# Depressive Disorders

**Third Edition**

*Depressive Disorders Third Edition* Edited by Helen Herrman, Mario Maj and Norman Sartorius
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WPA Secretary for Publications, University of Melbourne, Australia

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## *WPA Series*
## Evidence and Experience in Psychiatry

### Third Edition

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# Foreword

The World Psychiatric Association's series 'Evidence and Experience in Psychiatry', initiated about 10 years ago by Mario Maj and Norman Sartorius, aims to bridge the gaps in knowledge both within psychiatry and between psychiatry and the rest of medicine. Furthermore, the scope is to increase the applicability of research findings to clinical practice.

Each volume deals with one of the main mental disorders and consists of chapters that review the pertinent literature on major clinical aspects of the given disorder. Each extensive and comprehensive review is followed by several experts on the field providing critical remarks and insights from the perspective of their own knowledge and experience. These commentators come from different countries and cultural backgrounds and are associated with a range of different schools of thought.

One distinctive and novel feature characterising each chapter conceived by the editors and retained throughout the successive volumes of the series is that the authors of the reviews conclude by listing the findings they consider as consistent and inconsistent and by identifying areas open to further research. This means that the authors have to scrutinise and critically evaluate the available research findings and weigh their relevance to clinical practice.

The first volume of the series, published in 1999, was on depressive disorders. These disorders have significant consequences for the afflicted individual in terms of emotional suffering and cognitive and social functioning. They also constitute a major public health problem: epidemiological evidence indicates that they are becoming more common and the World Health Organization predicts that in about 10 years from now they will be second among all clinical disorders in terms of burden of disease.

The first edition of *Depressive Disorders* covered extensively and comprehensively the most crucial and clinically relevant aspects of depression – its diagnosis; pharmacological treatments; psychotherapies; effects in children, adolescents and the elderly; and its costs. In all chapters, in addition to the thorough literature review, the authors and commentators examined and amplified the existing information with their own complementary views and critical remarks, thus enabling disputed issues to be touched upon and conflicting views to be raised to stimulate further investigation.

A second edition was published in less than three years, attesting to the great interest that the first volume aroused, as reflected in its wide readership.

Now we have in hand this revised third edition that combines change and continuity in a masterful way.

The editorship has been enlarged to include Helen Herrman. The content has undergone considerable changes. The chapter on costs in the first two editions is replaced by a chapter on depressive disorders in primary care. This change corresponds to the increased significance attached to primary health services, not only as a referral filter but also as an

appropriate setting to provide early recognition, case identification and effective management of common mental disorders such as clinical depression. The authors and the commentators of the chapter, following an informative introduction on policy and organisational aspects of primary health care services, proceed to a comprehensive and critical presentation of the variables that determine the benefits experienced by depressed patients attending these services.

In three other chapters (Pharmacological Treatment, Psychotherapies and Depressive Disorders in the Elderly), the authorship of the main review article is the same as in the previous editions and only the panel of commentators is partly changed. However, the content does not remain the same. The reviews are updated with new information. Moreover, they are enriched with additional comments and critical remarks by the main authors and the commentators. Although no radical changes have occurred in the fields that these chapters cover since the second edition, the authors have been able to slightly modify the list of findings for which consistent and inconsistent evidence exists.

The authorship of the other two chapters – Diagnosis, and Depression in Children and Adolescents – has changed and there is a substantial restructure of the content.

The review on Depression in Children and Adolescents written by Jacobs and Taylor differs from earlier editions in style and material arrangement as well as in adding new information and bringing out new dilemmas in age-related diagnostic and treatment issues. The authors present the conflicting views in a balanced way. Some of the commentators more strongly support a sharp distinction in clinical profile between infants, children and adolescents, suggesting differential management approaches for each age-stage.

The chapter on the diagnosis of depressive disorders is substantially different from the previous one. The review is written by the widely known investigator of clinical depression, Gordon Parker. The panel of commentators has also partly changed.

Diagnosis of mental disorders, and depressive disorders in particular, is the most significant and at the same time one of the most thorny and controversial issues that has tormented psychiatry for years. The entrance of pharmacological treatment raised again the need for a diagnostic and classification system not entirely built on descriptive grounds and solely dependent on the individual professional's judgement and clinical insight.

