

CLINICAL AND EVOLUTIVE ASPECTS IN PATIENT WITH MONOPOLAR DEPRESSION

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Abstract:

Objective: Recurrent depressive disorders are the most prevalent psychiatric disorders worldwide and in consequences this fact raise several major problems related to public state of health. Our main goal was to establish a clinical and socio-demographic profile of patients with recurrent depression admitted in our Clinic.

Material and method: We conducted a retrospective study on 136 patients admitted in our Clinic during 2001-2003 with diagnostic of recurrent depressive disorders according with ICD-10 criteria. The results were statistical analyzed.

Results: Recurrent depression was more prevalent in females than in males, males developed more sever clinical forms than females including psychotic features. Professional status was significant impaired by depression while marital status didn't indicate important changes. Psychotic depression was present just in almost one third of all depressive patients. Personality has had just a limited and guiding role to predict severity of depression. Somatic comorbidities were very important both at the onset but especially after several years of depression.

Conclusion: Some data resulted from our study confirm data from international literature. Depression has a differential impact on subjects with depression, professional status being the most impaired due to academic disabilities related to depressive disorders. The suicidal risk was direct correlated with instructive level and with severity of depression. The high prevalence of somatic comorbidities could indicate both the effect-causal relation between depression and some somatic illnesses or the two different fenotypical aspects of the same genotype. Finally both pathological conditions require equal attention by clinicians.

Introduction

Various epidemiological studies carried on during time have indicated that the morbidity profile worldwide, apart from several peculiarities related to the ethnical and social-economical groups also has a certain dynamic inside the groups. This dynamic of the epidemiological profile is, alt least partially due to the social and technological progress, and it is to presume that as soon as the globalization extends, the profile will become more similar regardless of the peculiarities of the groups. One of the most wide-spread disorders, that has a trans-generational and trans-cultural character is depression. We must also take into consideration the pathoplastic variable of the ethnic background, that makes depression take several forms of clinical manifestation, a fact that can lead to complications in the design of the epidemiological studies.

Even if on a less scientific note the perturbation of the affective disposition has been described almost 2,500 years ago, the World Health Organization has only recently given the necessary attention to the disturbances of affective mood, placing them on the fourth place on the list of the most urgent health problems to be address worldwide. This is mainly due to the harmful effects of depression

Another estimation of the WHO has shown that in the year 2020 depression will become the second cause for disability after heart diseases induced morbidity.

From a categorical approach, we can say that the syndromes of depression can be found in a large variety of psychic disturbances, as: mourning, adaptation disorders (more precisely, the depressive reaction), depression associated with the use of psychoactive drugs (during both consume and withdrawal periods), drug induced depression (e.g. by interferon, cortical steroids, oral contraceptives, etc), depression induced by a somatic illness (a systemic illness with consequences upon the functioning of the CNS, like the Cushing disease, or a primary neurological illness associated with depressive symptoms), and so on. In the next pages we will address the problem of major depression in the frame of affective mood disorders, according to diagnostic criteria of DSM-IV and ICD-10.

Despite the fact that major depression is one of the addressable psychic disorders, we should mention some problems related to the diagnostic and the natural course of depression. Unfortunately, depression is often under diagnosed because of the presence of other psychic disorders, due to its' complex clinical picture. Specifics related to age should always be taken into consideration, as some subjects from extreme age groups can be sometimes mis-diagnosed. For example, depression in children is often manifest thorough an irritable disposition, while depression in adolescents can take the form of behavioral modifications, or educational failure (due to the extremely important impact of the depression upon the cognitive functioning), and in elderly people it is often discussed the problem of masked depression (confusion with somatic complains and the neglect of depressive mood). Even it is less "trendy" this concept is now discussed again by the international experts, possibly due to the significant economical consequences it has, induced by the large (and often inefficient) use of the health services by this category of patients. The second problem discussed concerns the natural course of major depression, an illness with high recurrence. Studies have indicated that 30% of the patients remain depressive one year after the disorder has been first diagnosed, 18% after two years and 12% after five years. On the other side, even the response rate to antidepressant medication is high (according to some studies up to 75-80%), 50% of the patients will still experience at least one depressive episode in the future. We should also consider the problem of the resistant (to medication) depression, for which the most common causes are: associated comorbidity (either with another psychiatric disorder, especially alcohol consumption and personality disorders, or with some somatic illnesses, like HTA, diabetes mellitus, digestive diseases, etc.), the lack of an adequate therapeutic treatment (related to the administered medication's dose and period of administration) but also the lack of social support (especially for elderly people, who, apart from the loss of professional and social status through retirement must also face loneliness).

