Major depressive disorder: causes and treatments

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Introduction

Often referred to as the common cold of psychopathology, depression, or major depression disorder, is a state of sadness characterized by feelings of worthlessness, hopelessness, despair, and withdrawal from others that has a constant interference on the lives of those suffering. Depression is usually accompanied by low energy, loss of interest, pain, and low self-esteem. Behind lower back pain, depression is the second highest cause of years lived with disability.

Diagnostic Criteria

As stated in the DSM-5, major depression disorder needs five, or more, of the following symptoms, over a reoccurring two-week tie period and must represent a change in previous functioning of life. In addition, one of those five symptoms must be either a loss of interest or pleasure, or a depressed mood. These symptoms include; (1) a depressed mood most of the day, nearly every day, as indicated by subjective report or by observations by others, (2) a diminished, or loss, in interest or pleasure in all, or almost all, activities most of the day, nearly every day, sometimes referred to as anhedonia, (3) weight loss or gain, or an increase or decrease in appetite, (4) hypersomnia or insomnia, (5) psychomotor retardation or agitation, (6) loss of energy, (7) feelings of inappropriate or excessive guilt, or worthlessness, (8) indecisiveness, or lack of concentration, and (9) suicidal thoughts, usually reoccurring without a specific plan, or a specific plan for committing suicide. These symptoms must be present during the same two-week period and

cause impairment in occupational, personal, and social life settings (American Psychological Association, 2013).

Most criterial symptoms of major depressive disorder must be present nearly every day to be considered present, with the exception of suicidal thoughts or intention, and weight change. Depressed mood must be present for most of the day. Insomnia, or fatigue, is a complaint that is usually present. The lifetime prevalence of major depressive disorder ranges from 5%-17% and the prime, or average, onset is mid to late 20s. Females are usually more prevalent and experience a 2-3 times more of a chance to be diagnosed. An average major depressive episode typically lasts for approximately three to five months, and 80% of those diagnosed with this disorder will experience another episode up to an average of four episodes throughout their lifetimes (Depression and Anxiety Issue Information, 2017).

Historical Considerations and Differential Diagnosis

The diagnosis of depression go back as far as to the times of the Ancient Greek era. A renowned physician, by the name of Hippocrates, described a syndrome of melancholy, as a disorder with certain physical and mental symptoms (Hippocrates & Coar, 1982). The actual term depression was not used until the late 14 th century, where it was derived from the Latin verb to press down, or deprimere (Depression, 2003). The first DSM, published in 1952 had content of depressive reaction and then further evolved into depressive neurosis as stated in the DSM-II (1968). Major depressive disorder was introduced into the DSM-III, (1980). However, since 1980, the DSM-III and DSM-IV classified all depressive disorders under bipolar and related

disorders, but was not until 2013, DSM-5 where they separated the chapters giving depressive disorders acknowledgement (American Psychological Association, 2013).

There are different diagnosis that all physicians should be aware in order to prevent miss or over-diagnosis in relation to major depressive disorder. There is a distinction between manic episodes with mixed episodes, and that of major depressive episodes due to the symptoms, and thus requires careful clinical evaluation to not confuse the two in the diagnostic period. When observing mood disorders, a physician must make an appropriate diagnosis an episode if it is based on individual history, laboratory findings, physical examination, and if the mood disturbance is unbiased and not judged. These observations, if present, will prove to be a pathophysiological consequence of a specific medical condition such as a stroke, multiple sclerosis, or even hypothyroidism.

A huge diagnosis mistake made by physicians, is a substance or medication induced depressive or bipolar disorder, meaning that toxins, medication, or even drugs, appear to be present and related to the disturbances and alterations of mood. ADHD, or attention-deficit hyperactivity disorder, can cause the symptom of a low frustration threshold and definitely can cause distractibility. These symptoms can be present in both diagnosis, but the clinician must differentiate the two by observing if the mood disturbances are caused by irritability and not loss of interest or depression.

