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# Depression

Discussion paper prepared for

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Dr. Emmanuel Persad graduated from the University of Durham, England in 1964. He did post-graduate training in Psychiatry at the University of Toronto from 1966 to 1969. He was granted his fellowship in Psychiatry in 1969. He was awarded a Gold Medal in Psychiatry from the University of Toronto. He joined the faculty at the University of Western Ontario in 1990 and currently holds the rank of Professor Emeritus at the University of Western Ontario and Adjunct Professor at the Queen's University. His clinical and research interests were in Mood Disorders, and he has published widely in that area. He served as Chair, Department of Psychiatry, University of Western Ontario from 1995 to 2001, and Chief of Psychiatry, London Health Science Centre & St. Joseph's Health Centre from 1993 to 2001. Dr. Persad was an assessor for the Tribunal from 1991 to 2002.

This medical discussion paper will be useful to those seeking general information about the medical issue involved. It is intended to provide a broad and general overview of a medical topic that is frequently considered in Tribunal appeals.

Each medical discussion paper is written by a recognized expert in the field, who has been recommended by the Tribunal's medical counsellors. Each author is asked to present a balanced view of the current medical knowledge on the topic. Discussion papers are not peer reviewed. They are written to be understood by lay individuals.

Discussion papers do not necessarily represent the views of the Tribunal. A vice-chair or panel may consider and rely on the medical information provided in the discussion paper, but the Tribunal is not bound by an opinion expressed in a discussion paper in any particular case. Every Tribunal decision must be based on the facts of the particular appeal. Tribunal adjudicators recognize that it is always open to the parties to an appeal to rely on or to distinguish a medical discussion paper, and to challenge it with alternative evidence: see *Kamara v. Ontario (Workplace Safety and Insurance Appeals Tribunal)* [2009] O.J. No. 2080 (Ont Div Court).

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## Introduction

Depression is a commonly used word to describe a mood (sad), a reaction (getting bad news) or a disorder (a clinical syndrome). This paper addresses the category of Depressive Disorders. Such disorders are diagnosed on the basis of **internationally agreed upon criteria** (ICD 10 or DSM IV TR<sup>\*</sup>). These disorders are defined as disturbances of mood accompanied by difficulties in thinking (slowed down) behavior (withdrawn or agitated) and inability to perform activities of daily living. Depressive Disorders can occur as single episodes or as recurrent episodes. A diagnosis is made if the symptoms last for two weeks. If not treated, the disorder can affect the person for months or years.

### **This paper deals with the following features of depression:**

- Prevalence in the community and in the workplace
- Diagnosis
- Co-morbidity
- Causation
- Adjudication issues
- Treatment

## Prevalence

Depression occurs across all cultures. It is responsible for significant disability and death. Approximately 15% of people who suffer from depression commit suicide. It occurs throughout the life span. The World Health Organization (WHO) reported that the worldwide prevalence rates range from 2% to 15%. It is rated as the 4th leading cause of disease burden in 2000.<sup>1</sup> It is projected to become the second leading cause of disability after heart disease by the year 2020 globally. Every year about 7.5 million Canadians suffer from Depression and other related disorders. Most of them are in the age group of 25 to 64 years. Depression accounts for 4.4% of total Disability Adjusted Life Years (DALY). DALY is designed to quantify the impact of premature death and disability on a population by combining them into a single comparable measure. Studies show an incremental growth in the rates of depression in developed countries: 6.4% in 1991, 7.2% in 1995

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\* International Classification of Disease 10th Edition 2005 and the Diagnostic/Statistical manual of the American Psychiatric Association 2000.

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and 7.5% in 2001. This data appears to hold true in all developed countries. The situation elsewhere in the world is less clear. It is felt that greater awareness of depression leads to more people seeking professional help and therefore higher rates are reported. The issue requires greater study.

