

Understanding Depressive Disorders

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ABSTRACT

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Background: Depression is one of the commonest human experiences, differentiating depression and depressive disorder is of paramount importance in clinical practice.

Objectives: To understand different types of depressive disorder and its diagnosis and management.

Methodology: Descriptive analysis of various types of depression, its evolution, diagnosis and management.

Results: Depressed patients may need to be given antidepressants for at least six months after full recovery. Depression as part of bipolar disorder will require co-prescription with mood stabilizing drugs under supervision of a psychiatrist

Keywords: Depressive disorder, Depression diagnosis, Depression management

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Depression is one of the commonest human experiences. There is hardly anyone who has not felt depressed during his life time. Hence understanding Depression is of paramount importance during our clinical practice. Depression can be part of normal sadness. Similarly depression can occur in various medical illnesses. But Depressive Disorder is a distinct clinical entity. It is different from normal sadness, or the feelings of depression which may be observed when people are medically sick.

Depressive Disorder – History: Depression has been recorded from time immemorial. King Saul in Old Testament is said to have been suffering from depression. Ajax's Suicide in Homer's Iliad points to depression. In 400 BC-Hippocrates, father of medicine has distinguished between mania and melancholia. In 30 AD, the famous Roman physician Celsus had said, melancholia is due to predominance of black bile. In 1854, Jules Falret identified Folie Circulaire, which was a cyclical type of depressive disorder. In 1882, Kahlbaum spoke about Cyclothymia, in which instability to mood was the main feature. In 1889 Kraepelin distinguished Manic Depressive Psychosis (M.D.P) in which there were episodes of mania and depression at different times in the same patient. He also wrote about involuntional melancholia, a type of depression occurring in the involuntional age group.

Coming to the recent times, in 1992 the International Classification of Diseases, 10 the revision– ICD-

10 (authored by WHO), renamed MDP as Mood Disorders, which is the currently used terminology. In 1994, the Diagnostic and Statistical Manual – DSM-IV (authored by American Psychiatric Association) also accepted the term Mood Disorders, which includes both Depressive Disorders & Bipolar Disorders.

Depression Today: is a common illness in all societies. The lifetime prevalence is estimated as 10%. It is the fourth largest cause of burden of disease (years lost to disability/premature mortality). It will become the second largest cause of burden of disease by 2020. It is under-diagnosed and under-treated. It has much higher risk for suicide. Most importantly, it is an eminently treatable condition. It is necessary to understand the difference between the symptom of depression (which can be normal) and the syndrome of depression (which is pathological).

The “Symptom” of Depression: is to feel unhappy, sometimes with depressed mood. It is present in many psychiatric conditions, in physical illnesses and in neurological disorders. Role of life events may be a significant factor here.

The “Syndrome” of Depression: is important and should not be missed by clinicians. Depressed Mood will be the most prominent feature. Others are pessimistic thinking (Depressive Cognition), disinterest or lack of enjoyment (Anhedonia), lowered self-esteem, increased self-criticism, decreased energy and decreased psychomotor activity.

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Depression - Clinical Features: Mood is of misery and there is inability to get reassured. There is a black cloud pervading over their mental activities. Patients may try to hide their depressive feelings. Depressed people show pessimistic thinking. They see unhappy side of every event; foresee failure in work, misfortune for his family, ruin of finances. They may tell you, "Life is not worth living", Death is seen as a welcome relief. Often suicidal ideas and plans, guilt and self blame are also seen. Lack of interest/enjoyment may be prominent. Patients find no enthusiasm for anything, no zest for living and no pleasure in everyday life. Also seen is decreased energy and lethargy. They may find everything an effort. Biological symptoms are characterized by early morning awakening (waking up several hours before morning), diurnal variation (feeling worse in the morning and better in the evening), loss of appetite and weight, decreased libido and amenorrhea (in women).

Recognition of a depressed patient need patience. It involves discussion, enquiry about his worries and beliefs, advising him and providing information, willingness to spend more time and participation of all in clinical team.

Physical illness and Depression: Depression often affects the onset & course of physical illness, produces unexplained physical symptoms, causes Stress, anxiety and worry, and may lead to suicide and Deliberate Self Harm. It can also lead on to alcohol and substance abuse. Thus we must always consider depressive comorbidity when treating medical disorders.

