INTRODUCTION

Depression is both a common and a debilitating disorder, demonstrated by the World Health Organization to have the largest effect on worsening health worldwide compared with the other chronic medical conditions. Major depression is currently ranked fourth worldwide in disease burden, and it is expected to rank first in disease burden in high-income countries by the year 2020 ***(Briley et al., 2011).***

Major depression significantly affects a person's family and personal relationships, work or school life, sleeping and eating habits, and general health. A person having a major depressive episode usually exhibits aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. Depressed people may be preoccupied with thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. Insomnia is common among the depressed ***(Kendler et al., 2006)***.

A depressed person may report multiple physical symptoms such as fatigue, headaches, or digestive problems. Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur ***(Belmaker and Agam, 2008).***

Epidemiological studies have consistently shown that the prevalence of major depression is between 5% and 10% of

people seen in primary care settings with women being twice as likely to be affected as men ***(Hywel and Timothy, 2012)***.

Unlike most disabling physical diseases, mental illness begins very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24.Thus, mental disorders are really the chronic diseases of the young. For example, anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's. Unlike heart disease or most cancers, young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive. Prevalence of mental illness increases from the youngest group (age 18-29) to the next-oldest age group (age 30-44) and then declines, sometimes substantially, in the oldest group (age 60 +) ***(Celine and Antony, 2014).***

While depression can strike anyone at any time, research has identified that age is associated with an increased risk for depression. Most people experience their first episode of depression between the ages of 20 and 40. In fact, the average age of onset for depression is the mid-20s. Alarmingly, recent research shows that the average age of onset is decreasing with each generation. Children, adolescents and elderly persons often display unique symptoms of depression and have specific stressful events that predispose them to depression ***(Katon, 2002).***

It has been well established that life events are associated with depression. Several major life changes could induce depression. One is death of a family member, friend, or pet. Others include parents' divorce, separation, or remarrying. Relocating to another place or school can also affect an individual making him depressed ***(Paykel, 2003).*** It has also been increasingly recognised that a depressed person might generate his or her own negative life events and stress ***(Hammen, 2006).***

Rationale

There has been a lack of studies on symptomatic profile of depression in our community. Therefore, the present study was conducted to assess the symptomatic profile difference of depression in young compared with older adults.

Hypothesis

It was hypothesized that symptoms of depression in young adults differ from that of middle-aged and elderly.

AIM OF THE WORK

1. To compare the self –rated severity of depression with the clinician rated.
2. To compare the phenomenology of depression in young, middle-aged and elderly.
3. To find the relation of onset of depression with stressful life events.

Chapter 1

DEPRESSION: LIFE SPAN PERSPECTIVE

1. Introduction

Depression has been defined generally as an affective condition, sometimes pathological, involving emotion of helplessness and hopelessness which can sometimes be overpowering and which is often accompanied by a general lowering of psychophysical activity ***(Rampund and Moore, 2000)***.

In the field of psychiatry, depression defined as recurrent disorder, consisting of discrete episodes of abnormal low mood, associated with functional impairment. The core symptoms of depression include depressed mood and/or loss of interest (anhedonia). Vegetative symptoms include alteration in sleep (insomnia or hypersomnia), appetite (increase or decrease), and low energy. Cognitive symptoms include excessive guilt, hopelessness, helplessness, and suicidal ideation. Depression may also be associated with impaired concentration or even frank cognitive impairment. Severe depression may be complicated by psychosis; that is, hallucination and /or delusion (typically persecutory delusions or delusional of guilt) ***(Kaplan and sadock, 2003).***

Also depression is known to be an extreme, persistent and recurrent condition that interferes significantly with the

ability of the individual to function within his or her environment, and one's vulnerability to depression is determined by the interplay of multiple genes and the environment ***(Solomon et al., 2000)***.

Depression is among the most prevalent of all psychiatric disorders. In fact, the rates of depression are so high that the World Health Organization (WHO) Global Burden of disease study ranked depression as the single most burdensome disease in the world in terms of total disability adjusted life years among people in midlife ***(Blazer, 2000)***. In epidemiological studies, depression has been found to be associated with poor physical health, in particular, with fibromyalgia, high rates of cardiac problems, and higher rates of smoking ***(Wulsin and Singal, 2003)***. There is also a significant economic cost of depression. In a recent analysis of depression in the workplace estimated that the annual salary-equivalent costs of depression-related lost productivity in the United States exceeds $36 billion ***(Kessler et al., 2006)***. In addition to these findings concerning the impact of depression on health and workplace productivity, there is now mounting evidence that depression adversely affects the quality of interpersonal relationships and, in particular, relationships with spouses and children. Not only is the rate of divorce higher among depressed than among non depressed individuals ***(Wade and Cairney, 2000)***, but also the children of depressed parents have themselves been found to be at elevated risk for psychopathology ***(Kessler et al., 2001)***.

