



MAJOR DEPRESSIVE DISORDER: A REVIEW OF VARIOUS PERSPECTIVES ON DEPRESSION AND METHODS OF TREATMENT

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ABSTRACT

Major depressive disorder is one of the most common psychological disorders in the general population and among psychiatric patients, and is often accompanied by significant symptoms and impaired function. The results of epidemiological studies have reported depression as the most common psychiatric disorder. In such a way that from every 100 people, approximately 13 males and 21 women suffer from this disorder during a period of their life. Considering the importance of depression disorder and the need for people's awareness about this disorder and attempting to control and treat it in this descriptive-analytical study and by using library resources we aimed to investigate the major depressive disorder and address cases such as the features of the mentioned disorder, its etiology, various perspectives on depression and its treatment methods. It is hoped that the contents of this research will make people aware of this disorder and try to cure it.

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Introduction

Major depressive disorder is one of the most common psychological disorders in the general population and among psychiatric patients, and is often accompanied by significant symptoms and impaired function. [1]. According to studies conducted, of every 100 people, approximately 13 males and 21 women are affected by this disorder during their life [2]. Depression symptoms that appear in older people are different from signs of younger adults. In the elderly, the body symptoms are more obvious. Moreover, the elderly are less likely to say that they are experiencing psychological distress. Approximately 14.8 million adults in the United States are suffering from major depressive disorder. This disorder has resulted in a disability among people who are aged between 15 and 44. Major depression disorder is a psychotic disorder with an incidence of about 16% over a lifetime [1]. Approximately, one percent of children show the pattern of depression. This percentage remains the same until the early days of adolescence but the prevalence of depression is sharply rising after the age of 14. From the age of 14 to adulthood, the prevalence of depression reaches 15% [3]. After examining the trend of major depressive disorder, researchers have concluded that depression is a heterogeneous disorder that has many trends. Nearly 40% of people who have had a major depression period have never had another period, which means nearly 60% of them will have a second period. 70% of those who have experienced two periods will have the third period and 90% of those who have had three periods, will experience the fourth period [3].

Considering the importance of depression disorder and the need for people's awareness about this disorder and attempting to control and treat it in this descriptive-analytical study and by using library resources we aimed to investigate the major

depressive disorder and address cases such as the features of the mentioned disorder, its etiology, various perspectives on depression and its treatment methods. It is hoped that the contents of this research will make people aware of this disorder and try to cure it.

2 .Major depressive disorder

In depression, the level of mental rumination of the person about negative issues has increased and the patient has a pessimistic feel about unpleasant events of the past, current mental preoccupation and the future. When we say mental rumination it means anxiety, distraction, attention biases, memory slips, mental cranking, daydreaming, self-attention, obsessive thoughts, and intrusive mental processes that interfere with cognitive activities [4]. Depressed mood and lack of interest and pleasure are the key symptoms of depression. The patient may state that he feels sorrow, despair, vanity and worthlessness. For the patient, depressed mood usually has a specific quality that is different from normal sadness. Approximately, two thirds of depressed patients think about suicide and 10 to 15 percent of them end their lives [4]. Depression periods can be classified in terms of severity into, weak, moderate, severe, or severe with psychotic features (such as delusions or hallucination in depression periods). A major depression period typically leads to the formation of one of the important components in some mood disorders. When there is such a period in its simplest form, in other words, there is no mood disorder syndrome; the most appropriate diagnosis is the diagnosis of major depression. Patients who suffer from major depression are more likely to be worried about the recurrence of depression. This process leads to maintaining a non-useful self-focus, monitoring signs and symptoms of depression, misinterpretations about their internal state and affects the relapse of depression. Monitoring the threat has many negative effects and leads to rumination and prolongs the mood of depressed [5].