Types of Depressive Syndromes; A large number of depressive syndromes of depression has been described. Some of them can be considered as subtypes. The major ones described are:

1. Major depression
2. Depressive episode
3. Agitated depression
4. Psychotic depression
5. Involutional depression
6. Reactive (or Psychogenic) depression
7. Masked depression
8. Atypical depression
9. Post Schizophrenic depression
10. Recurrent depressive disorder
11. Endogenous depression
12. Depressive Phase of Bipolar disorder I&II

13. Unipolar Depression
14. Cyclothymic disorder
15. Dysthymic disorder
16. Neurotic depression
17. Depressive personality
18. Schizo-affective depression
19. Mixed anxiety and depression
20. Brief depressive reaction
21. Prolonged depressive reaction
22. Periperal depression
23. Depressive conduct disorder
24. Organic depressive disorder
25. Substance Use depression

Basically we are addressing unipolar depression and bipolar depression. The above long list is mentioned to emphasize the fact depression is not a unitary entity. We cannot have a simplistic view about the diagnosis, evaluation, management, course and prognosis of depression. Some of the above categories are not universally accepted but are used in certain regions and cultures. Some are heterogeneous sub-syndromes of depression. These sub-groups cannot be clumped together and a homogenous platform cannot be given.

Aetiology of Major Depression: As mentioned, depression is not a homogenous entity. Biological, genetic and psycho-social factors are important in aetiology:

- Genetic - Family history of depression
- Development - Parental discord, child abuse
- Personality - Neuroticism
- Environmental - life events, lack of support
- Biochemical - There are several theories. The present acceptable view is, major depression is caused by heterogeneous dysregulation of biogenic amines especially Nor Adrenaline and Serotonin.
- Psycho-social factors important in the causation of depression are:
 - Social factors: Unemployment, job strain, social isolation, poor social support
 - Life events: Usually acts as precipitant.
 - Personality: Eg: Hostility contributing to the development and course of I.H.D. and psychiatric & behavioural variables affecting course of illnesses like cancer.

- Depression: is important determinant of compliance with medical care.
- Depressed mood: Major risk factor for death following Myocardial infarction (Frasure Smith-95)
- Life-style and health related behaviour. Eg: Smoking and diet in IHD, healthy life-styles. Here depressed patients may not follow the physicians advice.
- Emotions inducing physical changes: Neuroendocrine and immunological mechanisms in depression is an emerging area of research.

Depression in the medically ill should always be diagnosed as it is known to precipitate or exacerbate the physical condition. Further it can influence course of medical illness, interferes with treatment and can produce additional health risks.

Terminologies in use: Medical practitioners commonly use the term “functional”, to describe emotional problems including depression. What is meant by the term is that functional disturbance is more evident than pathological process. But this is now considered an undesirable term. A better term is “Medically unexplained symptoms”. The advantage is, it describes a clinical problem without assumptions of aetiology. But the disadvantage is, it wrongly implies that there is in fact no medical explanation.

When the term Medically Unexplained Symptom (M.U.S) is used:

- Consider psychiatric factors from outset.
- Appropriate physical investigations must be done.
- Clarify physical and psychiatric complaints
- Assess previous personality
- Understand patient’s beliefs and expectations
- Identify depression or other psychiatric disorders and
- Look for psycho-social problems

Diagnosis of Depression: requires careful and unhurried assessment. The clinician must be compassionate and should encourage the patient to express his feelings. If a majority of the following symptoms are present for at least two weeks, a diagnosis of Major Depressive Disorder can be made:

- Depressed mood
- Loss of interest (disinterest) or pleasure (anhedonia)
- Loss (or increase) of appetite and weight
- Poor (or increased) sleep
- Psychomotor agitation or retardation

- Fatigue or loss of energy
- Poor concentration, inability to think and indecisiveness
- Feelings of worthlessness or guilt about trivial events
- Death wishes or suicidal ideation

Besides the symptoms produce considerable distress and there will be social and occupational dysfunction manifested by inability to perform as well as earlier in his job or work and in interaction with people.

Atypical depression: usually shows increased appetite rather than poor appetite. Similarly there will increased sleep rather than disturbed sleep. Anxiety may be more prominent than depression. Patients may have a variably depressed mood with positive reaction to favourable circumstances.

Dysthymia: is a state of chronic depression characterized by long standing sub threshold depression, which may be fluctuating or persistent in nature. There is gloomy and joyless disposition, lethargy and low drive, low self-esteem and pre-occupation with failure.

Cyclothymic disorder: refers to persistent instability of mood. There is lethargy alternating with euphoria, low self-confidence alternating with over- confidence, mental confusion alternating with sharpened thinking. Such people seeks friends at some time and at other times, they remain self absorbed.

