and over-generalization (viewing one instance of loss or failure as indicative of an overall pattern of worthlessness) (Bernard and Joyce, 1984).

Marxist theory and the theory of oppression: Explanations for depression

Marxist Theory

Perhaps no thinker in human history has had a greater impact, or has been more misunderstood, than Karl Marx. Fromm (1961) notes that Marx's conception of mankind has been distorted in the United States largely for political reasons. Due in large part to the cold war, Marx's thinking has been discredited and devalued in American thought. When it is discussed, it has largely been relegated to economics or politics. However, according to Fromm, Marx's main concerns were for the liberation of man/women; his focus was the overcoming of alienation and the restoration of his/her capacity to be fully human. Fromm sees Marxist thought as constituting a "spiritual existentialism in secular language," opposed to the coercive and alienating effects of capitalism. Marx's main concern was not economics, but the relationships and effects of economic structures on man and his social relationships. For Marx (Ollman, 1971), a society's mode of production is the determining factor in the creation of consciousness and human relationships. Therefore, economics and labor were not necessarily important as an end in themselves, but as means of understanding human consciousness.

Central to Marx's view of human kind, and most relevant to our analysis of depression, is the notion of alienation. Marx (1844) theorized that, through the processes of the division of labor, the structural hallmark of capitalism, work shifted from being an expression of one's creative capacity to being an activity that made him/her isolated from him/herself. Work becomes merely an object, a means to an end, and stands in opposition to workers' best interests or life plans. This sense of estrangement and disengagement creates a sense of alienation, in that the

object (work) is external, hostile, and powerful independent of the worker. Thus, the worker is oppressed and subjugated in the process of this alienated labor. Work, which was once an outlet for self-expression and a sense of pride, now becomes an alien means toward meeting the economic goals of ruling class elites. Therefore, the worker becomes estranged (alienated) from their work, and in the process from themselves.

According to Fromm (1961) alienation, or estrangement, means that man/woman does not feel that he/she is a part of the world, but that he/she remains alien and separate from the world, from other men and women, and from him/herself. The alienated man/woman is "empty, dead and depressed" (p. 44).

Seeman (1959) breaks alienation into five main components: powerlessness, self-estrangement, isolation, meaninglessness, and normlessness. Mirowsky and Ross (1989) assert that the loss of control and power caused by alienation is a central component to many experiences of depression. They associate depression with the social variables of powerlessness, structural inconsistency, alienated labor, and dependency.

To Marx (Ollman, 1971), alienation did not begin in capitalist societies, but it was within the context of early industrialization that man/woman became most estranged from his/her labor, and thus from him/herself. Marx saw the work of the industrialization as being labor for the sake of production of things not for the purpose of man/woman expressing his/her true nature. In other words, labor became the end, and man/woman became the means. Under previous modes of production, man/woman's use of tools in manufacturing objects was a direct expression of him/herself, controlled by his/her own hands and will. Under industrialization, the machine controlled man/woman's motion; his/her expression and use of intelligence was negated. Postman (1992), in his psychohistorical account of technology, affirms that new technologies, and our relationship to them, affect the way we feel about our lives, others and ourselves.

Theory of Oppression

Research exists which correlates membership in an oppressed group with susceptibility to various mental illnesses, specifically depression (Burns, et al., 1995). Being a member of an oppressed

group makes one susceptible to life circumstances and stressors that leave one vulnerable. Oppression becomes a multiplying psychosocial factor that can lead to an increase in depressive symptoms.

Depression is one of the main impacts of oppression (Allport, 1954; Bulhan, 1985; Chodoff, 1997; Dubois, 1993). Allport (1954) developed the concept of the "intropunitive" response in his analysis of the effects of discrimination. "Intropunitive" responses are the internalization of beliefs about oneself that are propagated by the dominant group. According to the theory, when it is not safe for an oppressed group to express their rage from being the targets of prejudice outwardly, they become "intropunitive" or self-punitive. Allport observed that oppressed people who become "intropunitive" tend to feel intensely insecure, guilty and ashamed, hallmarks of depression.

Foster (1993) calls this perspective the "mark of oppression" theory. He notes that "mark of oppression" theorists focus on the psychological damage created by experiences of oppression. Franz Fanon (1963) an Algerian psychiatrist, observed this phenomenon with clients in Northern Africa. He found that the oppression caused by racism and colonialism was responsible for many types of mental health disorders, including depression. According to Fanon, oppression leads to a "negation of the self," causing one to lose touch with who he/she is. Oppression strips one of his/her humanness, leading to a sense of confusion and despair.