Depression as a workplace issue is relatively common. With an estimated 10 million Canadians in the workforce, Canada loses approximately 35 million work days per year due to poor mental health.<sup>2</sup> A 2006 report indicated that depression and anxiety disorders cause more work absences than any other medical condition. Studies have found that some specific workplace issues are likely to contribute to the onset and/or perpetuation of depression. These include poor morale, perceived unreasonable demands, loss of control of one's work environment and perceived criticism.<sup>3</sup> The question is, why do not all people exposed to these workplace stressors become depressed? The (likely) answer is that some people, by reason of genetic disposition, personality and/or previous life experiences, are more vulnerable to these workplace stressors.<sup>4</sup> Even though millions of dollars are spent in treating Depressive Disorders in Canada, many individuals who suffer from Depression do not receive adequate care because of lack of service, undiagnosed depression or lack of motivation to seek help. Lack of access to psychiatric services might be a barrier to treatment but it is known that Depression can be effectively treated in primary care settings.<sup>5</sup>

## Co-Morbidity

This refers to the co-occurrence of two or more clinical disorders. Depression as a clinical disorder can co-occur with Anxiety Disorders, substance abuse, physical or medical illnesses, Post Traumatic Stress Disorder and chronic pain. Some less well established conditions, i.e. without solid clinical evidence, which co-occur with Depression, are Chronic Fatigue Syndrome, Fibromyalgia, Borderline Personality Disorders and the dementias. Pseudo-dementia is a condition in which a depressed patient presents with symptoms of dementia. The diagnosis can be clarified through an in-depth assessment and with the use of cognitive testing.

## How Depression is Diagnosed?

### Rating Scales:

A variety of rating scales are available for clinical use. They can augment the clinical assessment but cannot replace it. They can be useful screening devices. These scales (e.g. Montgomery-Asberg, the Burns or the Hamilton

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Depression Scales) can provide an indication of severity. Self administered rating scales (e.g. the Beck Rating Scale) can help patients assess their mood on a daily basis. Rating scales, both the self administered and the ones completed by clinicians, have limited applications. They provide a score which can be an index of severity and can reflect change over time.

### **Depressive Disorder:**

Five or more of these symptoms should be present for at least a two week period.

- Depressed mood all or most of the day
- Diminished interest
- Significant weight loss/gain
- Insomnia or hypersomnia
- Agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness, guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death and suicide

### **Depressive Episode - Recurrent:**

Same as Depressive Disorder above but the individual may have discrete recurrent episodes.

### **Depression as part of a Bipolar Mood Disorder:**

Mood Disorders include two main clinical types: unipolar (Depression only) and Bipolar (Depression alternating with mania or hypomania). Mania is a mood state in which the affected individual experiences elation, euphoria or irritability. This is accompanied by increased energy and physical activity, lack of the need for sleep and poor judgment leading to social and financial indiscretions. Some of these individuals may become psychotic, that is, out of touch with reality. Some individuals who suffer from a Bipolar Mood Disorder can experience "mixed states". In these states, the individual may experience symptoms of both depression and mania at the same time. In the Depressive phases the symptoms are the same as for the Depressive Disorders. However some individuals who are Bipolar experience symptoms such as over eating and oversleeping during the Depressive Episodes.

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### **Depression as part of Seasonal Affective Disorder (S.A.D.):**

Depression can also occur as part of Seasonal Affective Disorder. S.A.D. is characterized by the occurrence of depression in the fall and winter months. The symptoms include lethargy, overeating and oversleeping. All the other symptoms are similar to Depressive Episodes. There is usually a spontaneous remission in the spring. Hypomanic episodes, (a less severe form of mania), may also follow the depressed episodes.

### **Dysthymia:**

Dysthymia is a type of Depressive Disorder which is longstanding and lasts for several years. Dysthymia is a depressive condition in which the affected individual may feel depressed but is able to function. The following features are usually present: poor appetite or overeating, insomnia or oversleeping, low energy, low self esteem, poor concentration. The symptoms are less severe and these are individuals who may report "I have never been happy". Dysthymia is the new term for "Depressive Neurosis" (See Appendix 1).

