Clinical Depression A Diagnostic Puzzle

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With an under reported prevalence of seven percent (7%), clinical depression gets to be a very serious and dangerous player in the health arena. Let's consider the fact that it is the most costly condition for this nation, after you factor in not only direct cost but also time away from work, loss of productivity and disability payments. It carries an immortality rate of fifteen (15%) percent (by suicide), putting it up there with many kinds of cancers.

Not to mention that many of our reported accidental deaths could be a result of a suicide attempt. In fact, suicide is the first cause of death in our youth (ages 14-24), if you exclude accident of all kinds (alarming isn't it!). When you consider as well that it is probably greatly underdiagnosed and undertreated, as a clinician you cannot help but to wonder what to do to help alleviate and control this epidemic.

We can start by shaping our diagnostic skills in these regards. Differentiating between a depressive reaction to a stressful situation and a depressive disorder, is not as easy as it might seem. Especially if you take into consideration the wide clinical spectrum you can encounter. The closest condition to consider would be an Adjustment Disorder with Depressed Mood. As implied by the descriptive name, it is a response to a known stressor and you also need a depressive syndrome of less than six months duration.

Such syndrome might present itself with many faces; anywhere from the somatizing patient to the dysphoric, sad, irritable and insomniac ones. Crying spells are common as well as cognitive deficits (memory and concentration) as well as appetite changes. You need to start listening carefully when the dysphoria is accompanied by feelings of worthlessness, hopelessness and helplessness (the latter a common denominator for suicide). Especially if the death wishes and suicidal ideation are present. Something good to look for is anhedonia; the inability to enjoy any particular activities that were previously enjoyed. Lack of energy and motivation are also common as well as a degree of ambivalence and the list can go on and on.

Major Depressive Disorder is a mood (affective) dysfunction, you can expect all of the above signs and symptoms and much more. There needs to be at least two weeks of such agony and the main differentiated factor might be the severity of symptoms. Look for any prior episodes (recurrent) as well as a family history of depression. And do not be surprised with the presence of psychotic symptoms; hallucinations, delusions and melancholy can be a devastating combination. Pay special attention to auditory hallucination of the self-derogatory, command type. This would be considered a high-risk group for suicide. Prior attempts, middle aged single Caucasian male (especially if separated, widowed or divorced) makes a stand out profile. Inquire about availability of weapons, support systems, religious believes and the consumption of drugs or alcohol.

All of these might spell RISK! Do not forget that although females are three times as likely to attempt suicide, males are three times as likely to be successful at it. If need be, let's err on the safe side.

Dysthymia is another Mood Disorder, which implies a chronic course (at least two years of duration). And a predisposition for acute depressive bouts (double depression). A lot of dysthymic will complain of anger and irritability rather than sadness and depression. Poor self-esteem, dependency and poor coping skills are common as well as problems with interpersonal relationships. Dysphoric seldom describe periods of happiness and if they have experienced them, it is short lived (a week to two at the most). Some experts speculate that this is more of a Depressive Personality Disorder than anything else, but this is still controversial.

Since I brought up the issue of Personality Disorders, let me clarify that the most common single factor related to refractoriness to conventional antidepressant treatment is comorbidity. Of all the comorbid conditions the one mostly tied up to the same are character-logical or personality dysfunction's. The patients can present as Histrionic, Dependent, Passive-Aggressive, Paranoid, Self-defeating and potentially worst of all, Borderline.

I want to avoid at this time going into the different Personality Disorders since this topic in itself can occupy all the space in this publication (perhaps it might be more appropriate at a different time in an upcoming issue). Just keep these comorbid conditions in mind since these patients do not do well at all and

the prognosis is quite guarded. The same could be said as well for comorbidity related to drug and alcohol abuse, which again in itself could be a separate topic.

Well, I was hoping I would have time (and space) to go into treatment but given how much I have covered, I feel it would be better to leave for a "second round." Let me just add that most people respond very well to conventional anti-depressant treatment. This is both psychopharmacological and psychotherapeutic intervention. Some studies have quoted up to eighty-five percent (85%) response rate especially if you end up applying both modalities of treatment. For those who do not respond well enough to an acceptable degree, well-developed augmentation techniques, as well as the safe and improved procedure of Electro-convulsive Treatment (ECT). This is as far as I will go this time, I hope I will have the opportunity to address you all again and cover the topic of treatment in more detail.