2.1. Features of the major depression period

Mental health experts believe that depression develops rapidly when changes in social conditions or individual values occur. Apparently, there is no relationship between depressions, social class, literacy, race, income or marital status. Generally, the risk of developing major depressive disorder varies from 10-25% for women and from 5 to 12% for men [3].

Depression is characterized by high rates of self-immolation [6]. The emotional symptoms of major depressive period include a bad mood which is greater than the usual disappointments and sad excitements of everyday life. This frustration can emerge in the form of an intense nostalgia or a lack of interest in the enjoyable aspects of life. In some cases, the causes of depression are the experience of the loss due to the loss of a dear person. Although depression is normal after the death of a dear person, it is a mood disorder if the period of sadness becomes too long (more than 2 months). However, most of the major depressive periods do not follow a particular event.

The fact that sadness is caused without a specific event often makes people to feel smashed confused. Usually the person's life is drawn into chaos in a period of major depression as a result of impairment in his work and his family. Physical Symptoms of the major depression period are called body symptoms. The suffering person is tired and impulsive and experiences slow physical motion which is called psychomotor retardation. Some depressed people show conflicting signs of psycho-motor restlessness; consequently, their behavior is insane. Many depressed people have difficulty in thinking, concentrating, or making decisions. They may be easily distracted or have a memory problem. In most cases, there might be thoughts about suicide or proceeding to the suicide. The scope of these thoughts varies from thinking about suicide to taking action. Frequency, severity and fatality of these thoughts also fluctuate [3]. People in the depression period have a significant change in their patterns of sleep so that they either sleeping too often or suffer from sleeplessness. In fact, in people experiencing major depression periods, dramatic changes in sleep patterns, Rapid eye movements (REM), indicates the disturbances in sleep, intermittent insomnia, and early morning awakening. During REM sleep, eye movements are greater and the duration of REM sleep increases in the early hours of the night. These abnormalities in sleep are usually before the onset of basic major depression and are among those people who are at the risk of mood disorder such as first-degree relatives who have experienced major depression [6].

2.2 The etiology of depression

2.2.1 Biochemical factors

It's not clear yet that what mechanisms cause depression in people who are biologically ready to be depressed. The oldest theory in this regard was the Catecholamine hypothesis [7], which states that the deficiency of norepinephrine (a kind of Catecholamine) causes depression. Catecholamine hypothesis is replaced by indoleamine hypothesis [8], which declares that the deficiency of serotonin is involved in the behavioral patterns of depression.

Changes in the Gama Amino Beutric Acid (GABA) play a role in depression [9]. GABA levels have been reduced in the brains of people with depression. These observations have been reinforced by the finding that announces some anticonvulsant medications that stimulate GABA have an anti-depressant effect. Research in the field of nervous system- Indocrine also refers to the important relationship between hormonal activity and depression. Researchers have focused on the production of body cortisol, a hormone that intervenes in mobilizing body functions during stress. It seems like this hormone is produced to a greater extent in people with major depressive disorder [10]. Depression is often determined by long-term activity and amygdala's performance in response to negative information [11]. Reliable evidence has been observed for the bias in emotional processing at the memory level [12]. Recent brain imaging studies have shown that depression is accompanied by a reduction in the activity of the brain in the cortex of the anterior cingulate and posterior prickly cortex [13]. Evidence suggests that despite medical and psychological treatment of depression, [12] many remaining periods may recur again:

A. Biogenic Amines

Of the biogenic amines, norepinephrine and serotonin are two neurotransmitters that are most commonly discussed in the physiopathology of mood disorders.

B. Norepinephrine:

The relationship between reducing the number of adrenergic receptors and the clinical response to antidepressants that has been shown by basic science studies is probably the most convincing part of the data suggesting the direct role of neuroendocrine system in depression. Other evidence has shown the involvement of presynaptic beta adrenergic receptors in depression since the activation of these receptors reduces the release of norepinephrine. Presynaptic beta adrenergic receptors are also located on serotonergic neurons and regulate released serotonin levels. The existence of adrenergic antidepressant drugs and clinically effective such as venlafaxine enhance the role of norepinephrine in the physiopathology of at least some of the symptoms of depression [14].

