New Perspectives of Persistent Depressive Disorder

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Abstract. This paper is a general review of persistent depressive disorder. By reviewing pertinent literature, this paper focuses on etiology, impacts, treatments, and recommendations for future improvement. Persistent depressive disorder affects all ages people. Young people with persistent depressive disorder need special attention because if not receiving treatment early, it will deteriorate into major depressive disorder, especially in early-onset patients. Although the persistent depressive disorder has been shown to have strong associations with other depressive disorders and even affect cognition, such as spatial working memory, relationships are still not clear and not empirically tested. Several factors will increase the likelihood of persistent depressive disorder, including family and heredity factors. In addition to the worsening of the disease due to untimely treatment, there is a high chance of recurrence in the future. This is not a disorder that can be easily cured and can take years to fight it. In all, this study provides new thinking for the understanding of persistent depressive d in both theory and practice.

Keywords: Depression · Persistent Depressive Disorder · Causation · Impacts · Young People

1 Introduction

Everybody encounters feelings of unpleasantness and sadness occasionally. When these discouraging feelings begin to overwhelm daily life and cause a physical and mental breakdown, the feelings turn to know as depressive disorder. In 2013, DSM-5 released a new depressive disorder called persistent depressive disorder that combines two previous disorders of dysthymic disorder and parts of major depressive disorder. Persistent depressive disorder is described as a mood disorder with long time depressive symptoms. The depressive mood symptoms need to display most of the day for at least two years or at least one year in children and young people [1]. Patients with the persistent depressive disorder need a more extended treatment period, more psychotherapy sessions, and higher measurement of antidepressant medication than patients with intense forms of depression. For at least one year, persistent depression disorder regularly causes irritability and depressed mood to appear in youth. Other symptoms include insomnia or hypersomnia, overeating or losing appetite, decreased energy, decreased self-esteem, lack of concentration, and distress [2].

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2 Literature Review

2.1 Definition

Persistent depressive disorder is one form of depressive disorder that was first introduced in DSM-5. After researching some chronic depressive disorders in DSM-4, the similarity is more than the difference. Persistent depressive disorder is the new depressive disorder that integrates different types of chronic depressive disorders.

Chronic depression can describe different forms of depressive disorders that share one symptom of long persistence for an extended period. Depressive symptoms lasting two or more years can be used to diagnose many different types of chronic depressive disorder. In 2013, diagnostic classification systems made different types of chronic depression relatively different categories. However, because of an incapability to figure out scientifically significant differences among these chronic disorders, the developers of the DSM-5 combined diagnosis of some chronic depression and defined a new disorder, persistent depressive disorder. This change indicates that it is more important to clarify chronic and episodic depression than to distinguish subtypes of chronic depression through symptom severity [3].

2.2 Diagnosis

In the DSM-5, two main symptoms that can diagnose persistent depressive disorder are sad mood and losing interest or pleasure. The international classification of Disease (ICD) also introduces the third symptom, reduced energy. Physical symptoms contain significant weight loss when not dieting, unstable appetite, sleep disorders, and psychomotor. Mentally symptoms include feelings of worthlessness or unreasonable or unexpected guilt, loss of thinking or concentration ability, frequently thinking about suicide, and attempting to act. The symptoms need to last for at least two weeks. According to the number and severity of symptoms, mild, moderate and severe depression occurred successively.

The new diagnosis of persistent depressive disorder in the DSM-5 is characterized by a sad mood for most of the day, for more days than not, and at least two years and subsumes the subtypes of depressive disorders with a chronic course.

The diagnosis of persistent depressive disorder can be defined more precisely as some episodes, which are pure dysthymic, persistent major depressive episode, the intermittent major depressive episode with the current episode, and intermittent major depressive episode without a recent episode. Moreover, current severity, further explanation of other depressive disorders, and the onset of depressive disorders around 21 years all need to consider when making a diagnosis. The diagnosis needs to consider a more complicated situation [3].

2.3 Causation

Persistent depressive disorder diagnosis can happen at any age. However, some factors will increase the probability of having a persistent depressive disorder diagnosis in children and adolescents. The reasons for depression are complicated and not fully

understood yet. The causes of depression can be sleep abnormalities, hormones, neurotransmitters, upbringing, heredity, and stressors [4]. There is limited information about the persistent depressive disorder and dysthymic disorder because of the new diagnostic method for persistent depressive disorder. Unfortunate childhood, unpleasant relationships with family members, low-income status, poor self-esteem, poor academic performance, physical unhealth, special substance use, and lacking adapting abilities are other factors that may increase the probability. Moreover, from a mental health survey by World Health Organization, compared with low-or middle-income countries, dysthymic disorder appears more frequently in high-income countries. Suicide risk behaviors are more likely to appear in people who have greater family problems, more significant feelings of hopelessness, and greater severity of depressive symptoms.