A major economic problem of general interest, as well as a direct consequence of depressive pathology, is the aspect related to the (direct, but especially indirect) costs for depression. The direct economic costs are caused by the early death (e.g. accomplished suicide), hospital treatment costs, while indirect costs, which are a lot higher, are caused by the reduction in the work productivity and loss of working time. In USA the direct annual costs (for hospitalization, drug therapy, consultations) for treating depression are estimated at 12.47 billion USA dollars. In Great Britain, the excessive morbidity induced by depression is estimated at 4.7 billions sterling/year, while in Canada the indirect costs of depression (reduced work productivity) are estimated at 2.53 billions Canadian dollars. This is one of the reasons in many countries there is widely recognized the importance of diagnosing and treating depression.

The present study has the aim to identify the clinical and course particularities of depression and the social and demographic characteristics of the patients population in the Western part of Romania.

Materials and method

The study is a retrospective one, carried on a sample of 136 patients hospitalized in the Timisoara Psychiatric Clinic during the years 2001-2003 with a diagnosis of Recurrent Depressive Disorder, established according to the ICD-10 criteria.

Inclusion criteria;

- A diagnostic of Recurrent Depressive Disorder established according to the ICD-10 criteria;
- At least two years of evolution;
- Age between 18 and 65 years

Exclusion criteria:

- Comorbidity with other psychiatric disorders, according to the ICD-10 criterial
- Less than 2 years of evolution
- Age under 18 or over 65

Have been collected a series of clinical and socio-demographic data:

- The diagnostic of the present depressive episode, according to the ICD-10 criteria;
- Personality traits have been recorded based on the catamnesis data, of the psychological exams performed during previous hospitalizations and (sometimes) on the recorded diagnosis. All data have been transferred and recoded according to the PAS-I Interview criteria (ICD-10 version).

- Heredo-colateral and personal history;
- Somatic comorbidity
- The total number of episodes
- The number of hospitalizations, the total length of illness course, the age of the subject at the onset of the depressive disorder;
- The marital and professional status of subjects at onset and at the date or present examination.
- The presence in the subject's biography of stressing events previous to the psychiatric illness' onset in terms of loss-type (real and/or symbolic) events and danger type events.

The assessment of suicide risk was made using three grades of severity:

0 – lack of suicide ideation = no suicide risk

1 – suicide ideas and/or suicide plans, as reported by patients – average or minimal suicide risk

2 – previous suicide attempts – maximal suicide risk

Statistical tests performed:

- According to the results of the Liliefors normality test, data is normally distributed. For further results we will use parametric tests, namely:
- The χ^2 for comparing frequencies;
- The T (Student) test for independent samples;
- The Pearson correlation test.
- Were also calculated numeric and percent frequencies, central tendencies and standard deviations.

Results:

1. *Social and demographic data for the studied sample:*

1.1. *Subjects distribution on sexes:*

Tab. I Distribution on sexes

Females		Males	
No.	%	No.	%
104	76.5	32	23.5

The χ^2 test indicates that females more frequently present Depressive disorder without psychotic symptoms than men ($\chi^2 = 6.14$, $p = 0.013$).