C. Serotonin:

With the dramatic effects of selective inhibitors of Serotonin absorption such as fluoxetine in the treatment of depression, serotonin has become a biogenic amine neurotransmitter that is most associated with depression. In addition to the fact that Serotonin Specific Reuptake Inhibitor (SSRI) and other serotonergic drugs are effective in the treatment of depression; other data also suggest that serotonin is involved in the physiopathology of depression. Evacuating serotonin may cause depression; and in some suicidal patients, the density of serotonin metabolites is low in the Cerebro Spinal Fluid (CSF) and the density of the serotonin absorption sites is low at the platelet level [13].

D. Dopamine:

Although norepinephrine and serotonin are bio-amines that are most closely associated with the physiopathology of depression, dopamine is also thought to play a role in depression. The data show that a reduction in dopamine activity may be effective in depression. Drugs that reduce dopamine concentrations, such as reserpine, and diseases that lower dopamine concentrations, such as Parkinson's disease, are associated with depression symptoms. Also, drugs that increase dopamine concentrations such as tyrosine, amphetamine, bupropion can reduce depression symptoms. Two new theories about Dopamine and depression are that Mesolimbic dopamine routes may be disturbed by depression and that the dopamine receptor type 1 (D1) may have a lower activity in depression [13].

3. Different perspectives of psychology on Depression Disorder**3.1. Psychoanalytic theories**

Old psychoanalytic theories on mood disorders have focused on the subjects of injuries of intra-mental processes as the basis of mood disorders and have less emphasized on lack. For instance, John Bullaby, the famous British psychologist, believed that if people were raised by parents who could not establish a stable and secure relationship with them, they would be depressed in adulthood [15]. Yules Bemporad (1985) presented another form of the issue of the lack of parents' affection who believes that children in these families need others to love them. When they grow up, they establish relationships in which they value excessively for the sake of their spouse's support and when such relationships are cut off, the depressed person is drowned in feelings of incompetence and loss. In the psychoanalytic process, using the method of free association, verbal evacuation takes place. Interpretations also provide a new insight into the conflicts of depression and past events [14].

3.2. Cognitive Theories

According to the cognitive perspective, individuals experience depressive disorder if their early experiences make them sensitive to a particular type of lesion or response to a particular stressful event. Depressed people respond to stressful experiences by activating a range of thoughts that are named cognitive triangle by Beck [16]. The cognitive approach is directly designed for depressed people. Understanding the hypothesis of depression, in addition to the depressive thinking cycle, are cognitive distortions; which means the mistakes that depressed people commit when they conclude their experiences [17]. These cognitive distortions include the use of irrational rules, such as arbitrary inference, immediate conclusions, excessive generalization, and enlarge the issue. Using these rules makes a depressed person to attribute negative meanings to the past and present events and make frustrating predictions about the future. According to Beck, what is more annoying depressed people is their thought. Depressed people feel sorry because they believe they are deprived of something that threatens their self-esteem. In addition, they are convinced that they are responsible for this loss. Their stupid attitudes make them suppose that they are worthless and helpless and their efforts are doomed to failure. They distort their experience including positive experiences in a way that is consistent with this general belief [18].

3.3. Behavioral Theories

One of the oldest depressive behavioral theories was that depressed people abandon life because they no longer have any incentive to be active. An old behavioral stance states that defective social skills are involved in depression. One who has a defective interpersonal relationship loses the reinforcements that others care for [20]. As a result, this person probably becomes depressed and stays depressed. Sometimes, the depressed person may acquire secondary benefits. Getting out of responsibility, such as job responsibilities or family obligations, can aid in boosting depression.