Gender is also a possible risk factor for persistent depressive disorder because girls are more likely to suffer from depressive disorder during adolescence [1]. After taking research about 3.3 million adults, the prevalence by gender is approximately to be 4.1% for women and 2.2% for men, and the total rate of people whose age is 18 or above in the U.S. population is 1.5%. The research indicates that the prevalence in the age group 25 to 64 years old is 6% for women. In children, the persistent depressive disorder can occur equally in both genders. The median age of appearing symptoms is 31 years [4]. Researchers found a 4.6% lifetime prevalence rate in a study that attempted to estimate rates of DSM-5 persistent depression [5].

Even though stressful life events usually happen before both persistent and nonpersistent depressive disorders, people who have persistent depressive disorder often live higher pressure and more stressful lives. The direction of this relationship is ambiguous. Long-time stress may cause or preserve depression, but chronic depression can also develop difficulties that may last a long time. In general, chronic stress helps maintain chronic depression [6].

2.4 Impacts

2.4.1 Personal Health

When comparing normal developing children with children who have a persistent depressive disorder, the recruitment of brain regions in a frontoparietal network shows some differences. The current study is largely consistent with findings that decrease activation in lateral frontal regions. in adult major depressive disorder patients. In a mental rotation experiment, persistent depressive disorder displayed less activation in left frontal regions, including left ventral- and dorsolateral prefrontal cortices. Activations were also not frequently detected in medial frontal regions including dorsomedial prefrontal cortices, anterior cingulate cortex, and frontal pole. Patients displayed high activity in the right precuneus and posterior cingulate cortex when they did a delay-match to sample task. Although working memory tasks can evaluate the executive function, unusual functions were also found in cortical midline structures during resting-state studies [7]. Long-term negative feelings may impact this network over time, leading to major depressive disorder. Thus, the pathophysiology of childhood persistent depressive disorder is similar to the pathophysiology of adult major depressive disorder patients suggesting continuity

across the lifespan. Also, using Generalized Estimating Equation (GEE) models, persistent depressive disorder independently predicted more intense depression, anxiety, and somatic symptoms among people with the major depressive disorder [8].

The connection of irritability with conduct disorder symptoms shows a special relationship between irritable mood to conduct disorder features in young people. It does not matter if people have depressive disorders or not. Young patients with persistent depressive disorder can get help by reducing irritability and anxiety through more precise and comprehensive management methods [9].

2.4.2 Social Functioning

One primary risk factor for major depressive disorder is persistent depressive disorder [7]. Chronic sadness and anxiety lasting at least one year is one symptom to diagnosis persistent depressive disorder in children and adolescents. Mild to moderate depressive symptoms are related to persistent depressive disorder, so the condition is usually not recognized and treated unless a major depressive disorder occurs.

Mood disorders, including anxiety, substance use, and personality disorders, are more likely to be diagnosed in people who have a persistent depressive disorder. Rates of comorbid anxiety usually are avoidant, borderline, and dependent, substance use and personality disorders are significantly higher among individuals with the persistent depressive disorder than those with episodic depression.

Family studies indicate that first-degree family members of people with persistent depression exhibit higher chronic and nonchronic depression levels than people from healthy families. Also, the transmission of persistent depressive disorder is unique because family members from the family of people with persistent depressive disorder have a higher possibility of having persistent depressive disorder than family members of people without a persistent depressive disorder.

Preschoolers of mothers with persistent depressive disorder display more positive emotions and fewer negative emotions than children of a mother without a persistent depressive disorder. A study showed that children had a higher possibility to experience persistent depressive disorders and suicide attempts (but not anxiety disorders, alcoholism, or antisocial behavior) at the age of 21 years by doing a longitudinal study to 3 years old children showed more negative emotion and less positive emotion. Because these children were highly influenced by their families at ages 13 and 15 years, it is possible that many of these children had the persistent depressive disorder since adolescence [10].

In inpatient and outpatient treatment, persistent depressive disorder plays an essential role. Approximately up to one-third of all patients seeking help for mental health have a persistent depressive disorder. After once appearing symptoms of depression, patients who have a record of early-onset, before 21 years old, depression, a family history of mental illness, mental health comorbidities, coping problems, and a mild status of depression will have a higher chance to have a persistent depressive disorder. People with persistent depressive disorder have a higher possibility of experiencing mental health comorbidities. Many of these people have a history of early trauma [3].

