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SUBTHRESHOLD DEPRESSIONS: DIAGNOSTIC AND THERAPEUTIC PROBLEMS

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SUMMARY

In the present paper we want to emphasize the importance of more and more obvious subthreshold depressions, both for their high incidence in the general population and the high economic cost that results in terms of loss of working days, due to the difficulty of diagnosis especially for general practitioners in grasping the different aspects of Depression, when this is expressed not in the classical forms but as more and more often happens, in 'dimmed 'forms and body language- included in the category of "not otherwise specified" (minor depression and brief recurrent depression), which are the main innovation compared to the DSM-IV DSM-III-R. The precocity of their diagnosis and the implementation of an effective treatment results in a lower severity of depressive symptoms and decrease in the risk of relapse. It is important therefore that doctors acquire knowledge and tools that allow early recognition of this clinical picture.

Key words: *depression - sub-syndromal*

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INTRODUCTION

Depression is the fourth leading cause of "disability" in the world, and it is expected that in 2020 the disease will be second only to ischemic heart diseases.

Frequently underestimated for the early onset of symptoms and consequently with a delay in the diagnosis and the commencement of treatment, it determines significant consequences both in terms of quality and duration of life of the patient who is affected. Earlier diagnosis and initiation of effective treatment ensures a lower severity of depressive symptoms in the long term, and reduces the risk of relapse. It is therefore important that general practitioners acquire the tools and knowledge that would enable early recognition of the clinical picture.

Many studies report prevalence rates for depressive disorder at 15% in the general population over a lifetime, estimating that 340 million people in the world suffer from depression, and among them females suffer almost twice as much as men.

Nowadays, major depression, despite being always present in nosographic classifications, seems to have lost the leading position in terms of prevalence and incidence: clinical pictures that come more frequently to the observation of general practitioners and psychiatrists are often those which can generally be defined as "subthreshold depressions", a term used to indicate those clinical conditions that, while not fully corresponding to the descriptive criteria of a specific depressive disorder, in duration, severity and number of symptoms, have as consequence inadequate treatment and cause a lack of social or occupational functioning.

Table 1. Major depressive episode with melancholy (DSM-IV-TR diagnostic criteria)

One of the following examples is present during the most serious phase of the present episode	decline of interest or pleasure in every activity
	no reactivity to usually pleasant incentives (the subject does not feel better, even temporarily, when something good happens)
Three (or more) of the following symptoms occur	specific quality of depressive mood (that is, for example, felt as clearly different from the sensation felt after the loss of a loved one)
	depression usually get worse in the morning
	premature morning awakening
	marked psychomotoric slowing down or agitation
	significant anorexia or weight loss
	excessive or inappropriate sense of guilt

SUBTHRESHOLD DEPRESSION

Cassano et al. point out how clinic reality rarely reflects the theoretical classifications and propose instead much more regularly sub-threshold depressive states that provoke a personal suffering and therefore require an appropriate treatment (Cassano 1999).

Dysphoric premenstrual disorder, depressive personality disorder, adjustment disorder with depressive mood, not otherwise specified depressive disturbance, anxious-depressive mixed disturbance, are also considered sub-threshold depressions.

Some authors think that generally patients ascribable to this picture do not display or refer either “anhedonia” or “depressed mood”, thus the researchers attempted to re-classify the symptomatic clusters of depression by coining the term “symptomatic subsyndromal depression” (SSD), defined as a depressive condition with two or more symptoms among the ones of the Major Depression diagnosis (MD), except the depressed mood and anhedonia, that has to be associated to an impairment of the social operation.

It is important to note how a large body of work has shown that the subthreshold depressive symptoms are united to depressive symptoms that meet the diagnostic criteria by the same indicators of "malfunction", differing from "subclinical" Depressions in which the symptoms of a disorder do not determine mental functional impairment or a significant clinical deterioration, in reverse to what occurs in the subthreshold disorders.

Considering subthreshold depressive conditions estimated from DSM IV, depression Not Otherwise Specified, we remember that minor depression is defined by the presence of at least two depressive symptoms, but less than five, depressive mood and lack of interests included, over a period of two weeks (Table 2).

In the absence of a story of major depression or dysthymia, whereas brief recurrent depression is defined by depressed mood and lack of interests, with at least four of eight depressive symptoms and inadequate functioning at work, during less than two weeks.

Table 2. DSM IV, depression Not Otherwise Specified, or minor depression (DSM-IV-TR diagnostic criteria)

A mood alteration defined as:	
At least two (but less than five) of the following symptoms have been showing in the same period of two weeks and represent a changing of the previous operation, at least one of the symptoms is a or b	Depressed mood during most of the day almost every day
	Significant reduction of interest or pleasure in every or almost every activity for most of the day
	Important weight loss, in absence of a diet, or relevant weight gain or growth or decrease of appetite almost every day
	Insomnia or hypersomnia
	Agitation or marked psychomotoric slowing down almost every day
	Fatigue or lack of energy almost everyday
	Feelings of worthlessness or excessive or inappropriate feelings of guilt almost everyday
	Decreased ability to concentrate or make decision almost every day
	Recurrent thoughts of death and recurrent suicidal ideation without a specific plan processing
Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas	
The symptoms are not due to the direct physiological effects of a substance or a general medical condition	
The symptoms are not better justifiable by grief	
A main depressive episode has never shown and do not met the criteria for dysthymic disorder	
There has never been a manic, mixed or hypomanic episode and patient does not meet the criteria for cyclothymic disorder	
The mood disturbance does not occur exclusively during the course of schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or psychotic disorder NOS.	