With the introduction of the DSM III and IV and ICD 10 diagnostic systems, psychiatry acquired tools that improved diagnostic reliability and supported its claim for an equal footing among the medical disciplines. Expectations ran high, but frustration regarding their capacity to resolve long-standing conflicts and to assimilate the advances in biological research into clinical practice became apparent over time.

The controversies over the categorical versus the dimensional or the monothetic versus the polythetic taxonomies and between the variety of mixed models still exist. Validation of the proposed schemas by external validators safeguarding diagnostic and treatment specificity is still lacking, despite progress being made in the field.

Following the introductory remarks on the need to develop an improved classification and diagnostic system for depressive disorders, Parker proceeds with a constructive criticism of the inadequacy and limitations of the currently available diagnostic systems and, based on results obtained from his own clinical investigations, strongly and convincingly advocates his proposal for a new approach to classification. This involves a sharply defined categorical subtype named melancholia with or without psychotic features, and a non-melancholic subtype as a non-categorical class of depressive disorders lacking psychomotor symptomatology and largely dimensionally defined.

The input of the commentators is of equal importance and makes this chapter an excellent ground from which more novel proposals may grow in a field in which the phenotypic complexity of depression greatly impedes the incorporation at the clinical level of the burgeoning advances in neuroscience.

Altogether this volume is an excellent reference book and in many respects a seminal one from which readers, clinicians and researchers will not only draw updated information on depressive disorders but also benefit from coming across fresh ideas generated by a host of eminent experts in the field.

A final note. The publication of this third edition is timely in the advent of major research breakthroughs and while we are in the midst of the preparatory phase of radical revisions of the DSM and ICD diagnostic and classificatory systems.

**Professor Costas Stefanis**
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# Preface to Third Edition

Two main reasons made us produce the third edition of this volume. The first is that the gap between research evidence, clinical experience and guidelines for practice and quality assurance remains large, despite considerable efforts of the many governmental and non-governmental agencies. The second is that the gap between the needs for care of people with depression and the care available to them has become even larger than it was when the first edition of this book was published. We felt that it was therefore timely to update the reviews of evidence and make them available to those engaged in research and in the provision of practice.

It has gradually become accepted that for a vast majority of people with depression, care could be provided through primary health care supported by appropriate referral chains. Unfortunately, between the acceptance of this strategy and its appropriate implementation lie many obstacles, including the stigma of mental illness and the limited knowledge that health care workers have about depression and its treatment. These obstacles exist at the level of primary health care as well as at the level of specialised services of disciplines other than psychiatry. We hope that the material assembled in this book will be helpful in overcoming these obstacles.

We also hope that the reviews and commentaries in this edition offer and encourage new opportunities for all to learn across countries and cultures. The gap between information available from low and middle income countries and the countries from which most of the research literature derives is almost as wide as when the first edition was published. The publication of the World Psychiatric Association's official journal *World Psychiatry* has helped initiate a movement to close this gap, but the wisdom, experience and research findings relating to treatment of depression in most countries are available neither to practitioners and governments in these countries nor to practitioners, researchers and policymakers elsewhere. This book cannot review all research findings nor represent all opinions worldwide, but does aim to include evidence and experience from across the world.

We kept the structure of the volume the same as in its earlier editions but replaced the chapter on economics of health care by a chapter on the management of depression at the

level of primary health care. The exclusion of the review of economic aspects of care for people with depression was made in light of the fact that several comprehensive reviews of this matter appeared in recent years.

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# Preface to First Edition

Among the most serious difficulties that beset the field of psychiatry are the stigma marking mental illness and all that is connected with it (from its treatments and institutions to mental health workers and families of people with mental illness), disunity within the profession, and the gaps between findings of research and practice. These three sets of problems are interconnected: the disregard of research findings contributes to the persistence of differences in the orientation of psychiatric schools, and this diminishes the profession's capacity to speak out with one voice and to demonstrate that most mental illnesses can be successfully treated and are not substantially different from other diseases.

The diagnosis and treatment of depressive disorders illustrate the gaps that exist between research evidence, clinical experience, and guidelines for practice and quality assurance. Although clinicians, for example, feel that there are significant difficulties in the application of research criteria to the diagnosis of depression in people who suffer from a severe physical illness, current classifications of mental disorders contain no provisions that would make them easier to apply in such instances. Psychodynamic psychotherapies, the efficacy of which is not supported by empirical evidence, are still widely used in many countries, whereas other forms of psychotherapy, for which research evidence of effectiveness is available, remain unknown or scarcely used. Many clinicians continue to believe that there are significant differences in the effectiveness of antidepressant drugs, although research tends to demonstrate that they are equivalent, and some claim that tricyclic antidepressants are active when given in doses that are below the range that research has proved to be effective.

