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A comparative study of major depressive disorder -treatment and outcomes

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Abstract
Major depressive disorder (MDD), commonly called major depression, unipolar depression, or clinical depression, wherein a person has one or more major depressive episodes. In major depressive disorder the person exhibit more symptoms than are required for dysthymia and the symptoms are more persistent (not interwoven with periods of normal mood). Psychiatrist and clinicians have recognize several subtypes of major depressive disorders. There are different types of treatments available for mood disorders, such as therapy and medications. Behaviour therapy, cognitive behaviour therapy and interpersonal therapy have all shown to potentially beneficial in depression. Major depressive disorder medications usually include antidepressants, while bipolar disorder medications can consist of antipsychotics, mood stabilizers and or lithium.

Keywords: Major Depressive Disorder, Treatment, Bipolar, Behavior Therapy & Cognitive disorder

Introduction

Major depressive disorder (MDD), commonly called major depression, unipolar depression, or clinical depression, wherein a person has one or more major depressive episodes. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent).Individuals with a major depressive episode or major depressive disorder are at increased risk for suicide.

In major depressive disorder the person exhibit more symptoms than are required for dysthymia and the symptoms are more persistent (not interwoven with periods of normal mood). An affected person must experience either markedly depressed mood or marked loss of interest in pleasurable activities for at least two weeks. In addition the person must experience at least for more of the following symptoms during the same period: fatigue or loss of energy; insomnia or hypersomnia (that is, *too little* or *too much sleep*); decreased appetite and significant lose psychomotor agitation or retardation physical activity); diminished ability to think or concentrate; self-denunciation to the point of claiming worthlessness or guilt out of proportion to any past indiscretions; and recurrent thoughts of death or suicide).

Psychiatrist and clinicians have recognize several subtypes of major depressive disorders:

- *Atypical depression* (*AD*) is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or somnolence (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.
- *Melancholic depression* is characterized by a loss of pleasure (anhedonia) in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early-morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.
- *Psychotic major depression* (*PMD*), or simply psychotic depression, is the term for a major depressive episode, in particular of melancholic nature, wherein the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations.
- *Catatonic depression* is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here, the person is mute and almost stuporose, and either is immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms can also occur in schizophrenia or a manic episode [13].
- *Postpartum depression* (*PPD*) is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which affects 10–15% of women, typically sets in within three months of labor, and lasts as long as three months.
- *Seasonal affective disorder* (*SAD*), also known as "winter depression" or "winter blues", is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. It is commonly hypothesised that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD. SAD is also more prevalent in people who are younger and typically affects more females than males.
- *Dysthymia* is a condition related to unipolar depression, where the same physical and cognitive problems are evident, but they are not as severe and tend to last longer (usually at least 2 years). The treatment of dysthymia is largely the same as for major depression, including antidepressant medications and psychotherapy.
- *Double depression* can be defined as a fairly depressed mood (dysthymia) that lasts for at least two years and is punctuated by periods of major depression.
- *Depressive Disorder Not Otherwise Specified* According to the DSM-IV, DD-NOS encompasses *"any depressive*

disorder that does not meet the criteria for a specific disorder."

- *Depressive personality disorder* (DPD) is a controversial psychiatric diagnosis that denotes a personality disorder with depressive features. Originally included in the DSM-II, depressive personality disorder was removed from the DSM-III and DSM-III-R. Recently, it has been reconsidered.
- *Recurrent brief depression* (*RBD*), distinguished from major depressive disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2–3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.
- *Minor depressive disorder*, or simply minor depression, which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks.

Bipolar disorders

Bipolar disorder (BD), an unstable emotional condition characterized by cycles of abnormal, persistent high mood (mania) and low mood (depression), which was formerly known as "manic depression". In the mild to moderate range the disorder is known as Cyclothymia, and moderate to severe range the disorder is known as Bipolar disorder.

Cyclothymia

Mania is in some ways the opposite of depression. It is a state involving excessive levels of excitement elation or euphoria. In its milder forms it is known as hypomania. It has long been recognized that some people are subject to cyclical mood changes with relative excesses of hypomania and depression that, though substantial, are not disabling. These in essence are the symptoms of cyclothymia.