Treatment Options

The three most common forms of treatment for major depressive disorder include, anti-depressants, electroconvulsive therapy, and psychotherapy being the main treatment choice for those under the age of 18 (Marchand, 2012). With psychotherapy, there are many variants that can affect and be administered to groups, individuals, or families. These variants include the basic psychotherapy, as well as cognitive behavioral therapy, mindfulness-based cognitive therapy, and rational emotive behavior therapy. The most common of these therapies is cognitive behavioral therapy, or CBT. This form of psychotherapy teaches and encourages clients to change counter-productive behavior, by challenging their thoughts of self-defeat with enduring cognition of positivity. Occupational programs, like CBT, have been shown to reduce sick days taken by working class depressive clients.

Anti-depressants are typically used in people with all ranges of depression, from mild or acute to moderate. However, evidence has been shown that there is a stronger usefulness in the treatment of severe and chronic depression, dysthymia. The primary anti-depressants prescribed are selective serotonin reuptake inhibitors, SSRIs, and are typically less toxic than other anti-depressants in relation to overdosing.

Electroconvulsive therapy, ECT, is a psychiatric treatment not only used for depressive disorder, where patients are exposed and treated with small surges of electricity that induce seizures to provide relief from their disorders. ECT is referred to as the last defense or treatment option, and must be used with informed consent before the start of treatment. Common side effects of electroconvulsive therapy include similar symptoms to that of general anesthesia, memory loss and confusion.

Controversies

The biggest controversy with major depressive disorder, or any depressive disorder, is are the clients really suffering from a disorder, or are they just experiencing long periods of sadness. The mood in a major depressive disorder episode is described as being down in the dumps, experiencing hopelessness, sadness, depression, and are usually discouraged. The sadness, again being controversial, can only be determined by interview, and may be denied at first by clients. There are a wide variety of relative terms used for the episodes of major depressive disorder, but a reoccurring answer found by clinicians is that individuals complain about having anxiety, no remorse or feelings, and often describe their mood as blah. Now sadness, or periods of sadness are inevitable aspects of human life. These episodes should never be self-diagnosed until criteria has been met for severity with a mental health professional (Field, 2014).

Prognostic and Risk Factors

A well-established risk factor is negative affectivity, or neuroticism. Meaning that individuals render a higher risk of depressive disorders and can develop them through a cause and effect relationship with stressful or anxious life events. An uncommon risk is environmental, and usually only affects childhood diagnosis due to adverse childhood exposure of diverse types, which constitutes a potential risk. A precipitant of major depressive disorder that is well recognized are stressful life events that can have negative repercussions on individuals. These events are controversial in prognosis and treatment because the absence or presence near onset cannot be ratified as

a useful guide to diagnosis. Biological, genetic and physiological factors, is a risk factor that has been thoroughly researched within the fields of major depressive disorder. Family members of the first-degree have a two to four higher chance of being diagnosed with major depressive disorder than the general population. Neuroticism, being a personality trait, is a substantial portion of the approximate 40% heritability and thus makes it a genetic liability if individuals are exposed.

Suicidal risk is a possibility that exist at all times during episodes of major depression, and should be approached very carefully by not only clinicians, but the sphere of influence the individual might interact with. There are social, and environmental factors associated with suicide, being sexual activity, hopelessness, or living alone. Studies have also proved that the presence of borderline personality disorder can increase the risk for suicidal attempts during future episodes (Wodarski, Dulmas & Wodarski, 2003).

Conclusion

Major depressive disorder is huge risk to the rates of comorbidity in the United States, and the general public should be aware of the symptoms and the impairment that affects the individual’s life. A disorder that can affect a total of 5%-17% of the population at any given time, should rise more attention and help to those suffering. There are a lot of functional consequences that derive from individual symptoms, and the impairment can range from mild to catatonic, or mute. Meaning, that if one can notice symptoms, seeking help could be the most beneficial thing for those

individuals who are too afraid, or are contemplating suicide to permanently end their temporary problem.

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