Depression brings other disorders

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Levels of residual morbidity in mood disorder patients followed up long-term under community conditions of treatment are remarkably high. Both unipolar major depressive disorder and bipolar disorder patients tend to be ill 40-50% of follow-up time; in bipolar patients, three-quarters of that residual morbidity was depressive. Based on the proportion of time ill, depression is the dominant morbidity of type I bipolar disorder, the major clinical feature of type II bipolar disorder, and the essence of major depressive disorder. Mania and hypomania

contribute less to time ill in bipolar disorder as depressive episodes generally are longer-lasting.

A fundamental clinical challenge in dealing with depressive illnesses is the timely differentiation of depression associated with bipolar disorder, so as to guide appropriate treatment. Typically, latency from the onset of initial depression to appropriate treatment of bipolar disorder is 5-10 years, or even longer following juvenile onset. Diagnosis is particularly difficult in type II bipolar disorder since hypomania is often overlooked or viewed by patients as nonpathological or even desirable. Differentiation of BD from MDD is supported by evidence of BD, such as (a) multiple family members with mood disorder, suspected mania, or 'nervous breakdown', (b) young onset of depression with multiple, especially brief, recurrences, (c) postpartum mood disturbance or psychosis, (d) classically energic-retarded ('atypical') depression, but sometimes with prominent anxiety, agitation, anger, or psychosis, (e) co-occurring substance abuse or anxiety syndromes or (f) excessive or rapid mood elevation after exposure to an antidepressant, stimulant, or corticosteroid.

Improved outcomes in the treatment of depression might evolve by clarifying the relative efficacy of particular treatments as well as by closer matching of specific treatments to types of patients (e.g. mild vs. severe, anxious or agitated, psychotic, bipolar). However, the assessment of candidate antidepressants has traditionally been broad, and efforts to rank specific agents by efficacy or tolerability have proved challenging. Given that unsatisfactory responses to treatments for depression in both bipolar and major depressive disorders are a major problem, it is of interest to identify factors, especially modifiable ones, that may contribute to poor responses. Indeed, both bipolar and depressed patients treated by current community standards appear to be unwell 40-50% of the time in long-term follow-up, and the great majority of that unresolved morbidity is depressive.

The lack of effective methods for the treatment and prevention of bipolar depression, shortcomings of antidepressant treatment in major depressive disorder, and maintaining treatment adherence are leading therapeutic challenges for modern psychiatry. For decades, there seems to have been a tacit, but highly questionable, assumption that major depressive syndromes are more or less similar clinically and therapeutically, leading to a stunning paucity of controlled studies of treatments for acute depression in bipolar disorder and even fewer for the prevention of recurrences. Promising recent developments include leads to innovative treatments for MDD and efforts to develop and test treatments for bipolar depression.

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