1.2. *Distribution of subjects according to the residential area:*

Tab. II Distribution of subjects according to the residential area

Residence			
Urban		Rural	
No.	%	No.	%

Residence			
Urban		Rural	
112	82.4%	24	17.6%

There are clearly more subjects from the urban area. This is not to say that depression is less frequent in rural areas, but, it is possible that due to the cultural specifics, of the social level and the educational level, the depression in rural areas is more often manifest through somatic complains and can be masked under other diagnostics (somatization disorder, conversive disorder, etc).

1.3. Distribution of subjects on age groups (age at the onset of the depressive disorder)

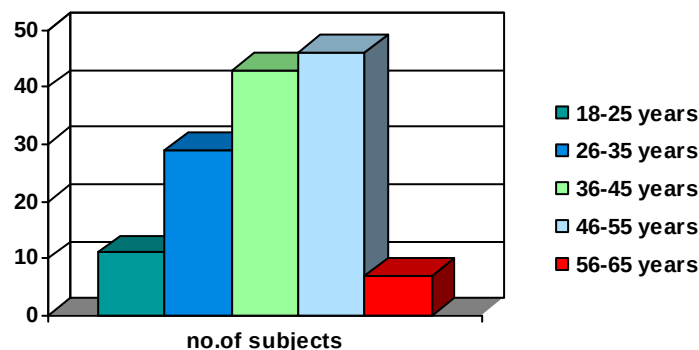


Fig. 1. Age of the subjects at the depressive disorder's onset.

As mentioned in literature, most subjects (65.4%) had an onset at an age between 36-45 years.

1.4. Distribution of subjects according to their educational level

Educational level	No	%
4 classes	6	4.4
8 classes	37	27.1
10 classes	49	36.0
12 classes	24	17.6
Post-high school courses	3	2.2
Faculty	15	11.2
Post-graduate studies	2	1.5

Most subjects have a high educational level (68.5% of the subjects have 10 classes or more).

2. Subjects' distribution according to the diagnostic for the current episode:

ICD-10 Diagnostic	No	%
Recurrent depressive disorder. Depressive episode of medium severity (F33.1)	45	33.3
Recurrent depressive disorder. Severe depressive episode without psychotic symptoms (F33.2)	61	44.8
Recurrent depressive disorder. Severe depressive episode with psychotic symptoms (F33.3)	27	19.8
Recurrent depressive disorder, presently under remission. (F33.4)	1	0.7
Other recurrent depressive disorders. (F33.8)	1	0.7
Non-specified recurrent depressive disorder. (F33.9)	1	0.7

Most subjects (44.8%) have a diagnosis of Recurrent depressive disorder – Severe depressive episode without psychotic symptoms (F33.2).

3. *The distribution of subjects according to the type of depression: psychotic depression (at least one episode of depression with congruent or incongruent psychotic symptoms) versus non-psychotic depression*

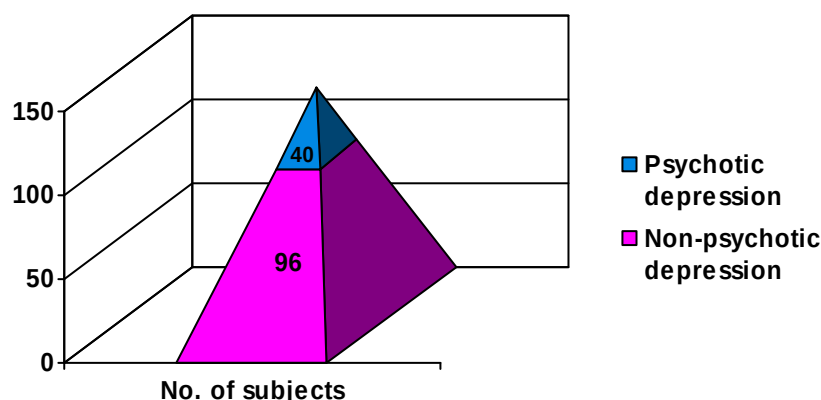


Figure 2 The distribution of subjects according to the type of depression: psychotic depression versus non-psychotic depression.

