Editorial

Depression – The Global Crisis

With the backdrop, Depression – The global crisis, as the theme for the year 2012–2013, this is an attempt to compile some clinical pearls, a few loud thoughts, lingering dilemmas, myriad questions, current challenges, research questions, and tomorrow's optimism!

WHO – Depression will be the second most common cause of disability by 2020, and the first by 2040!

Sadness may be adaptive, in the evolutionary sense, by permitting withdrawal to conserve inner resources or signal the need for support from significant others.

Hippocrates (460–357 BC) described melancholia. The first English text entirely devoted to affective illness was Robert Burton's "Anatomy of Melancholia" published in 1621.... described "causeless" melancholia.

Sartorius, in 2001, predicted the prevalence of depressive disorders would increase in the years to come, citing various reasons. *Did it really increase in the last decade?*

The international consortium of psychiatric epidemiology interviewed 37,000 adults in 10 countries (USA, South America, Europe, and Asia) using WHO composite international diagnostic interview and found the lifetime prevalence of depression for adults varied from 3% in Japan (the country ravaged by the series of war, earthquakes, tsunamis, economic slowdown, and with high rates of suicide) to 16.9% in USA. *Fashion of the day will be to dismiss this difference due to methodological issues. Probing into the reasons for this striking difference in these two developed countries may offer useful insights, data invaluable for primary prevention of depression in the population*.

Depression is a risk factor for type II diabetes mellitus, and cardio vascular and cerebrovascular disorders, and a bidirectional positive association has been assumed. Depression is an independent risk factor, and the mediating factor could be hyper cortisolism / Dysregulation of HPA axis.

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DSM IV TR makes no provision for family history and history of past episodes. In clinical practice, these factors would strongly weigh in diagnosis of depression.

"Recurrent" episodes of behavioral abnormality – consider always the diagnosis of mood disorder as the first choice. Recurrent schizophrenia is described, but is an uncommon presentation.

Is MDD with psychosis mostly misdiagnosed as schizophrenia?

One-third of depressive patients fulfill the diagnostic criteria for a personality disorder, most commonly of obsessive–compulsive personality.

40% of patients with depressive disorders have anxiety disorders/alcohol abuse as co-morbidity.

Kraeplin believed that no more than 5% of patients with mood disorders have chronicity, whereas the current figures show chronicity going up to 30% – *? Reasons*

Akiskal *et al*., in 1978 - reported that in a 3-year follow-up of 100 patients diagnosed with neurotic depression, 18 developed bipolarity, 36 had revised diagnosis of endogenous depression, and 42 showed episodic course.... *The classification into endogenous - reactive subtypes seems to be passé and mood disorders are best conceptualized as endoreactive, unitary model of Major Depressive Disorder (MDD)*.

The increasing clinical diagnosis of depressive disorders should not be dismissed as mere therapeutic fad. External validating strategies, such as genetic and prospective follow-up studies, buttress the broadened concept.

In dysthymic and cyclothymic disorders, representing milder forms/intense temperamental instability, impairment is not due to the severity of mood disturbance *per se*, but to the cumulative impact of the dysregulation beginning in the early years and continuing unabated or intermittently over long periods. The sub-threshold conditions appear to be fertile terrain for interpersonal conflicts and post-

affective pathological character development that may ravage the lives of patients and their families.

Evaluation of suicidal risk in the individual patient is the single most important and priority factor in the assessment and treatment plan of depression.

About 60%–70% of people who commit suicide suffer from depression.

Angst *et al*. in 2005 reported that in a 40-year follow-up of 406 patients with mood disorders from 1963 to 2003, 11.1% committed suicide.

FDA commissioned an independent group of investigators at Columbia University following case reports in the 1990 on new-onset suicidality with fluoxetine. It reviewed 4400 patients in 24 studies. There were no completed suicides; however, the risk of suicidal ideation or activity was 4% on active mediation and 2% on placebo. Grunebaum *et al*. in 2004, in an analysis of US registries for the years between 1985 and 1999, found that prescription of SSRIs..… was inversely associated with suicide rates. Gibbons *et al*. in 2007 reported that suicide rates have increased in the USA, possibly secondary to decline of antidepressant prescription due to FDA black box warning!

Suicide prevention at the national level, attributed to the widespread use of SSRIs and primary care physician education, has been achieved in many but not all European countries.