An important model of behavioral approach to depression is the learned inability model that states that depressed people are not able to influence their environment. [20] The revised version of the theory takes into account the role of assignments which means justifying events that happens to people. In the revised model of learned inability, facing situations that cause distress

(harmful life events), encourages depressed people to attribute their disability to the lack of personal facilities. They perceive this fact as inferiority and extend their inability to every aspect of their lives. Such assignments are "Internal, stable and general." all types of assignments made by depressed people can make them vulnerable when they encounter life-threatening events [21]

According to behavioral models, stressful life events are the third major factor involved in depression because they differ in the ability of an individual to perform important and relatively well-behaved patterns [21].

3.4. Social, cultural and interpersonal views

Some depressed people have had permanent problems in their interactions with others. In depressed people who their social skills are so deficient, their persistent pessimism cause other people to feel guilty and depressed and this creates a cycle. As a result, others react with criticism that this reinforces the negative attitude of the depressed person towards the world. Weissman, M. along with Klerman, J. and colleagues based on this view created a model for awareness of mood disorders that emphasizes disturbing social performance. It incorporates the beliefs of behavioral psychologists that emphasize on the defective social skills of depressed person, but goes one step further and address to the source of depressed person's problems. The interpersonal theory of depression originated from the interpersonal approaches of Adolph Meyer (1957) and Harry Stack Sullivan (1953) John Bolby's Attachment Theory. Mayer, because of his psycho-biological approach was known for his maladaptive behavior, emphasized on this matter that how mental problems can show individual mistakes to adapt to the psychosocial environment. He believed that physical symptoms could be created in relation with psychological distress. Sullivan considered abnormal behavior as the result of defective interpersonal relationships, including inadequacies in communication. Each of these theories can be applied to a variety of mental disorders but Boleby's theory, with its particular emphasis on disturbed attachment associations in early childhood, as the cause of later dissatisfaction in life, is more associated with depression.

4. Various depression treatments

4.1. Psychosocial treatments

Although most doctors and researchers believe that the combination of psychotherapy and drug therapy is the most effective way to treat major depressive disorder, some data suggest a different perspective. Some data suggest that each of these two methods, psychotherapy and drug therapy, can work on their own at least in those who have a mild period of major depression and usual use of combined therapy will only increase the cost of treatment and cause unnecessary side effects.

Three types of short-term psychotherapy, cognitive therapy, interpersonal therapy and behavioral therapy have been studied in terms of the effects of treatment for major depressive disorder. Although analytical psychotherapy is not well studied for its effect on major depressive disorder, it has long been used to treat depression disorders, and many professionals use this method as their primary treatment method. The active and guidance role of the therapist, direct identifiable goals and specific termination point of short-term psychotherapy can separate three types of short term psychotherapy from analytical psychotherapy.

Although less research has been undertaken on psychosocial theory of depression compared with other types of psychotherapy, the evidence obtained on the effect of psychodynamic psychotherapy is promising. In a randomized controlled test of psychodynamic psychotherapy or cognitive-behavioral therapy, the results of depressed patients did not show any difference between the two types of treatment. [21]

4.2. Cognitive Therapy

The therapeutic cognition created by Auran Beck is focused on cognitive transformations that are supposed to be in the major depressive disorder. These changes include the selective attention to the negative aspects of sickly and unrealistic situations and the understanding about consequences. For example, lethargy and lack of strength are the result of expecting failure for the patient in all areas. The aim of therapeutic cognition is to eliminate depression periods and prevent them from recurring by identifying and testing negative cognition; creating different, flexible and positive thinking methods and practicing cognitive and behavioral responses. Therapeutic cognition has been effective in the treatment of major depressive disorder; most studies have shown that therapeutic cognition has the same effect as drug therapy and has fewer side effects than drug therapy and tracking with it is also better [21].