### **Adjustment Disorder with Depression:**

An Adjustment Disorder refers to the development of emotional or behavioral symptoms in response to an identifiable stressor occurring **within three months of the onset of the stressor**. Bereavement is excluded.

Adjustment Disorders can present with a depressed mood, with anxiety or with disturbance of behavior. The symptoms of depression in an Adjustment Disorder are less severe and relate to a specific stressor. Stressors could include workplace related problems, relationship problems or dealing with a terminal illness, etc. The symptoms would not meet criteria for a depressive episode.

### **Other Depressive Disorders:**

Depressive Disorders can occur in the context of specific life events, e.g. Post Partum onset (after childbirth) or as co-morbid (see paragraph above) with Post Traumatic Stress Disorder or Chronic Pain. Also Depressive Disorders can occur as a result of a medical condition, e.g. diabetes or cancer. A diagnosis of a Depressive Disorder or Episode is made after a thorough clinical assessment which will include a full psychiatric history and mental state examination.

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The diagnosis of depression may change over time in the same individual and additional features might appear. These can include psychotic or chronic features. The former applies when the affected individual experiences loss of touch with reality; the latter term is used if the episode persists for more than two years.

### What Causes Depression

There is no single factor responsible for Depressive disorders. However, several factors may contribute to the development of a Depressive Disorder.

**Predisposing factors** (i.e. Factors which contribute to the person's vulnerability to Depression) include family history of depression, physical and sexual abuse, Substance Abuse Disorders, trauma and being female.

**Precipitating factors** (i.e. Factors which were related to the onset of Depression) may or may not exist. Episodes (i.e. periods in which the person is suffering from a Depressive Disorder), especially if they are the recurrent form, can occur out of the blue.

**Perpetuating factors** can include lack of diagnosis, lack of adequate treatment, chronic stress and severe medical or other psychiatric conditions.

A psychiatric report should provide a comprehensive account of all the factors which may be contributing to an episode. In most instances, the diagnostic formulation will indicate that the individual who becomes depressed may have had an inherited predisposition but external factors precipitated and perpetuated episodes of Depression.

### Adjudication Issues

Adjudication of claims for Depression is often a challenge for the Tribunal. This challenge exists because of the lack of specificity in medical reports carrying a diagnosis of Depression.

A medical report should include a psychiatric assessment and a diagnostic formulation as per the D.S.M. IV, (see Table 1 below):

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**TABLE I**

**The DSM IV provides diagnostic information along five axes.**

Axis I:	Clinical disorders (e.g. Depressive Disorder, Bipolar Mood Disorder, Schizophrenic Disorder, Anxiety, Somatoform Disorder).
Axis II:	Personality Disorders (e.g. Antisocial Personality Disorder, Mental Retardation).
Axis III:	Medical conditions.
Axis IV:	Psychosocial and environmental problems.
Axis V:	Global Assessment of Functioning (GAF).

### *Case Scenario*

The following case will illustrate the use of the D.S.M. IV.

- Mr. X was assessed on April 4, 2007 with respect to a claim for Psychotraumatic disability entitlement. He is a 47 year old welder who suffered burns to his left hand at his workplace on June 7, 1998. He required a skin graft for which he was awarded compensation in December 1998. After a comprehensive assessment his psychiatric diagnoses according to the DSM IV were given as follows:

Axis I:	Depressive Disorder - (recurrent) and now in remission - 1st episode ten years ago in 1997, 2nd episode five years ago in 2002.
Axis II:	Obsessional traits.
Axis III:	Chronic pain to left hand and to low back.
Axis IV:	Marital and financial issues. Workplace.
Axis V:	GAF 50. (See Appendix II)