Depression: Differential Diagnosis: Normal sadness should not be mistaken as depressive disorder. Anxiety disorders, schizophrenia etc should also be ruled out. Similarly organic conditions like hypothyroidism have to be ruled out. In older people, there may be considerable amount of memory loss and dementia may have to be excluded. Similarly depressed people may appear as demented, a condition known as “depressive pseudo-dementia”. Such people make a remarkable recovery, once depression is treated.

Depression - Management: Proper clinical evaluation to confirm the diagnosis of depression is important. In academic centres, diagnostic criteria may be applied. In routine clinical practice, this is seldom necessary or feasible. Routine investigations are to be done. Specialized investigations are to be ordered when indicated to detect any co-morbid medical illness.

Antidepressant Drugs: when used with discretion is extremely useful in the management of depression. Adequate trial with adequate doses needs to be given.

Newer and newer drugs with much less side effects are now available.

The major antidepressant drugs are:

- Tricyclic drugs (imipramine, desipramine, amitriptyline, nortriptyline, trimipramine, doxepine, etc.)
- SSRIs - Selective Serotonin Reuptake Inhibitors (fluoxetine, sertraline, fluvoxamine, citalopram, paroxetine)
- SNRIs - Serotonin Norepinephrine Reuptake Inhibitors (venlafaxine, milnacipram)
- MAOI - Mono Amine Oxidase Inhibitors (Phenelzine)
- RIMA - Reversible Inhibitors for Mono Amine (Moclobemide)
- NARI - Nor Adrenaline Reuptake Inhibitors (Reboxetine)
- DNRI - Dopamine Noradrenaline Reuptake Inhibitors (Bupropion)
- NaSSA (Mirtazapine)

Tricyclics have the advantage of being potent, low costs and decades long experience by clinicians. But patients may experience uncomfortable anti cholinergic side-effects.

SSRIs are now being extensively prescribed. Convenience of administration, lesser side effects and tolerability are advantages. They are useful especially in mild and moderate depressions and appropriate for all degrees of depression to initiate treatment. SSRIs are first line agents for:

- Depression in general population
- The elderly
- The medically ill
- Pregnancy
- No SSRI may be superior to another
- Poor response to one SSRI → 50% responds better to another SSRI.

SSRIs – Adverse Effects: SSRIs have markedly better adverse effect profile, but nervousness, agitation, poor sleep, GI symptoms, sexual dysfunction are more common.

- Sexual dysfunction which is often dose dependent. There can be delayed ejaculation and inhibition of orgasm.
- Weight gain (due to drug, due to increased appetite and better mood).
- GI side effects: Stomach pain, diarrhoea, nausea.
- Sleep disturbance.

Severe depression: drugs like Venlafaxine, Mirtazapine and tricyclics may be better. Besides augmentation with Lithium, T3/ T4, anti convulsants like sodium valproate/ carbamazepine etc may be useful.

Role of ECT

- ECT is an important lifeline.
- Refractoriness may vanish.
- Especially useful in developing nations.

Indications:

- Depression with suicidal risk,
- Depressive stupor,
- Postpartum depression,
- Depression with distress & agony
- Resistant depression
- Psychotic depression

Every physician and general practitioner should be aware about the beneficial effects of ECT in depression. It is life saving in patients with severe depression who have suicidal ideation, because antidepressants take 2-4 weeks for beneficial effects, whereas ECT gives almost instantaneous relief.

Role of Psychotherapy: Psychotherapy is a very useful treatment option, especially in less severe forms of depression. Cognitive behavioural therapy (CBT), Supportive psychotherapy and interpersonal therapy are some of the types used. It has the disadvantage of being time consuming and less cost effective. But elements of supportive psychotherapy need to be practiced by every physician, who is treating a depressed patient.

CONCLUSION

Depression is under diagnosed and under treated in our country leading to increased mortality and morbidity. If left untreated, depressed patients may resort to suicide, leading to loss of valuable life. Depressed patients may need to be given antidepressants for at least six months after full recovery. Depression as part of bipolar disorder will require co-prescription with mood stabilizing drugs under supervision of a psychiatrist. Similarly recurrent depressive disorders may also require specialized care. When management is difficult it is worthwhile to refer to a colleague psychiatrist.

But majority of the depressions can be managed by general practitioners and physicians, giving valuable

quality of life to our patients. Affordability by the patient should be an important consideration when prescribing, leading to better compliance.

END NOTE

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