2.5 Treatment

Successful cases prove some forms of psychotherapies are effective treatments for depression [10]. The most common treatments include different forms of interpersonal psychotherapy, cognitive-behavioral therapy, and psychotropic medication [1]. People with moderate to severe depression need treatment combined with medication and psychotherapy. These different forms of psychotherapy can effectively treat depression. The task force on promotion and dissemination of psychological procedures defined interpersonal psychotherapy that modifies for use with young people as a well-established, evidence-based intervention. This modification, known as interpersonal psychotherapy for depressed adolescents, is an efficient treatment to relieve symptoms of depression.

The main features of interpersonal psychotherapy for Depressed Adolescents include psychoeducation, emphasis on a central problem area, encouragement of effect, communication analysis, decision analysis, and role-play of appropriate and useful behaviors. Interpersonal psychotherapy for Depressed Adolescents is most useful if adolescents experience extreme depression because of communication difficulties, those who have not had trouble with communication problems before, and those who suffer acute depressive symptoms.

Except for interpersonal psychotherapy for Depressed Adolescents, many cognitive behavioral therapy treatments have been experimentally studied and can be used in children and adolescents. Two treatments of cognitive-behavioral therapy, the Treatment for adolescents with depression study and the penn resiliency project, have shown their efficacy in the treatment of childhood/adolescent-based depression. The essential parts of the Treatment for Adolescents with depression study include psychoeducation with young people and their parents, goal setting, mood monitoring, behavioral activation, cognitive distortion identification, problem-solving, development of social and communication skills which are negotiation and compromise, and relapse prevention. Penn resiliency rroject needs more people to fulfill and still uses cognitive-behavioral principles and the enhancement of social skills.

In a study of a 48 weeks clinical experiment comparing cognitive behavioral analysis system of psychotherapy and supportive psychotherapy in adult antidepressant-free patients with early-onset persistent depressive disorder, researchers set some variables from the following domains as hypotheses and reasons for treatment effectiveness: sociodemography, clinical status, psychosocial and global functioning, life quality, interpersonal problems, childhood trauma, treatment history, preference for psychotherapy, and treatment expectancy. They conclude that abuse, communication problems, and anxiety cause the severe symptoms of depression, including suicide and unpleasant childhood experiences, which is why psychotherapy is not useful in patients with the early-onset persistent depressive disorder [11]. Improving spatial working memory and attention through specific management methods may also help young people get better at these symptoms of depressive disorders [9].

There is a special treatment called electroconvulsive therapy, which has been approved useful. A patient with severe persistent depressive disorder and treatment resistance can achieve improvement in depressive symptoms through electroconvulsive therapy and the Cognitive Behavioral Analysis System of Psychotherapy [12].

Most of the studies about persistent depressive disorder do not last two years. Two years are short for a chronic illness. After doing a study that lasted 10 years about the dysthymic disorder (now is persistent depressive disorder) and double depression that included reviews every 30 months, the result shows that the recovery rate was 74%. The median time to recovery was 52 months. However, the possibility of deterioration into another type of chronic depression was 71%, and 84% of the people in this experiment experienced the major depressive disorder. This experiment also found chronic depression in first-degree family members, a record of having poor relationships with parents in childhood, and a past of childhood sexual abuse will have a higher level of depression after ten years. The presence of comorbid personality disorders predicted a slower rate of improvement over time.

Another 10-year experiment describes a result of a small group of patients with major depressive disorder. Patients in this experiment do not alleviate during the first five years. Only 38% of these patients healed in the next five years [6].

3 Imitations and Future Implications

In analyzing and organizing previous studies, it was found that persistent depression has not been adequately studied. After 2013, when the persistent depressive disorder was introduced in DSM-5, no more studies were conducted. Most of the theoretical and data support for persistent depressive disorder are still stuck in the DSM-4 generation. Many areas need further research on persistent depression. The pathogenesis of the persistent depressive disorder is still unclear, and further research is needed. Research has confirmed that persistent depression can trigger other depressive disorders, but only a few studies have examined other depressive disorders together with persistent depression. Research has demonstrated that untreated persistent depression can lead to major depressive disorder. It is important to draw attention to persistent depressive disorder. There is no research on how to draw attention to it.

4 Conclusion

Persistent depressive disorder is a very tormenting mental illness. Diagnosing this disorder requires a person to experience depression for at least one year or more. Many treatments have been proven effective in treating persistent depressive disorder, but it is still important to do more studies about this disorder. A variety of reasons can cause persistent depressive disorder, and at the same time, it is easy to cause other depressive disorders and affect cognition after a long period of mental depression. Despite this, we still lack an understanding of the disorder.

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