We recall also that both in the DSM IV and in ICD10 the categories of "neurotic depression" and "affective disorders of personality" have been eliminated. The main feature of subthreshold depressions, however, lies in the fact that they show themselves much more frequently with physical symptoms than with psychic symptoms, such as gastrointestinal disorders, sleep disorders, headaches, chronic fatigue and physical complaints. In a study carried out as part of Basic Medicine, Kroenke et al. have found the existence of a significant association between the number of physical complaints reported and the percentage of depressed patients, in patients with a number of somatic symptoms between 0 and 5, the prevalence of depressive disorder appeared between 2% and 23%, for subjects, with a number between 6 and 8, the prevalence reached 40%, and with the presence of at least 9 somatic symptoms prevalence reached 60%. Furthermore, in 50% of patients with chronic pain, a clinical depression was observed. The physical symptoms therefore complicate the diagnosis of depression, when you consider that patients with these clinical pictures often report physical symptoms, especially pain, as the only discomfort, without complaining psychological symptoms and problems of a social nature. So many doctors take a history geared primarily towards identifying organic disease and do not take into account the possible existence of a "subthreshold" Depression, resulting in a delayed diagnosis and treatment. And a lot of works, have shown that the physical symptoms and pain are not only an indicator of depression, but they can be, even after the acute phase, an index of recurrence. Another difficulty in making an early diagnosis of "subthreshold" Depression is linked to the stigma about mental illness: unlike the physical symptoms, Depression is viewed with shame and physical discomfort often hides the difficulty in recognizing one’s own feelings and inner conflicts. In modern society, where the body seems to become increasingly important compared to other spheres of the person, the symptoms and somatic syndromes in comorbidity with depression seem to be getting more and more frequent. It is particularly difficult then, to draw a distinction, even in purely nosographical terms, between somatoform disorders, which can also cause depressive symptoms, and depressive symptoms dominated by physical symptoms (masked depression). It is indeed evaluated that 30-40% of outpatients has physical symptoms not explained by organic disease. We remember the comorbidity of subthreshold depressive disorders, that with other organic diseases with psychiatric disturbances such as Anxiety Disorder and Panic Attack Disorder, often appearing in a more flashy way than depression, impede its recognition and subsequent treatment.

In conclusion, it seems important to emphasize that among the causes that determine these forms of subthreshold depression, the social ones have a decisive role. As Bauman writes in fact, modern society, called "the society of 'uncertainty", "liquid modernity", "individualized society", indicates the prevalence of uncertainty, loss of sense, liquidity and individualism. The new climate and the new freedoms, resulting in the split between the private and intimate sphere of the individual from the social world, cultivates those conditions on which inner discomfort is rooted, and which conceals the depressive syndrome, resulting from an accelerated change that has undermined the previous system of life. The loss of significance of the past and the future, that ceases to be the subject of existential investment and act as reservoirs of sense, no longer stimulates people to grow and to be reinforced, as they confine the desire only to the present time, turning it into a compulsive state. Emptying the perception of the future involves the inability to justify the states of deprivation and frustration, no longer mitigated by a system of personal mediation as the moral or social conscience, and become the cause of a "meaningless suffering, which takes the form of an imminent and inexorable fatality, as well as the procedural and iterative methods of suffocation.

This kind of suffering is clinically designated as Depression. ... "Clinical observation on patients with Depression, in our Mental Health Center, also validates as evidenced by Solovey Peter and John Mayer as the development of" Emotional Intelligence," defined as an aspect of intelligence related to the ability to recognize, use, consciously understand and manage their own and others' emotions.. promotes the control of their emotions and their emotional control fostering optimal levels of socially acceptable behaviors and a good psycho-physical balance, and how with Depression, understood as a psychiatric syndrome, with a dimensional perspective, this capacity is severely deficient. The depressed subject tends to misinterpret many situations that will inevitably affect his mood, the depressed person misunderstands himself and all those around him. Therefore, alongside a drug therapy to a psycho-educational psychotherapy that develops the IE, there is an improvement in mood, better compliance and a better quality of life. It is important, therefore, that doctors, and not only psychiatrists learn to capture the different "faces" of depression, especially when it is expressed, as is increasingly the case, with the "body language".

CONCLUSIONS

In the present time, Depression is one of the most frequent disorders with a higher social and economic cost for world's population, it therefore becomes a priority that doctors in general are able to recognize the onset depressive disorders, establishing an early treatment. Over the past thirty years, Depression is definitely changed, pure depressive pictures are increasingly rare, comorbidity has become increasingly important, the psychodynamic meaning itself, in postmodern society has been transformed from the neurotic conflict between norm and transgression to action pathology in an experience of inefficiency, where sadness and moral pain take a back seat compared to anxiety, insomnia and inhibition. We would like to

conclude with what is written by G.B. Cassano: "No problem that plagues a depressed person must be considered trivial, because this type of pathology involves a kind of suffering unmatched, that, in some cases, exceeds the limits of endurance".

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