4.3. Interpersonal psychotherapy

Interpersonal psychotherapy, developed by Gerald Klerman, focuses on one or two current interpersonal problems and uses two assumptions: first, current interpersonal issues are likely to be rooted in past disruptive relationships. Second, the current interpersonal problems are probably involved in the preparation or duration of the current depressive symptoms. An interpersonal psychotherapy program is usually made up of 12 to 16 weekly sessions. It is clear that this treatment with an active therapeutic approach doesn't deal with the intra-mental phenomena such as defense mechanisms and internal conflicts. Specific behaviors for example, the lack of decisiveness, social and functional disorder and Transformational thinking may be mentioned only in the context of their meaning or their effect on interpersonal relationships [14].

4.4. Behavioral Therapy

Behavioral therapy assumes that non-adaptive behavior patterns cause a person to receive a little positive feedback from the community or may be explicitly excluded. By paying attention to non-adaptive behaviors during treatment, patients learn to behave in such a way to receive positive reinforcement. Treatment therapy for major depressive disorder has been the subject

of numerous controlled studies. Limited data indicates that behavioral therapy is an effective therapeutic approach for major depression disorder [15].

4.5. Analytical psychotherapy

Psychoanalysis methods for treating mood disorders are based on depression psychoanalytic hypotheses. In general, the purpose of analytic psychoanalysis is to change the personality frame, not just removing the symptoms of depression. Improvement in the level of interpersonal trust, intimacy, coping mechanisms, the ability to experience bereavement and a broad range of excitements are the goals of analytical psychiatric.

4.6. Family Psychotherapy

Family Psychotherapy is not usually considered a primary treatment for major depressive disorder but increasing evidence indicates that helping a patient with mood disorder to relieve stress and coping with stress can reduce the probability of recurrence. Family Psychotherapy is permissible if disruption of family life or marriage put the patient at risk or mood disorder is facilitated or prolonged by family status. Family psychotherapy examines the role of depressed patients in the mental well-being of the whole family, while assessing the role of the entire family in the duration of patient's depression.

4.7. Drug therapy

Antidepressant medicine is the most common type of treatment for depressed people. The most commonly used drugs for treating depression are Tricyclic antidepressants, monoamine oxidase inhibitors and Selective serotonin reuptake inhibitors [19].

4.8. Schema Therapy

Schema therapy is a new integrated therapy that has been developed by Yang et al. and is mostly based on the development of concepts and methods of traditional cognitive-behavioral therapy. In truth, this approach is the cognitive behavioral therapy supplement; because cognitive-behavioral therapies have faced some problems in the treatment of cognitive diseases that the schema therapy has been trying to fill this gap. Schema Therapy is an innovative treatment that was developed by Yang et al. (1990, 1999) and is based on cognitive-behavioral therapies. In this method, various therapeutic approaches including cognitive-behavioral theories, psychoanalytic theories structuralism, object relationships and attachment have been used. Under the impression of structuralism, Yang (1994) developed a comprehensive model called Schema Therapy or Schema-based therapy [22].

5. Conclusion

Let's go back a little. With emphasizing on the introduction of major depressive disorder, we highlight some of the features of the mentioned disorder, its etiology, and various views on depression and the methods of treatment.

Regarding the fact that approximately 15% to 20% of people suffer from different levels of this disease and also, at least 12% of people need to be treated in their lifetime and 75% of psychiatric patients at mental hospitals suffer from this disorder, therefore, the need to control and treat depression is considered as one of the most urgent requirements of individual mental health. The World Health Organization predicts that by 2020, depression will be the biggest illness that will be the second leading cause of death. Clinical depression is so common that is called the cold of Psychiatry. In most cases, depression is limited in time. Untreated periods usually disappear after 3 to 6 months, but the likelihood of recurrence is high. Therefore, the aim of the treatment should not only be the acceleration in improving the current period but also creating sustainability in recovery and, if possible reduce the risk of recurrence [22].

In short, it is hoped that the contents of this passage will be helpful in improving the awareness of people about depression and efforts to treat it, and above all, helping other people recover from this disease.

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