Differences of opinion between skilled clinicians and discussions about reasons for the gaps between research findings and practice are not reflected in the current psychiatric literature. The experience of skilled clinicians is only rarely published in psychiatric journals, while the best of scientific evidence is only infrequently presented in a manner and in a place that would make it immediately accessible to clinicians. Reports on clinical practice in different countries—possibly enriching knowledge by providing a range of experience and a powerful commentary on the applicability of research findings in everyday work—are not easily found in accessible psychiatric literature. In the current era of promotion of evidence-based medicine, these separations between research evidence, experience, and practice are a dangerous anachronism.

The series Evidence and Experience in Psychiatry has been initiated as part of the effort of the World Psychiatric Association to bridge the gaps within psychiatry and between psychiatry and the rest of medicine. The series aims to be the forum in which major issues for psychiatry and mental health care will be discussed openly by psychiatrists from many countries and different schools of thought. Each volume will cover a group of mental disorders, by means of a set of systematic reviews of the research evidence, each followed by a number of commentaries.

No publication can expect to cover everything, or to present all possible views on a matter. The WPA series is not an exception to this rule. It is the editors' hope that the volumes will inform and stimulate further discussion, attract attention to controversial issues, and help to recreate respect for clinical experience and differences of opinion between psychiatrists in different parts of the world, all united in their wish to find a consensus that will make it possible to move psychiatry forward, and make it even more useful in diminishing the burden of mental illnesses and the plight of the many suffering from them.

**Mario Maj**
**Norman Sartorius**

CHAPTER 1

# Diagnosis of Depressive Disorders

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## INTRODUCTION

> *Taxonomy is described sometimes as a science and sometimes as an art, but really it's a battleground.*
>
> —Bill Bryson (2003)

Any diagnostic system depends on a classificatory model. Prior to the introduction of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (DSM-III) model for classifying depressive disorders in 1980 there was controversy over how depression should be classified. This controversy was largely to do with contrasting unitary and binary models of depression. The DSM-III resolved the debate in favour of a primarily dimensional model (a unitary approach). This model was also adopted in the World Health Organization's *International Classification of Diseases*, 10th Revision (ICD-10) (1992), which emerged in the following decade. As with any clinical domain that is modelled dimensionally, there are problems in defining when a particular individual's presentation should be considered a clinical 'case' and in readily identifying any differences in the usefulness of particular treatments for particular presentations.

This chapter provides an overview and critique of the current DSM and ICD systems of classification and highlights limitations that arise from their dimensional approach and lack of theoretical basis regarding cause. An alternative model by McHugh based on aetiopathic clusters is also discussed and a mixed categorical and dimensional model developed by the author and others is presented. The mixed model proposes that depression exists at multiple levels – normal, syndrome and disease – and seeks to define the clinical depressive disorders using phenomenological and aetiological distinctions (i.e. distinctions related to the person's experience of the disorder and/or its cause).

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## What is 'depression'?

'Depression' is, at first pass, a broad nonspecific term, encompassing multiple normal mood states as well as disorder and disease states.

A *depressed affect* is a state of feeling 'depressed', 'sad' or 'blue', usually in response to a specific trigger, that generally resolves within minutes to days – either due to reprieve from the stressor or the individual experiencing a spontaneous restoration of mood.

A *depressed mood* is more pervasive. It is more likely to be experienced by the individual as a drop in their sense of self-worth and self-esteem and is associated with depressive ruminations, such as feeling hopeless and pessimistic. It may or may not affect functioning. Experienced by most people, and again usually occurring in response to a negative stressor (particularly a loss that impacts on the individual's self-esteem), it may last minutes to days before resolving spontaneously or in response to neutralising of the stressor.

Three features – depressed mood, lowered self-esteem and increased self-criticism – distinguish depression phenomenologically from *grief* and *bereavement,* where, despite a distinct sense of loss of something valued, there is no primary loss of self-esteem. The mood features of depression also assist phenomenological distinction from *anxiety*, where a sense of fear, apprehension, worry, panic or of 'going mad' is more likely to be reported.

