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Social Factors for Major Depressive Disorder Negative Prognosis in Young Patients

Octavian VASILIU[1]*

Abstract

Young patients are vulnerable to major depressive disorder (MDD) due to various identifiable environmental stressors. Knowing the overall participation of these factors in the development and/or maintaining depressive symptoms is very important when establishing a patient's prognosis. The main objectives of this research were to define the most important social factors for negative prognosis in young patients diagnosed with MDD and to formulate a plan for approaching these factors during psychotherapy sessions. Methodology was based on searching medical databases (Pubmed, Medscape, Cochrane, EMBASE, PsychINFO) for information regarding negative prognosis factors in young patients with MDD and evidence based recommendation for processing these factors using psychotherapy. After applying inclusion and exclusion criteria for the review, we retained 9 researches that could be relevant to this paper's objectives. The most relevant negative factors for prognosis in the targeted population are tensions in the familial relationships, including emotional or sexual abuse, parent divorce during early childhood, loss of a parent, loss of employment, loss of a close friend, alcohol use in his/her immediate environment, urban residence, cultural modelling of the feeling expression and willingness to seek treatment. Regarding the approach of these factors in psychotherapy data are more limited, and evidence based recommendations are still lacking. Therefore, we proposed an inclusive plan addressing most of the above mentioned factors. In conclusion, while several clinical and epidemiological data regarding negative prognosis factors in young patients MDD have been identified, more research in the field of how to deal in psychotherapy with these factors is needed.

Keywords: major depressive disorder, social risk factors, young population, psychotherapy, negative prognosis factors.

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1. Introduction

Major depressive disorder (MDD) is an important health problem in young adults, with social, professional and familial consequences that could negatively interact with the patients' development. Recent data from National Institute of Mental Health (NIMH) shows that the highest 12-month prevalence of MDD is observed in 18-25-year population (10.3%), compared to 7.5% in 26-49-year persons and 4.8% in 50+year population [1]. Overall, it is estimated that 6.7% of all U.S. adults had at least one major depressive episode in the past year [1].

In Europe the situation is also alarming, as MDD is the third cause of disability-adjusted life-years (DALYs) and is responsible for 11% of all years lived with disability (YLDs). [2] Based on these data, MDD is the leading chronic condition in Europe. [2] It is also worth mentioning that suicide accounts for 17.6% of all death among young adults aged 15-29 in high income countries, being the second leading cause of death globally in this age group [2].

In Romania data regarding the incidence and prevalence of MDD in young adolescents are limited, but according to WHO, the overall non-age restricted rate of MDD is 5% in 2017 [3].

MDD is a very complex disorder, with both genetic and environmental pathogenic factors. Depressed patients with a history of childhood trauma may have a distinct depression endophenotype, with neurobiological and risk genotype that could moderate the treatment response quite different from the patients without childhood trauma [4]. Early changes in brain function associated with serotonin transporter 5-HTTLPR polymorphism could explain the link between childhood maltreatment and adult chronic depression [5]. Adverse life events occurring at any age had a significantly impact on the onset of depression for individuals with 5-HTTLPR s/s genotype [6].

2. Problem Statement

Due to the significant impact of MDD on the quality of life and daily functionality, finding factors that could have a role in the development of this disorder is considered a priority from many perspectives. For example, defining patients' evolution and prognosis, creating a treatment algorithm, formulating social policies for prevention or early detection of MDD, all these are based on the analysis of potential triggers or vulnerabilities.

3. Objectives

The main objectives of this research were to define the most important social factors for negative prognosis in young patients diagnosed with MDD and to formulate a plan for approaching these factors during psychotherapy sessions.

4. Methods

Methodology was based on searching the main medical databases (Pubmed, Medscape, Cochrane, EMBASE, PsychINFO) for information regarding negative prognosis factors in young patients with MDD and evidence based recommendation for processing these factors using psychotherapy.

Keywords used and search paradigms were "major depressive disorder"/"major depressive episode"/"major depression", and "prognosis factors", and "young patients"/"young adults".

All studies detected between 1990 and 2017 were included in this analysis.