ANTIDEPRESSANTS

a) May increase suicidality (even suicidal events) in some individuals early in treatment (Healy and Whitaker, 2003)
b) Decrease suicidal rates on a population basis (Ludwig and Morcotte, 2005).

A conclusion with enormous power highlighting the science in evidence-based medicine in particular, and allopathy in general.

Outcome studies coming form university centers tend to overestimate the proportion of cases with less favorable prognosis, and undeniably, many patients seen in private practice experience a favorable outcome. Not unexpectedly, current data indicate that depressed patients treated by psychiatrists in private settings receive much better care than those in other settings – *Some relief from the pessimism of STAR*D; Rejoice Oh Private Psychiatry!*

Fluoxetine, I personally believe, revolutionarized pharmacotherapy of depressive disorders and to a certain extent psychopharmacology in general.

"Listening to Prozac" seems to have added new insights to the management of depressive disorders.

Choice of antidepressant is still highly determined by the side effect profile – "clinician- and patient-friendly" drug.

"All antidepressants are equally effective" – *Clinicians disagree!*

Monotherapy is the preferred choice – Start treatment with only one antidepressant!

About 15% of patients with depression commit suicide. Lithium is the drug proven for its antisuicidal effect (the other one being clozapine), but is *never recommended as the first-line treatment in MDD/unipolar depression. Sir, But why?*

Electro Convulsive Therapy (ECT) is highly effective, rapidly so, in the management of suicidal, retarded, depressed patient.

Mother of all frustrations, to the patient and to the psychiatrist, is in the delay of antidepressant response for 3–6 weeks.

The average length of MDD is about 6 months and the mean number of episodes in a lifetime is about 6.

Two common causes of treatment failure are
a) Inadequate dosing of antidepressant
b) Too brief treatment trial – STAR*D – half of the patients who ultimately responded did so after 6 weeks.

(6 the magic number – 6 weeks of acute treatment, 6 months of natural course of depression, average of 6 episodes in a lifetime)

It is important not to mistake a chronic or recurrent depressive disorder for an Axis II disorder, because treatment objectives and strategies are different in each case.

Treatment compliance fluctuates in antidepressant therapy – Skeptical in the first 3–6 weeks till the patient responds, highly positive in the next 2–3 months, followed by negligence (I can manage now…) and irregular medication, and abrupt stoppage. Psychoeducation with family involvement is the key to improve compliance.

Unfortunately, findings published by Martin Keller *et al*. in the 1980s documenting gross under treatment of mood disorders continue to describe the current

treatment landscape worldwide. Henkel *et al*. in 2005 documented the delayed and relatively infrequent use of antidepressant treatments.

Adolf Meyer's terminological revision (from "melancholia" to "depression") left a somewhat confusing legacy, in that the term DEPRESSION is now applied to a broad range of affective phenomena ranging from sadness and adjustment disorders to clinical depression. *This semantic confusion about the term depression, and the resulting conceptual imperfection about depressive disorder could be the reasons for under treatment, especially with pharmacotherapy.*

It is doubtful that negative cognitions alone could account for the profound disturbances in sleep, appetite, and autonomic and psychomotor functions encountered in melancholic depressions. To interpret depressed patient's passivity as "manipulative" is disrespectful of the clinical agony of patients with mood disorders.

Nearly half of the cases of depression, just like those with adult-onset diabetes, remain undetected for years or inadequately controlled. This is all the more scandalous because the last quarter century witnessed a phenomenal increase in the manpower and also availability of user-friendly antidepressant drugs and also depression-specific psychotherapies.

It is to be regretted that despite the destigmatization efforts and a rich armamentarium of therapeutic developments, the clinical care of affectively ill patients at the severe end of the spectrum continues to be grossly inadequate… demanding …… depression to be addressed with clinical and public health policies.

SCIENTIFIC TRUTH IS A FUNCTION OF ITS TECHNOLOGY

Depressive disorders – black bile, witchcraft, intrapsychic conflicts, learned helplessness, negative cognitions, monoamines, and molecular biology to neuro-circuitry – had a long tortuous journey.

THREE WISHES FOR TOMORROW!

1. *An antidepressant effective in 5–7 days*
2. *A diagnostic test for clinical depression*
3. *A campaign to defeat depression globally*

(This paper mostly has excerpts from the two textbooks cited in the reference, with limited personal expression interwoven.)

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FOR FURTHER READING

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