Depression is a highly recurrent disorder. Over 75% of depressed patients have more than one depressive episode often developing a relapse of depression within 2 years of recovery. This high recurrence rate in depression suggests that specific factors serve to increase people's risk of developing repeated episodes of this disorder. In this context, therefore, in trying to understand mechanisms that increase risk for depression, investigators have examined biological, genetic factors, psychological and environmental characteristics that may lead individuals to experience depressive episodes ***(APA, 2006)***.

2. Epidemiology of depression

Major depression is currently ranked fourth worldwide in disease burden, and it is expected to rank first in disease burden in high-income countries by the year 2020 ***(Murray et al., 2001)***. 12-month prevalence of major depression is 6.7% of U.S. adult population, 30.4% of these cases (e.g., 2.0% of U.S. adult population) are classified as "severe" ***(Kessler et al., 2005)***. Women are 70% more likely than men to experience depression during their lifetime. Non-Hispanic blacks are 40% less likely than non-Hispanic whites to experience depression during their lifetime. Compared to adults over the age of 60 years, 18-29 years old are 70% more likely to have experienced depression over their lifetime, 30-44 years olds are 120% more likely, and 45-59 years are 100% more likely. For 12-month prevalence, 18-29 years olds are 200% more likely to have experienced depression than those

ages 60+; 30-44 years old are 80% more likely. Average age of onset of major depression is 32 years old ***(Andrade et al., 2003)***.

3. Clinical presentation of depression

Depression signifies an affective experience (mood state), a compliant (reported as a symptom) as well as a syndrome defined by operational criteria. As an affective experience of sadness, it is common to all humans; as a symptom, it is present in several mental and physical illnesses and, as a syndrome, it is associated with specific mental and physical disorders ***(Serby and Yu, 2003)***.

Depressive episode – major depression

The typical symptoms of depression are depressed mood and lack of interest, pleasure and energy. The typical symptoms are combined with the additional ones in many patterns, each one of them determining the clinical picture of a depressive episode at the individual's level. Symptoms may not be stable during the episode, and their change over time adds to the polymorphic presentation of each particular depressed patient ***(American Psychiatric Association, 2000).***

- **Depressed mood**

Depressed mood is the hallmark of all depressions, regardless of their additional specifying features and of their intensity, duration and variation. Depressed mood is a sustained

emotional state that is characterized by sadness, low morale, misery, discouragement, hopelessness, emptiness, unhappiness, distress, pessimism and other related affects that, if assessed in isolation, cannot easily be delineated from the emotional states universally experienced by all human beings when faced with life's adversities. The depressed mood lasts long enough to be felt as an unalterable affective state. It may occur spontaneously but, even if it has been triggered by a life event, it evolves autonomously, dissociated from that event, and resists being changed through reasoning or encouragement. It is associated with cognitive and somatic symptoms (guilt, self-reproach, suicidal thoughts and a variety of unpleasant and painful bodily sensations) that are not commonly encountered in non-depressed mood states ***(Geddes et al., 2006)***.

- **Anhedonia-loss of interest**

Anhedonia and loss of interest are symptoms closely associated with the depressed mood, varying in intensity along with the feeling of sadness. Patients are unable to express emotions, even their own psychic pain they are unable to draw pleasure from previously enjoyable activities or to preserve their interests and affections. In severe cases they disregard and abandon most of the things they valued in life. Yet to a great extent they retain insight of their own inability to experience and express normal emotions and this intensifies their suffering ***(Treadway et al., 2012)***.

- **Cognitive Disturbances**

Subjective complaints of impaired concentration, memory, and attention are common in people with major depressive disorder (MDD) and research shows that a variety of structural brain abnormalities are associated with MDD ***(Sheline, 2003).*** These findings have intensified the interest in quantitative assessment of cognitive and neuropsychological performance in patients with mood disorders. Many studies that used standardized cognitive tests have found that mild cognitive abnormalities are associated with MDD and that these abnormalities are more pronounced in persons who have MDD with melancholic or psychotic features. Older patients with MDD, especially those with onset of illness after age 55 years and patients who have signs of vascular injury to the brain, were also shown to have cognitive abnormalities ***(Herrmann et al., 2007)***.

More than 20% of the general population complaint of poor memory, increasing to more than 40% in those over the age of 65. Objective memory impairment is about half those rates, but the gap narrows with increasing age. Subjective memory problems are also common in depression. The mechanisms underlying these complaints and their relationship to the reported abnormalities in medial temporal structures remain to be determined ***(Armin et al., 2000)***.