Symptoms of the hypomanic phase of cyclothymia are essentially the opposite of the symptoms of dysthymia, except the sleep disturbance is invariably one of an apparent decreased need for sleep. As in the case of bipolar disorder, no obvious precipitating circumstances may be evident, and an affected person may have significant periods between episodes in which he or she functions in are relatively adaptive manner. In cyclothymia, however, the diagnostic criteria for adults specify at least a two-year span during which there are numerous periods with hypomanic and depressed symptoms (only one year is required for adolescents and children).

Treatment and outcomes

There are different types of treatments available for mood disorders, such as therapy and medications. Behaviour therapy, cognitive behaviour therapy and interpersonal therapy have all shown to potentially beneficial in depression, (Nolen-hoeksema. 2013 and Weston *et al*, b2011) [14]. Major depressive disorder medications usually include antidepressants, while bipolar disorder medications can consist of antipsychotics, mood stabilizers and or lithium.

Antidepressant tranquilizing, anti-anxiety drugs are all used with mood disorder patients. Lithium salts, were first tried for the treatment of affective disorders in the 1940s in of Australia but were found to have adverse side effects. There is a series of refinements since then, however, lithium therapy has become highly effective in the treatment of manic reactions and, more recently, in the treatment of depressive reactions as well (Brown, 1974; Johnson, 1974; Schou, 1974). In addition, *lithium therapy* can be used to prevent the recurrence of manic-depressive reactions. With depressive patients, antidepressant drugs such as imipramine or amitriptyline have also proven effective, both in treatment and the prevention of relapse (Prien, Klett, & Caffey, 1973; Raskin, 1974).

Since an estimated 60 percent or more of depressed patients are also anxious, tranquilizers and anti-anxiety drugs are commonly used in combination with antidepressants (Cole, 1974; Raskin, 1974). Lehmann (1968) pointed out. "Depression and anxiety are two symptoms which very often co-exist in the same patient. They are nevertheless different symptoms and they may vary independently in their intensity. Of the two symptoms, anxiety is by far the more conspicuous and depression the more dangerous."

Antidepressant drugs usually require a few days before their effects are manifested. Thus electroconvulsive therapy (ECT) is often used with patients who present an immediate and serious suicidal risk (Brown, 1974; Hurwitz, 1974). ECT is now considered both safe and effective; there is a complete remission of symptoms after about 4 to 6 convulsive treatments in over 90 percent of depressive patients. In such cases, maintenance dosages of antidepressant and anti-anxiety drugs ordinarily are used to maintain the treatment gains achieved by ECT until the depression has run its course.

Individual or group therapy is combined with drugs or ECT to help the patient develop a more stable long-range adjustment. The need for such mixed types therapies is indicated by the findings of Hauri (1974) Hawkins, and Mendels (1974), who studied the sleeping patterns of former depressed patients. While these patients were overtly recovered, they tended to evidence a "depressive life style" in their dreams. They also showed significantly more sleep disturbances than a matched "normal" control group, including delayed onset of sleep, more REM sleep, and greater night-by-night variability in sleep patterns.

Newer techniques of psychotherapy have been developed in recent years, particularly for the treatment of depression.

During treatment program, it is important to deal also with unusual stresses in the patient's life, since an unfavorable situation may lead to a recurrence of the reaction as well as necessitating longer treatment. Good nursing care is important during acute depression because depressed patients are frequently very ingenious in their efforts to put an end to their suffering. Despite the patient's repeated assurance that he will do nothing to harm himself, he may cut his wrists with a small fragment of glass or set fire to his cloths. Many studies have shown that even without formal therapy, the great majority of mood disorders recover within less than a year. And with modern methods of treatment, the general outlook has become increasingly favorable, so that most hospitalized patients can now be discharged within 60 days. While relapses may occur in some instances, these can usually be prevented by maintenance therapy.

The mortality rate for depressive patients appears to be about twice as high as that for the general population, however, because of the higher incidence of suicide (Bratfor, Haug, 1968; Schanche, 1974). The development of effective drugs and other new approaches to therapy have brought greatly improved outcomes for mood disorders psychoses, the need clearly remains for still more effective treatment methods, both immediate and long term. Moreover there is a strong need for research investigations in these fields.

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