Other commentators in other contexts have observed the internalization of negative concepts about the self as a response to oppression. Passive acquiescence and its concomitant depression are not merely dysfunctional reactions, but necessary for survival (Allport, 1954). For instance, African American slaves who were perceived to be too empowered and too optimistic were treated as mentally ill. Slaves who were passive and exhibited a dysphoric affect were far more likely to survive or escape torture.

The theory postulates that a goal of oppressive systems is to make oppression self-perpetuating. That is, the continuation of oppression is far more likely if the oppressed become their own psychological jailers. In his discussion of the history of slavery and racism in the United States, Burgest (1973) notes that, "the

Africans' psychological and cultural destruction could be perpetuated without much physical coercion for the African's view of himself was dictated by the oppressor" (p. 40).

This phenomenon is not only evident in the context of the third world or historical slavery. For instance, Titmuss (1959) demonstrates that the elite of modern welfare states, who control the means of mass communication, perpetuate notions about the laziness and inferiority of the poor as a means of social control. The welfare state, which primarily benefits the wealthy, is perpetuated in part by the poor's internalization of these social "myths" and resultant actions. By ignoring the structural arrangements of oppression, individuals will tend to blame themselves.

While both Marxist theory and theories of oppression are often seen as arcane, this is more a reflection of current socio/political realities and conservative tendencies within both society and social work, than it is of their utility. In fact, Marxist theory is very relevant today. Postman (1992), utilizing essentially a Marxist analysis, chronicles the changes that are occurring due to industrialization. In countless ways our lives are being altered due to current changes in the means of production. For example, the advent of cyberspace may change the very way people's work lives are organized, and may very well mean a continued deterioration of geographical communities. With the continued deterioration of communities, one might predict increased feelings of isolation, and possibly related depressive symptoms. It has even been postulated that, as geographical or organic communities deteriorate, social work could lose its context for service provision, spelling the "end of social work" (Kreuger, 1997).

Integration

A strength of social work lies in its ability to utilize theories from other disciplines. One of its weaknesses lies in developing conceptual systems for integrating such diverse pools of knowledge. The theories presented here each contribute significantly to understanding the phenomenon of depression, as well as the context of treatment, and subsequent intervention. Can these theories be integrated into a cogent whole?

It is our practice experience that the meta-perspective of cognitive theory can be an organizing principle for each of the theories examined in this paper, as well as other theories of social work practice. This section will present the beginning of a model that goes beyond traditional limitations of cognitive theory, which some construe as "blaming the victim." It is our hope that subsequent investigation may lead to a better defined model that can be validated empirically. Historically, social work has been criticized for producing knowledge that is not cumulative in nature (Greenwood, 1957). It is a limitation of this paper that this integration represents merely the beginning of a process.

Previous work towards the integration of some of these theories has been conducted. Goldstein (1982) argues for an existential-cognitive social work theory. He contends that existential concepts are largely cognitive phenomenon and are essential for social workers to address.

One of cognitive theory's key precepts is that all human knowledge is codified in our beliefs, philosophies and other types of thinking. As we have seen, different types of oppression do not haphazardly affect human emotion and behavior; nor do they do so directly. Instead, oppression affects an individual's cognitive content and structures. As a child internalizes racist messages, he/she develops a negative schema about him/herself, what is possible for his/her future, and the nature of his/her world. Mirowsky & Ross (1989) observed that conditions of powerlessness and alienation can lead to a learned sense of helplessness and the development of an external locus of control.

Kessler and Cleary (1980), as cited in Mirowsky and Ross (1989), make an important contribution to the relationship between distress and social class that has profound implications for practice and this integration. They found that members of lower socioeconomic classes are more effected by life stressors and failures than members of the middle and upper class. They found the variable was not class per say, but the perception of experiences of self-efficacy and control. That is, those in the upper classes had more experiences of efficacy, and thus were less likely to become depressed in response to distressing life events. The poor, however, develop passive styles of coping that

perpetuate their belief in their lack of control. The authors note that medication management for this population may perpetuate the notion of powerlessness. These findings lend support to our belief that clinical and ethical issues in the treatment of depression are interrelated, and need to be part of every client assessment.