96 subjects (70.6%) presented Depression without psychotic symptoms, while 40 subjects (29.4%) presented Depression with psychotic symptoms

4. *The average term of evolution for the first and the last depressive episode and the average length of course for the depressive disorder*

4.1. *The average length of the first depressive episode was of 7.8 months (std. dev =5.04), with the shortest episode of 1 month and the longest of 28 months*

4.2. *The average length of the last episode was of 3.8 months (std.dev.=2.1), with the minimal length of 1 month and the maximum length of 12 months*

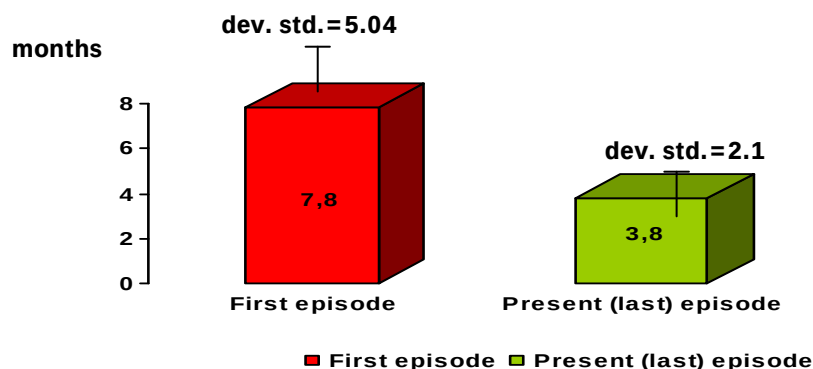


Fig. 3. The average length of the first depressive episode as compared with the average length of the present (last) depressive episode

Also, there is a statistical significant correlation ($R = 0.173$, $p = 0.04$) between the length of the first depressive episode and the number of hospitalization following the onset: the longer the first episode, the more hospitalizations are afterwards required by the patient.

4.3. *The average length of the illness' course was of 9.7 years (std.dev. = 7.9), with a minima course of 2 years long, and a maximal course of 36 years*

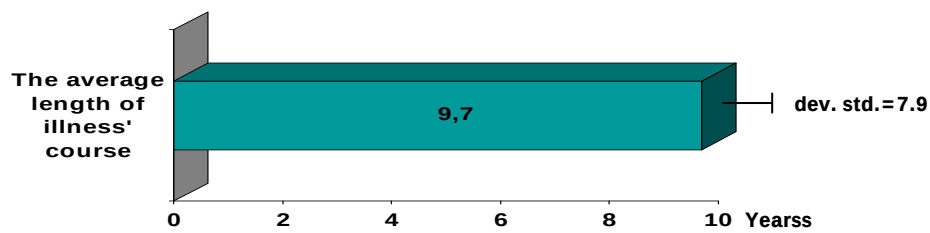


Fig. 4. The average length of disorder's course

5. The average number of depressive episodes, and hospitalizations:

5.1. The average number of depressive episodes was of 5.8 (std.dev. = 4.3), with a minimum of 2 episodes and a maximum of 28 episodes

5.2. The average number of hospitalizations was of 4.7 (std.dev. = 4.4), with minimum 1 hospitalization and a maximal number of hospitalizations of 32