There is abundant evidence that depression influences attention. People with clinical or subclinical depression tend to

report persistent ruminations about important problems in their lives. Indeed, people with greater levels of depression tend to ruminate more and are less easily distracted from their ruminations ***(Lam et al., 2003)***. Further evidence of depression's influence on attention thus comes from the fact that depressives' ruminations interfere with their ability to concentrate on other things. For instance, when people come into a psychological testing situation with clinical or subclinical depression, their ruminations interfere with their ability to focus on cognitive tasks and reduce their performance ***(Lyubomirsky et al., 2003)***.

Difficulty in concentrating, negative thoughts, low self-esteem and self confidence, hopelessness, self-depreciation and self-reproach, a sense of worthlessness and sinfulness, negative outlook on the world and suicidal thoughts are some of the most common negative features accompanying the depressed person's state of feeling. If these thoughts are many, persistent and non amenable to change by reason, they are regarded as delusions and qualify for the diagnosis of mood-congruent (delusional-psychotic) depression. When thoughts are discordant with the depressed mood, delusions of persecution, thought insertion, thought broadcasting and other similar delusion predominate, then mood-incongruent (delusional-psychotic) depression is diagnosed. Whether these cognitive disturbances result in depressed mood, as the cognitive theorists view it, or they are the derivatives of the depressed mood state, is still a debatable issue

of limited interest to the practicing physician ***(Delago and Schillerstrom, 2009)***.

- **Psychomotor Disturbances**

Psychomotor disturbances have the advantage of being readily observed and even objectively measured. They include, on the one hand, agitation (hyperactivity) and on the other, retardation (hypoactivity). Although agitation, usually accompanied by anxiety, irritability and restlessness, is a common symptom of depression, it lacks specifity. In contrast, retardation, manifested as slowing of bodily movements, mask-like facial expression, lengthening of reaction time to stimuli, increased speech paucity and, at its extreme, as an inability to move or to be mentally and emotionally activated (stupor), is considered a core symptom of depression. Their presence is currently being used as a diagnostic symptom of the melancholic type of depression in DSM-IV and the severe depression with somatic symptoms in ICD-10 ***(Benazzi, 2002)***.

- **Vegetative symptoms**

Vegetative symptoms constitute the most biologically rooted clinical features of depressive disorders and are commonly used as reliable indicators of severity (severe depression with somatic symptoms in ICD-10 and melancholia in DSM-IV). They are manifested as profound disturbances in eating (anorexia and weight loss, or the reverse, bulimia and weight gain), in sleep

(insomnia and/or hypersomnia), in sexual function (decreased sexual desire or in a minority of cases the reverse), loss of vitality, motivation, energy and capacity to respond positively to pleasant events. Additionally, concomitant bodily sensations, usually diffuse pains, and complaints of fatigue and physical discomfort are reported. Disturbances of biorhythms are frequent and are considered as characteristic features of melancholia. They are mainly manifested in sleep patterns, predominantly with early morning awakening ***(Maj and Srtorius, 2002)***.

4. Highlights of changes from DSM-IV-TR to DSM-5

DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. To address concerns about potential overdiagnosis and overtreatment of bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years who exhibit persistent irritability and frequent episodes of extreme behavioral dyscontrol. Based on strong scientific evidence, premenstrual dysphoric disorder has been moved from DSM-IV Appendix B, "Criteria Sets and Axes Provided for Further Study," to the main body of DSM-5. Finally, DSM-5 conceptualizes chronic forms of depression in a somewhat modified way. What was referred to as dysthymia in DSM-IV now falls under the category of persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. An inability to find scientifically meaningful differences between

these two conditions led to their combination with specifiers included to identify different pathways to the diagnosis and to provide continuity with DSM-IV ***(Grohol, 2013)***.

Major Depressive Disorder

Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV. Criterion A for a major depressive episode in DSM-5 is identical to that of DSM-IV, as is the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life, although this is now listed as Criterion B rather than Criterion C. The coexistence within a major depressive episode of at least three manic symptoms (insufficient to satisfy criteria for a manic episode) is now acknowledged by the specifier "with mixed features." The presence of mixed features in an episode of major depressive disorder in creases the likelihood that the illness exists in a bipolar spectrum; however, if the individual concerned has never met criteria for a manic or hypomanic episode, the diagnosis of major depressive disorder is retained ***(APA, 2013)***.

Specifiers for depressive disorders

Suicidality represents a critical concern in psychiatry. Thus, the clinician is given guidance on assessment of suicidal thinking, plans, and the presence of other risk factors in order to