Thus, social structures, including medically oriented mental health treatment, can create the belief that one does not have the capacity to regulate his/her own feelings. Oppression creates the sense that one is not able to control his/her fate, and that it is perhaps better not to even try. Social conditions can thus contribute to the creation of beliefs that can be characterized by the existential notion of "bad faith."

Conclusion

These implications lead to several important conclusions for social work practice on both the direct and indirect levels. Clinical social workers must help clients to understand the social context of their depression if they are to be empowered to act to change their lives. Clients who learn to deconstruct the social roots of their depression or other psychosocial problems may be more likely to become involved in their communities to enact change. As social encounters are essential for clients who are depressed, social activism can be seen as a type of clinical intervention, not merely political activism. Further, while we are not arguing that the medical profession is intentionally medicating dissidents or those with alternative political agendas, we may be tranquilizing those who might be more politically active or radicalized if they did find a social explanation for their depression. In this sense, system maintenance is severed through the medicalization of depression. Social workers thus have an obligation to help clients make the important connection between their personal conditions and social phenomenon as a means of social change. Practice that helps the individual become socially active bridges the often segregated worlds of micro and macro practice.

Social workers must also challenge the hegemony of managed care and its treatment protocols. Too often, managed care has dictated treatment for mental health disorders in terms of types of treatments provided, how many sessions are necessary or even the types of theories preferred (Miller, 1994).

In closing, the synthesis of these systems creates several possibilities for the treatment of depression and other emotional difficulties. It allows for an explanation of how social factors directly impact an individual. Further, it points to universal concepts (i.e. bad faith, low frustration tolerance, awfulizing and generalizations) that are causal to emotional problems, and can provide a guide to the treatment process. Additionally, as previously stated, by placing the etiology of these cognitions into the context of the social structures, clinicians can help clients take responsibility without blaming themselves. Lastly, the well-developed methodologies of cognitive therapies can be used to challenge these beliefs; helping to alleviate the painful symptoms caused by the social problem of depression.

References

- Allport, G. A. (1954). *The nature of prejudice*. New York: Addison-Wesley Publishing Co.
- Beck, A. T. (1972). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: Grune & Stratton.
- Beck, A. T., Rush, B. S., Emary, G. (1979). *Cognitive therapy of depression*. New York: Harper & Row.
- Bernard. M. E. & Joyce, M. R. (1984). *Rational emotive therapy with children and adolescents*. New York: John Wiley & Sons.
- Blumer, H. (1971). Social problems as collective behavior. *Social Problems*, 18(3), 298-305
- Boyd, J. & Weissman, A. (1983). Epidemiology of affective disorder. *Archives of General Psychiatry*, 38, 1039-1046.
- Boyle, P. J., & Callahan, D. (1995). Managed care in mental health: The ethical issues. *Health Affairs*, 13(3), 7-22.
- Brussel, J. A., & Irwin. T. (1973). *Understanding and overcoming depression*. New York: Hawthorn Books.
- Buber, M. (1955). *Between man and man*. Boston: Beacon.
- Bulhan, H. A. (1985). *Franz Fanon and the psychology of oppression*. New York: Plenum Press.
- Burgest, D. B. (1973). The racist use of the English language. *The Black Scholar*. September 37-45.
- Burghardt, S. (1986). Marxist theory and social work. In F. J. Turner (Ed.), *Social Work Treatment* (pp.590-617) . New York: The Free Press.
- Burns, B. J., Castle, E. J., Angled, A., Tweed, D., Sating, D., Farmer, E. M. Z.,

- & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14(3), 147-159.
- Burns, D. (1980). *Feeling good: The new mood therapy*. New York: William Morrow and Company, Inc.
- Carrigan, C. (1997). *Healing depression*. Santa Fe, New Mexico: Heartsfire Books.
- Camus, A. (1942). *The stranger*. New York: Alfred A. Knopf, Inc.
- Camus, A. (1955). *The myth of Sisyphus and other essays*. Alfred A. Knopf, Inc.
- Chodoff, P. (1997). The Holocaust and its effects on survivors: An overview. *Political Psychology*, 18(1), 147-157.
- Collins, B. G. (1986). Defining feminist social work. *Social Work*. May/June, 214-219.
- Devore, W., & Schlesinger, E. G. (1991). *Ethic-sensitive social work practice*. New York: Macmillan Publishing Company.
- DiGiuseppe, R. (1981). *Using rational-emotive therapy effectively*. New York: Plenum Publishing.
- Dubois, W. E. B. (1993). The souls of black folks. In Daniela Geoseffi (Ed.), *On prejudice: A global perspective* (pp. 468-471). New York: Anchor Books.
- Egeland, J. A. & Hostetter, S. (1983). Amish study, 1: Affective disorders among the Amish, 1976-1980. *American Journal of Psychiatry*, 140(1), 56-61.
- Ellis, A. (1958). Rational psychotherapy. *Journal of General Psychology*, 59, 37-47.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Stuart.
- Ellis, A. (1973). My philosophy of psychotherapy. *Journal of Contemporary Psychotherapy*, 6, 13-18.
- Fanon, F. (1963). *The wretched of the earth*. New York: Grove Weidenfeld.
- Fromm, E. (1961). *Marx's conception of man*. New York: Frederick Ungar Publishing Company.
- Foster, D. (1993). The mark of oppression? Racism and psychology reconsidered. In Lionel J Nicholas (Ed.) *Psychology and oppression: critiques and proposals*. (pp.52-87). Cambridge, MA: Harvard University Press
- Frankl, V. (1963). *Man's search for meaning*. Boston: Beacon Press.
- Goldstein, H. (1982). Cognitive approaches to direct practice. *Social Services Review*, 56(4), 34-42.
- Goodwin, D. W. & Guze, S. B. (1996). *Psychiatric diagnosis*. New York: Oxford University Press.
- Greenberger, D. & Padesky, C.A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: The Guilford Press.
- Greenwood, E. (1957). Attributes of a profession. *Social Work*, 2, 44-55.
- Kaelber, C. T., Moul, D. E. & Farmer, M. E.(1995). Epidemiology of depression. In E. E. Beckham & W. R. Leber (Eds.) *Handbook of depression*. (pp. 125-146). New York: The Guilford Press.
- Kaplan, H.1. & Sadock, B. J. (1998). *Synopsis of psychiatry*. Baltimore, Maryland: Williams and Wilkins.
- Katzenstein, L. (1998). *Secrets of St. John's wart*. New York: St. Martin's Press.
- Kessler, R. C., & Cleary, P. D. (1980). Social class and psychological distress. *American Sociological Review*, 45, 463-478.

- Kramer, P. D. (1993). *Listening to Prozac*. New York: Penguin Books.
- Kreuger, L. W. (1997). The end of social work. *Journal of Social Work Education*, 33(1), 19–27.
- Larsen, E. (1989). *Overcoming depressive living syndrome*. Liguori, Missouri: Triumph Books.
- Marks, K. (1844). Economic and philosophic manuscripts of 1844. Translated by M. Milligan in 1964. New York: International Publishers.
- Miller, I. J. (1994). *What managed care is doing to outpatient mental health: A look behind the veil of secrecy*. Boulder, Co: Boulder Psychotherapists' Press.
- Mirowsky, J., & Ross, C. E. (1989). *Social causes of psychological distress*. New York: Aldine de Gruyter.
- Mullan, H. (1992). Existential therapists and their group therapy practices. *International journal of group psychotherapy* 42(4), 453–458.
- Ollman, B. (1971). *Alienation*. New York: Cambridge University Press.
- Payne, M. (1991). *Modern social work theory*. Chicago, Ill: Lyceum Books, Inc.
- Postman, N. (1992). *Technopoly: The surrender of culture to technology*. New York: Random House Inc.
- Rosen, L. E. & Amador, X. F. (1996). *When someone you love is depressed*. Simon & Schuster.
- Sartre, J. P. (1937). *Nausea*. New York: New Directions.
- Sartre, J. P. (1965). *Essays in existentialism*. Secaucus, NJ: Carol Publishing Group.
- Seeman, M. (1959). On the meaning of alienation. *American Sociological Review*, 24, 171–184.
- Taft, J. (1933). *Living and feeling*. Child Study, January, 105–109.
- Taft, J. (1939). A conception of the growth process underlining social casework practice. *Social Casework*, October, 72–80.
- Titmuss, R. M. (1959). *Essays on "The welfare state"*. New Haven: Yale University Press.
- Turnbull, J. E. (1991). Depression. In Alex Gitterman (Ed.), *Handbook of social work practice with vulnerable populations*. (pp.165–204). New York: Columbia University Press.
- Werner, H. D. (1986). Cognitive theory. In F. J. Turner (Ed.), *Social Work Treatment*. (pp.91–129). New York: The Free Press.
- Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Harper/Collins Publishers.