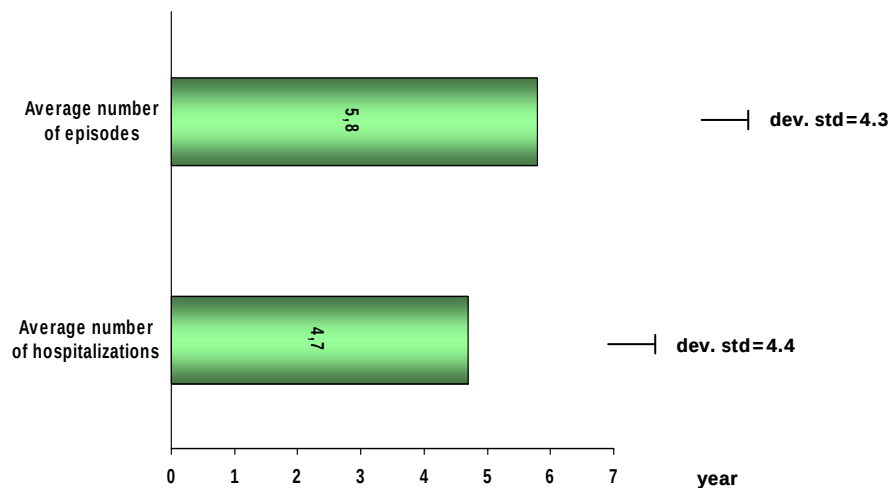


Fig. 5. The average number of depressive episodes and hospitalizations

6. The presence of stressful life events prior to the depression's onset (in the last 12 months prior to onset)

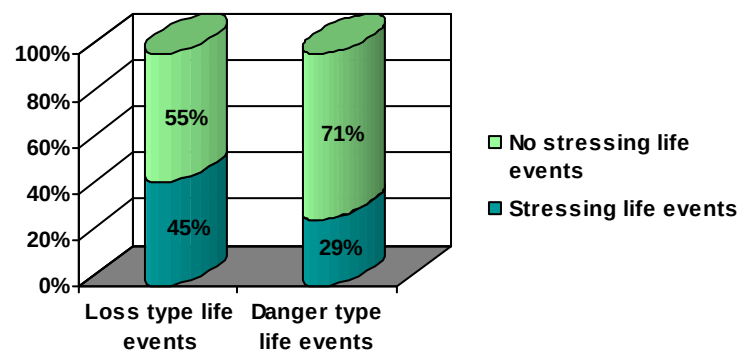


Fig. 6. Distribution of stressing life events

28.6% of the subjects mentioned in their biography at least an event of danger type. 45% had at least an event of loss.

7. *The changes in the marital status of the subjects.*

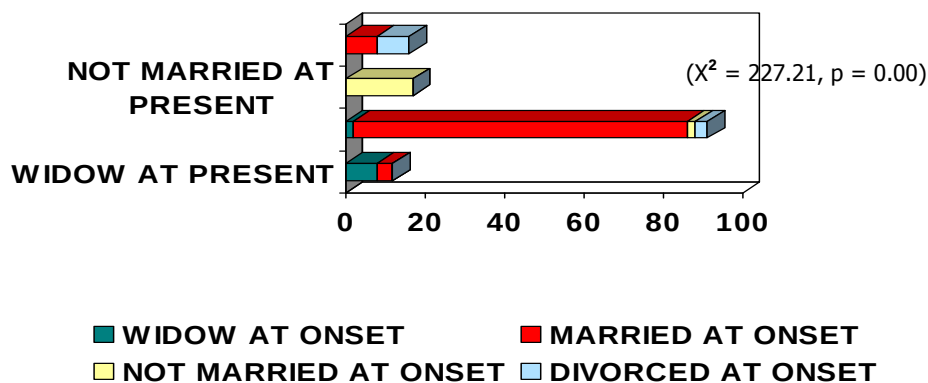


Fig. 7. *The changes in the marital status of the subjects during illness' course.*

The difference between the number of subjects who remained married or married during the disorder's course and the rest of the subjects is statistically significant ($\chi^2 = 227.21$, $p = 0.00$); from the 88 subjects who were married at the onset, only 8 have divorced and from the 11 initially divorced patients, 3 have re-married. The number of subjects who are married at the time of the final evaluation is 91, as compared with 96 subjects who were married at the time of the illness onset, but it is to be considered that 4 subjects have become widow.

