

EDITORIAL

Positive Emotions in Treatment of Depressive Patients

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I was asked the above question recently and asked to comment the Malaysian perspective on this question. These are some of my thoughts. Depression is a very common psychiatric disorder. The rate increases with increasing age. Children are less diagnosed than adults though the rates are increasing especially in adolescents. It is said that in the community the rates are 2% for school age children and 5% for adults. However depression is not a single disease, there are cases of Major Depressive Disorder (MDD), Dysthymic Disorder, and Bipolar Disorder and when taken together the rates are higher.

The diagnostic criteria in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) for Major Depressive Disorder, Dysthymic Disorder, and Bipolar I Disorder are the same for children and adolescents as they are for adults with some minor modifications. The modifications are that in children the mood may not be depressed but irritable and that weight loss or gain is not as important as failure to make expected weight gains in children compared to adults. To make a diagnosis of a Depressive Disorder the most defining symptom is depressed mood. DSM-IV describes it as depressed mood most of the day, nearly every day indicated by subjective report or observation by others. The other defining symptom is anhedonia (loss of pleasure) which DSM-IV describes as markedly diminished interest or pleasure in all, or almost all, activities for most of the day, nearly every day.

In my clinical practice and as I teach students, I emphasize these two points or symptoms in order to diagnose MDD. The way the symptoms presents as a continuous low mood and anhedonia not affected by environmental factors indicates biological abnormalities rather than purely psychological effects. The depressed mood that is involuntary to environmental change has been investigated in several studies. Functional neuroimaging studies have most commonly associated depressed mood and sadness with abnormal neuronal activity in the medial prefrontal cortex, including the anterior cingulate and orbitofrontal cortex^[1, 2]. These areas receive innervations from serotonergic, noradrenergic and dopaminergic pathways. As such low levels of NE, 5-HT, and DA may be associated with low mood. Reduced dopaminergic activity has been linked to decrease incentive motivation^[3], anhedonia^[4], and loss of interest^[5]. Increased functional dopaminergic activity has been linked to positive affect^[6].

In view of the above, it is clinically important to view negative emotions, viz low mood, anhedonia and blunting of affect as a diagnostic tool to make the correct diagnosis of biological depression and to take into account the amount of positive emotion present during the first visit to establish the severity of MDD. The lower the presence of positive emotion, the more severe the MDD. Scales for measuring negative and positive emotions must be used so that an objective measurement is made and patients can see the lowering of negative emotions and increase of positive emotions as they progress in their treatment.

In conclusion, MDD or Dysthymic Disorder or Bipolar I Depressive Disorder are biological disorders and changes in positive and negative emotions in these patients are due to biological abnormalities. As such, in the treatment of these patients, the initial assessments and measurements of negative and positive emotions will help to determine treatment efficacy and progress and assist in establishing better compliance and even better prognosis for patients who are able to experience and monitor the change from high negative emotions to low negative emotions and low positive emotions to high positive emotions.

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