Episodes of depressed mood are experienced by most people, and may be described as 'blue' states or even 'normal' depression. By contrast, current definitions of *clinical depressive conditions* generally (i) have their 'caseness' status defined by severity (i.e. they are more severe, persistent and/or recurrent), (ii) have symptoms that are more pathological in status and (iii) are impairing or disabling.

## Classifying depression – What do we want and why do we want it?

It might be useful to consider what we should expect of a classificatory system of the depressive disorders before considering what is available.

Firstly, we would almost certainly require it to define 'clinical' depressive states and distinguish them from 'normal' depressive mood states. Secondly, we would wish to have decision rules that differentiate unipolar from bipolar expressions of clinical depression (i.e. differentiating longitudinal patterns of depression only from oscillating depressive and 'high' episodes). Thirdly, we might want it to quantify severity, duration, recurrence or other dimensional parameters. This third classificatory option is less important, however, as these more define illness course than illness type.

Fourthly, above and beyond these minimal requirements, we might expect the system to divide the broad category of clinical depression into those subtypes that have differential clinical patterns, causes and/or intrinsic responses to different treatment modalities. The two key candidate depressive conditions for such subtyping are psychotic depression and melancholic depression. Assuming that these are categorical subtypes, we would expect clear clinical definition (principally embracing clinical symptoms and signs) that would differentiate them from any generic category of clinical depression.

The aims of such a classificatory system would be to ensure that there is a shared functional language to assist both clinicians to communicate effectively and researchers to

define the conditions and samples being studied. In terms of the depressive subtypes, we would expect that they could be clinically defined and differentiated, and that their subtyping status would be supported by studies showing evidence of specific causes or a distinct differential response to treatment modalities. For all diagnostic entities, we would expect that their clinical definition had established reliability, in that two independent raters would consistently correctly classify the same individual as meeting diagnostic criteria or not.

These considerations should be kept in mind when reading the following review of the two principal systems in current use – the DSM and ICD classificatory protocols – and the discussion of other potential models of classification.

## OVERVIEW OF THE PRINCIPAL CLASSIFICATION SYSTEMS CURRENTLY IN USE

### The DSM system

The current DSM-IV system is based on the DSM-III classificatory system that was introduced in 1980 (American Psychiatric Association, 1980). This system was radical at the time of its introduction. Firstly, it was atheoretical in relation to cause. Secondly, it imposed a criterion-based system for diagnosis. Thirdly, it sought to bring a new standard of reliability to diagnostic decision-making and so advance psychiatry as a science-weighted discipline. However, as detailed in a book titled *The Selling of DSM: The Rhetoric of Science in Psychiatry*, Kirk and Kutchins (1992) observed that, 'It was the claims of success, however, that were successful' (p. 159). In essence, while the DSM-III architects claimed high inter-rater reliability (superior to its DSM-II predecessor), the field trial reliability studies were poorly conducted (e.g. nonblinded raters), were often not reported and the architects' standard (a kappa value of 0.70) was rarely reached. It is against this general – and generally unappreciated – background that we consider the model in terms of its reliability, validity and clinical utility.

In moving to a criterion-based system, the DSM-III working group on depressive disorders needed to consider the competing unitary and binary models. At that time – from the mid-1970s to early 1980s – those proposing a binary model had failed to provide convincing evidence to support their case. The committee effectively chose a compromise, with an initial dimensional model positioning 'major' versus 'minor' disorders. If criteria for major depression were met, categorical second-order decisions about the presence of other conditions (e.g. psychotic depression or melancholia) were specified. That broad model is also evident in the next version of the system – DSM-IV.

According to DSM-IV (American Psychiatric Association, 1994), a diagnosis of 'major depressive disorder' requires the presence of two weeks of a depressed mood, a minimum number of symptom criteria and impairment. It can be single or recurrent, and can be specified as (i) of mild severity, (ii) of moderate severity, (iii) severe without psychotic features, (iv) severe with psychotic features, (v) in partial remission, (vi) in full remission and (vii) unspecified. Other specifiers include (a) chronic, (b) with catatonic features, (c) with melancholic features, (d) with atypical features, (e) with postpartum onset and (f) being due to a general medical condition. For those with recurrent major depression, additional specifiers allow ratings of (i) with or without interepisode recovery and (ii) any seasonal