8. *The changes in the professional status of the subject*

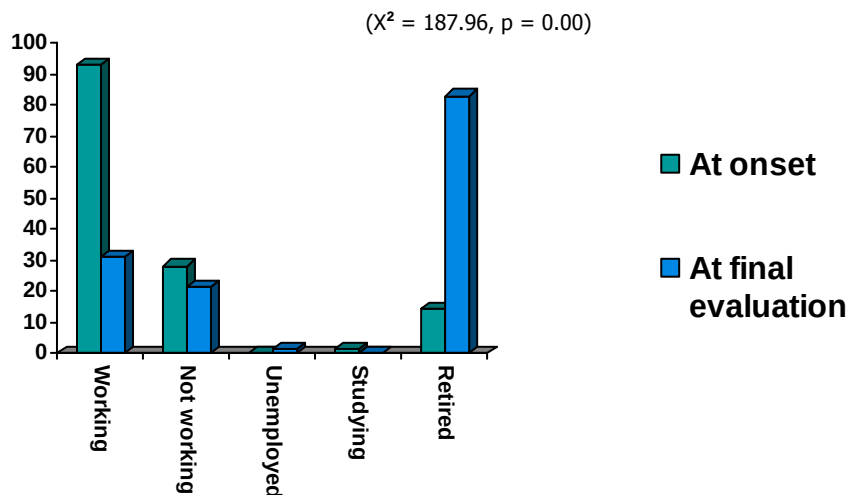


Fig. 8. *The dynamic of the professional status in the studied sample*

From the 93 subjects who were working prior to the disorder's onset, 56 (most of them) have retired, and only 31 are still working at the time of final evaluation. 6 subjects have ceased working. From the 15 subjects who were not working at the onset, 13 have retired. No subject who was not working prior to the illness' onset has managed to get a job. The difference is statistically significant ($X^2 = 187.96$, $p = 0.00$), but the interpretation of this significance is hard to make due to the relation with the severity and the course of the psychiatric illness, if we are to take into consideration also the social and economical changes induced by the political transformations in the country's structure during the analyzed years.

9. The distribution of personality traits in the studied sample (according to PAS-I)

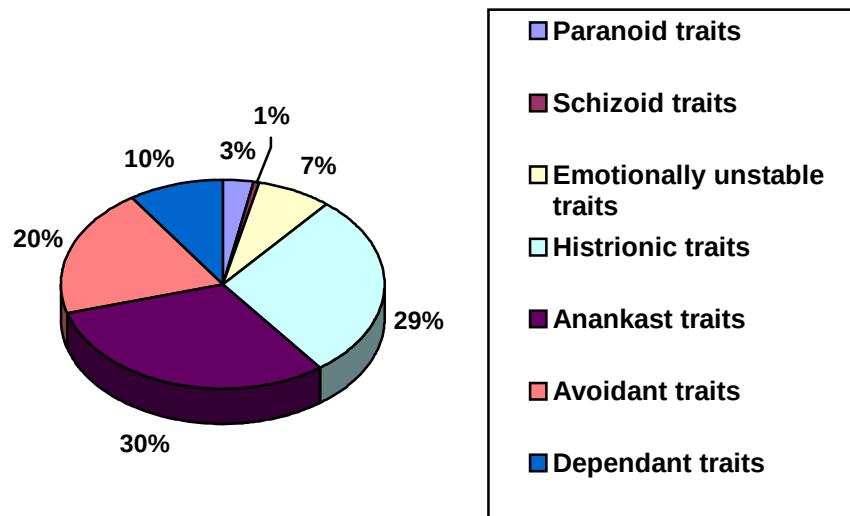


Fig. 9. The distribution of personality traits in the studied sample according to PAS-I

There was no statistically significant correlation ($p = 0.633$) between the severity of the depression and the personality traits. It is possible, however, to identify such a correlation if a larger number of subjects are studied.

Because of the multitude of categories induced by the PAS-I system, we have converted the ICD-10 type into DSM-IV, using conversion tables, grouping the personality traits in DSM-IV type clusters, also taking into consideration the intensity of trait.

On DSM-IV clusters we can notice that Cluster C type personality traits are predominant in the studied sample, and are present in 60% of the subjects, closely followed by the cluster B type personality traits present in 36% of the studied sample.

Cluster A type personality traits, though more frequent in the studied sample, have been statistically identified ($\chi^2 = 9.21$, $p=0.05$) more frequently in patients with severe depressive episodes with psychotic symptoms.