Population age limits were established at 18 and 35 years, but all studies that included general population were taken into the consideration, if the statistical analysis allowed for a stratification of population according to the age criterion. Diagnoses were limited to major depressive disorder, either recurrent or at the first episode, regardless of other clinical specifiers, like the presence or absence of psychotic features. Due to the time range of included trials, different versions of DSM and ICD were allowed as basis for diagnosis confirmation.

Selection of the trials wasn't restricted to a specific therapeutic intervention or study design. Observational, naturalistic or interventional trials, as well as epidemiological researches, were included, and psychotherapy, pharmacotherapy or electroconvulsive therapy were allowed.

The main variable(s) monitored by the study should have prognostic value, in order to select the respective trial in this analysis.

Table 1. Inclusion and exclusion criteria

Operational criteria	Inclusion	Exclusion
Population	Age between 18 and 35 Diagnosis of MDD (recurrent, single episode, with/without	<18 years and >35 years old Schizoaffective

	psychotic features) according to DSM or ICD criteria No severe organic comorbidity that could falsely increase depression severity scores	disorder, mixed depressive and anxiety disorder, organic depression, depression induced by psychoactive substances
Intervention	Any psychotherapy, pharmacotherapy or combined intervention	Unspecified intervention
Environment	Hospital-based or outpatient regimen	Unspecified environment
Variables	Prognosis factors	
Studies design	Any interventional, naturalistic or observational design Meta-analyses and systematic literature reviews	Unspecified design
Language	English	

5. Findings

After applying inclusion and exclusion criteria for the review, we retained 9 researches that could be relevant to this paper's objectives.

According to Colman I et al. [7] patients with depression who have low levels of mastery have a high risk of relapse, if the MDD is recurrent, but in those subjects who had only one depressive episode, high severity of symptoms and migraine headaches have predictive value for relapse.

A systematic review realized by Holzel L et al. [8] identified a large number of risk factors for relapse in MDD- younger age at onset, longer duration of depressive episode, family history of mood disorders, and psychological comorbidities (like anxiety disorders, personality disorders, low level of social integration, substance abuse, negative social interaction).

A study about multiple recurrences in MDD realized by Solomon A et al. [9] which included 318 subjects followed for 10 years states that the

number of lifetime depressive episodes significantly associates with the probability of recurrence (a risk of 16% for recurrence is calculated with each successive episode), and the duration of recovery is negatively associated with the risk of recurrence.

Female sex, a longer depressive episode before admission, more prior episodes, and never being married were significant predictors for recurrence according to a large (N=485) 15-year prospective follow-up conducted by Mueller TI et al [10].

Lack of continuation-phase treatments (pharmacotherapy, psychotherapy or electroconvulsive therapy) after successful acute-phase interventions is associated with risk of relapse [11].

Specific psychosocial factors in childhood (familial or personal stressors), female gender, social isolation and a negative attitude towards one's own occupation have been associated with risk for depression and recurrent episodes, as well as with the prediction of negative outcome [12].

A large epidemiological follow-up study (N=5733) detected baseline severity of the MDD, measured with Beck Depression Inventory, predicted MDD persistence and increased mortality risk [13]. The same study found other variables, like never being married, being separated or widowed, as predictors for persistence of MDD [13].

A recent study that included patients with residual symptoms of MDD showed, using regression analysis, that residual insomnia symptoms were significantly associated with relapse [14].

A review of prospective studies indicated, based on a large amount of data (N=23 studies), that subjects with subthreshold depression have a larger risk for developing MDD [15]. As a consequence of this information, treatment of all MDD symptoms until the complete remission is achieved represents a necessity in order to prevent relapse or recurrence.

Analysing all the data derived from the cited researches, it could be concluded that the most relevant negative factors for prognosis in the targeted population are *psychological stressful life events in childhood* (tensions in familial relationships, including emotional or sexual abuse, parent divorce during early childhood, loss of a parent), *recent/current stressful events* (loss of employment, loss of a close friend), *psychiatric comorbidities* (alcohol use in his/her immediate environment, personality disorders, anxiety disorders), *demographic variables* (urban residence, never being married, being divorced or widow, female gender), *cultural modelling of the feeling expression and willingness to seek treatment, residual symptoms of MDD,* and *lack of continuation treatment for MDD.*

Regarding the approach of these factors in psychotherapy data are more limited, and evidence based recommendations are still lacking.

