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S22. Long-term course of depressive disorders
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EPIDEMIOLOGY AND PUBLIC HEALTH IMPACT OF DEPRESSION

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Recent progress in the field of classification of mental disorders and improvement of research designs in epidemiology by using the so-called new diagnostic instruments, new sampling procedures and methods of analysis have allowed making more comparisons between epidemiologic surveys conducted in different countries. Results available from several parts of the world have shown that rates of bipolar disorder are quite consistent across several countries. However, for major depressive disorder lifetime prevalence rates vary widely with low rates in Asia (1.5-2.9%) and high rates in Europe, Lebanon and New Zealand (11-19%). The rates found in the Epidemiologic Catchment Area Study conducted in the US have been found as intermediate (5.2%). However, the most recent National Comorbidity Survey based on a sample of persons aged 15-54, have shown that over 17% of respondents had at least one episode of major depression during their lifetime and over 10% have had an episode in the past year.

As regards risk factors for major depression there is a marked increased vulnerability in women, and rates have been found to be the highest in young and in divorced or separated subjects. The mean age of onset of depression is between 25 and 30 years of age and recent results have suggested that more recent birth cohorts are at increased risk for major depression. Community surveys have not found a sex difference in the course of depression or the risk of either chronic or recurrent depression.

Well-defined affective disorders are associated with increased use of medical services and emergency departments, reports of both physical and emotional impairment, disturbances in functioning in the occupational and marital field, lost time at work and increased rates for attempted suicide. Moreover, depressive symptoms which are relatively common in the community are also associated with social morbidity and service utilization.

WHAT IS THE RIGHT TREATMENT MODALITY TO PREVENT DEPRESSION?

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The hypothesis will be submitted of a subgroup of depressions characterised by disturbances in serotonergic functioning; in which anxiety and/or aggression (anger) are the primordial symptoms, while mood lowering being a derivative, and that occur preferentially in stressor-prone individuals.
In that subtype of depression maintenance treatment should primarily consist of psychotherapy aimed at increase of coping skills and stressor-resistance, and secondarily of drug therapy aimed at decreasing the anxiety and/or aggression susceptibility, preferably via regulation of serotonergic pathways.

The moral of the theory is threefold.

1. In present day's psychiatry, symptoms are arranged horizontally as if they were all of the same diagnostic valence. This latter supposition seems incorrect. It is much more likely that some symptoms are directly linked to the deranged cerebral systems underlying a particular syndrome, while others are secondary. Attempts to "verticalise" psychopathology should be much more central in psychiatric research than they presently are.
2. Verification of hypotheses regarding the vertical arrangement of discrete psychopathological phenomena is possible if correlations can be established between those syndromal components and biological variables and if there are means to correct the biological abnormalities. The present hypothesis is a telling example.
3. Paradoxically, biological psychiatric research can result in the conclusion that in a particular psychiatric condition, not drug treatment but psychological intervention should be the premier form of intervention both therapeutically and prophylactically.

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