There is a statistically significant difference ($\chi^2 = 15.05$, $p = 0.019$) between the frequency of presence of personality traits clusters in relation with the professional status of the subject at the onset of the psychiatric disorder. Most subjects with Cluster C and A type personality traits were working at the onset of the psychiatric disorder as compared with the predominance of retired and not working subjects with cluster B type personality traits (Fig. 10).

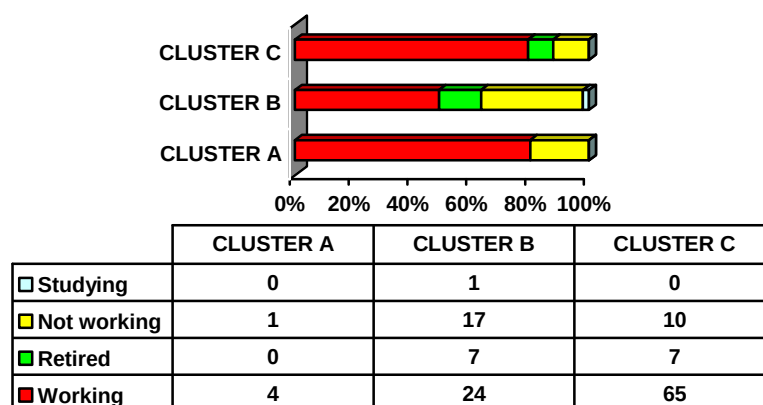


Fig. 10. Clusters of personality traits and the professional status of subjects at the onset of the depression

10. The Mann-Whitney test indicates that the suicide risk is higher for subjects with psychotic depression (an average score at suicide risk scale of 0.9) as compared with patients with depression without psychotic symptoms (an average score at suicide risk scale of 0.46) ($Z = -3.27, p = 0.001$)

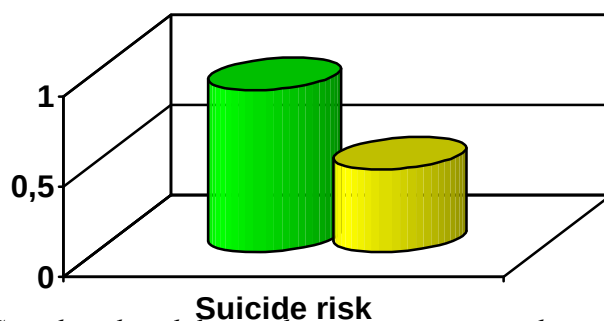


Fig. 11. Suicide risk and the psychotic versus non-psychotic depression

■ Psychotic depression ■ Non-psychotic depression

11. There is a statistically significant correlation ($R = 0.233, p = 0.006$) between the education level and the suicide risk: the suicide risk is higher for subjects with higher educational level.

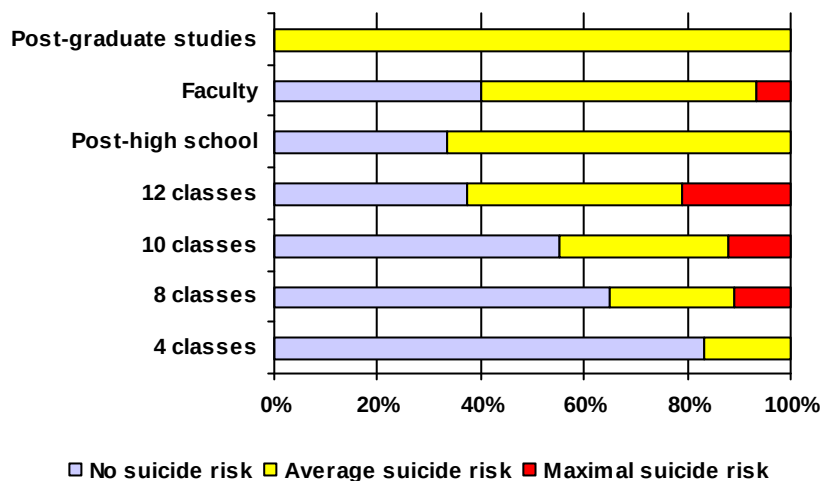
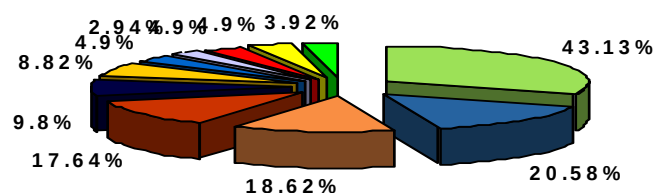