Therefore, we proposed an inclusive plan addressing most of the above mentioned factors (table 2).

Table 2. Negative prognosis factors for MDD- a therapeutic approach

Variable	Approach	Observations
Psychological stressful life events (childhood or current)	Psychotherapeutic intervention focused on events that could trigger relapse	Stressful events should be actively investigated and integrated in the case management. Even if non-psychodynamic therapies are applied, integrating childhood trauma or current stressor in the treatment plan could improve patient's probability for recovery.
Psychiatric comorbidities	Psychotherapy +/- pharmacotherapy (according to the severity of comorbidity) until the complete remission is achieved	Drug related disorders and personality disorders could interact with MDD prognosis at multiple levels (quality of life, occupational, social and familial functioning)
Demographic variables	Screening for vulnerable populations, with early interventions focused on specific social conditions	Early interventions could reduce long-term costs associated with MDD treatment and improve patient's prognosis
Cultural factors	Integrating cultural factors in psychotherapy. Being open to cultural specifics of MDD is a condition for success in the context of globalization	Mental health specialists should be familiarized with cultural modelling of the MDD, some clinical manifestations could be otherwise neglected

Residual symptoms of MDD	Psychotherapy and/or pharmacotherapy should address all symptoms of MDD until complete remission. Monitorization of MDD symptoms using clinical scales.	If clinical scales are used periodically for evaluation of the patient's severity of symptoms, quality of life, and functionality, residual symptoms could be more easily detected
Lack of continuation treatment for MDD	Adherence therapy, counselling focused on the compliance issues (tolerability, adverse events of medication, perceived stigma of treatment etc).	Adverse events like somnolence or decreased libido could be related to several antidepressants, and young patients could be especially sensitive to these issues.

6. Ethical considerations

This article does not contain any studies with human or animal subjects performed by the author.

The author has no conflict of interest to declare.

7. Discussions

Although analysing MDD prognosis factors is considered an important problem in the context of a continuously increase incidence of major depression, data from literature are sparse in the domain of young population. Lack of data regarding specific interventions over these prognosis factors is also a problem that necessitates further studies. The relevance of this paper's objective is determined by the usefulness of finding negative prognosis factors for MDD, factors which can be addressed during psychotherapy.

In this context, a review of the available evidence was considered necessary, and all relevant data found in the main electronic databases were analysed according to rigorous inclusion and exclusion criteria.

Conclusions are based on 9 trials and reviews found in the literature, detected between 1990 and 2017. More trials are needed in order to detect

more prognosis factors that could be addressed in the future programs for MDD early detection, prevention and treatment.

Based on the found data, several directions of intervention could be further investigated: (1) screening for MDD in vulnerable population (single persons, unemployed, with recent stressful events, that could also have childhood undetected traumas); (2) close monitoring of the residual MDD symptoms and treatment until complete remission; (3) treatment of drug induced disorders, anxiety disorders or personality disorders that could be comorbid with MDD; (4) educational programs for mental health specialists regarding cultural modelling of the MDD clinical manifestations.

8. Conclusions

While several clinical and epidemiological data regarding negative prognosis factors in young patients diagnosed with MDD have been identified, more research in the field of how to deal in psychotherapy with these factors is needed.

Psychotherapy could be helpful in improving MDD prognosis in young patients through its actions at multiple levels: (a) detection of psychological stressful life events in childhood and integrating these elements in a psychodynamic approach; (b) approaching recent/current stressful events, either psychological or psychosocial; (c) treatment of psychiatric comorbidities (alcohol use in his/her immediate environment, personality disorders, anxiety disorders); (d) addressing vulnerable population for detection of early MDD signs, even in patients who could come to therapy for other, more benign, problems (d.e. difficulties in adjustment to a new job, or relational problems); (e) addressing cultural modelling of the feeling expression; (f) therapy for increasing pharmacological treatment adherence, by discussing adverse events and stigma associated to this kind of intervention; (g) treatment of residual MDD symptoms, who could be resistant to pharmacological interventions.

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