In the assessment of a worker claiming for depression, an assessor in Psychiatry would enquire into the worker's personal history, including the emotional, developmental history, family history, educational and vocational histories as well as coping abilities. A comprehensive inquiry into the symptoms, duration, severity, daily variation, interpersonal exchange and self harm thoughts would be included in such an assessment. A psychiatric report would carefully weigh the contributions from several of the injured worker's life's domains including the work place and provide a diagnostic formulation as per the DSM IV system (See Table 1). It should be noted that

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the diagnostic procedure relies a great deal on the subjective reporting by the affected individual but the mental state examination can provide some objectivity and offer an impression of the validity of the subjective reports. Collateral information from significant others does help in the diagnostic procedure. It is not unusual that psychiatric reports lack the precision found in other situations where the disorder or pathology is validated by objective tests.

This person had a first episode of depression in 1997, so it can be seen that the 1998 workplace accident was not the original cause of the depression. When seen in 2007 he was said to be in remission. Whether the accident may have precipitated a further episode, and whether this episode had remitted at the time of the hearing, would be findings of fact for the Tribunal. However, the GAF i.e. Axis V, could indicate ongoing disability that would be accounted for by the chronic pain or the social stressors.

## Treatment

Treatment for Depressive Disorders can be effective. Treatment is usually a combination of medications (antidepressants/mood stabilizers), psychotherapy and lifestyle changes. Antidepressants fall into the chemical classes of cyclic antidepressants and Mono-Oxidase Inhibitors. The former group includes Serotonin Re-uptake Inhibitors and Selective Serotonin Norepinephrine Re-uptake Inhibitors. Older antidepressants are used less frequently. Response to antidepressants can take four to six weeks. All antidepressants have side effects including weight gain and sexual dysfunction.<sup>6</sup> Ongoing treatment with medication and/or psychotherapy may be necessary to prevent relapse and recurrences. Some depressed patients do not respond to treatment. They are then said to have chronic features, that is, often over two years of no response. Such patients require expert help from centers which specialize in mood disorders.

There are various forms of psychotherapy for Depression. Cognitive /behavioral therapy and interpersonal psychotherapy are well established forms of psychotherapy which require specialized training.

Electroconvulsive therapy (ECT) remains an effective, infrequently used treatment for depression.<sup>7</sup> Debates in the public domain and in the media tend to portray ECT in negative terms. In some situations, it can be life saving. ECT is administered under a general anesthetic. An electrode is placed on the head of the patient and an electric current is passed through the brain. The convulsion caused by this is modified by muscle relaxant drugs. The entire procedure takes 3 - 4 minutes.

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Phototherapy or Light therapy has been used by individuals who suffer from Seasonal Affective Disorders. This may be used in conjunction with antidepressants.

## Summary

Depression is a treatable disorder which affect between 2% to 15% of the adult population in most developed countries. Some studies suggest that the rates of Depression are increasing. Depression causes significant impact on the affected individual's personal, social, family and vocational life.

## Appendix I

The following terminology changes should be noted:

<b>DSM III R (past)</b>	<b>DSM IV TR (current)</b>
Anxiety Neurosis with Depressive Features	Anxiety Disorder
Anxiety Neurosis with Psychosomatic Manifestations	Somatoform Disorder
Conversion Neurosis	Conversion Disorder
Obsessive-Compulsive Neurosis	Obsessive-Compulsive Disorder
Anxiety Neurosis with Phobic Features	Generalized Anxiety Disorder
Anxiety Neurosis with Hypochondriasis	Hypochondriasis

### Appendix II

#### **Global Assessment of Functioning (GAF)**

The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. It is reported on the Axis V of the DSM IV classification.

91 - 100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
81 - 90	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
71 - 80	If symptoms are present, they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.
61 - 70	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51 - 60	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
41 - 50	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
31 - 40	Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
21 - 30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.

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11 - 20	Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
1 - 10	Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
0	Not enough information available to provide GAF.

## References

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## Recommended

Mental Health Economic Statistics. Inst. of Health Economics and the Alberta Mental Health Board 2007.

Depression in the workplace booklet. Canadian Mental Health Association 2004.