Fig. 12. Suicide risk and the level of education

12. The distribution of subjects according to associated somatic comorbidity at onset and present evaluation

At onset



At present evaluation

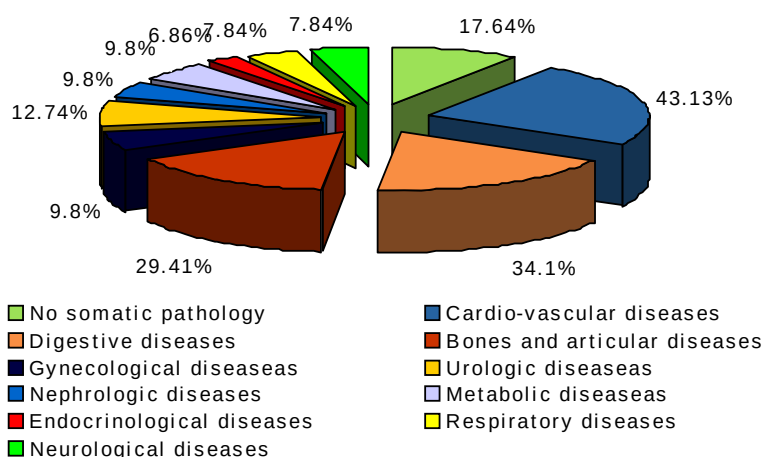


Fig. 13. The profile of somatic comorbidity at the onset of depression and present evaluation

The figures for somatic comorbidity's frequency in the studied sample are higher than the general prevalence data for both onset of depression but especially after several depressive episodes, when, at least in some cases, they nearly double. It is possible that these pathological conditions, the somatic pathology and the psychiatric one (depression) are mutually interrelated. Among the somatic comorbidities cardio-vascular diseases is the most representative and of these essential hypertension is the most frequent.

Conclusions

1. Some results of our study confirm the existing data in the medical literature.
2. Though the prevalence of monopolar depression is higher among women, men have a higher risk of developing severe forms of depression, with psychotic symptoms, and therefore, are at higher risk for suicide.
3. The first depressive episode needs to be properly diagnosed and treated with antidepressant medication because the length of the first episode and its severity has predictive value for the further course of the depressive disorder.
4. The impact of the recurrent depressive disorder upon the individual's life is different for each individual, but most patients manage to maintain a good family functioning. Nevertheless, the impact of depression upon professional functioning is devastating. We must admit, though, that some of our results in this regard could be influenced by the changes in the economical structure of our country during the years of the study, but we still think that this explanation can be true for just a part of the cases.

5. In our study, the profile of personality traits had a limited predictive value ($p = 0.633$) for the type of depression (psychotic versus non-psychotic depression). It is possible that this value could be more significant for larger samples. It is also possible that on larger samples could be identified a statistically significant correlation between personality traits and the severity of depression.

6. Cluster A type personality traits, though less present in the studied sample, have been more frequently identified in patients with severe depressive episodes with psychotic symptoms ($\chi^2 = 9.21, p=0.05$)

7. As is to be expected, the suicide risk is higher in psychotic depression than in the non-psychotic one.

8. Suicide risk is higher in patients with higher educational level.

9. Somatic comorbidity is a real problem to be considered in the treatment of depressive patients. Recurrent depression and some somatic illnesses could represent the different phenotypes of the some genotypes.

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