

Sample Topic

## Depression, Major



### *The Medical Disability Advisor: Workplace Guidelines for Disability Duration*

Fifth Edition

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Editor-in-Chief

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## Depression, Major

### Related Terms

- Depressive Psychosis
- Major Depressive Disorder
- Psychotic Depression
- Unipolar Depression

### Medical Codes

- **ICD-9-CM:** 296.2, 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.3, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.5, 311
- **ICD-10:** F31.3, F31.4, F31.5, F32.0, F32.1, F32.2, F32.8, F32.9, F33, F33.0, F33.1, F33.2, F33.3, F33.4, F33.8, F33.9

### Definition

Major depression is a serious psychiatric illness that negatively affects how an individual feels, thinks, and acts. Everyone experiences depressed moods as a result of a change, either in the form of a setback or a loss, or as Freud said, “everyday misery.” The sadness and depressed feelings that accompany the changes and losses of life are usually appropriate, necessary, transitory, and can present an opportunity for personal growth. However, depression that persists and results in serious dysfunction in daily life could be an indication of a depressive disorder that may need to be treated as a medical problem. Severity, duration, and presence of other symptoms are factors that distinguish normal sadness from a depressive disorder.

Major depression, called major depressive disorder in the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition, Text Revision), is a mood disorder distinguished by the occurrence of one or more major depressive episodes. A major depressive episode is diagnosed when an individual experiences persistent feelings of sadness or anxiety, with loss of interest or pleasure in usual activities (anhedonia). In addition, five or more of the following symptoms must be present for at least two consecutive weeks: changes in appetite that result in weight losses or gains not related to dieting; insomnia or oversleeping; loss of energy or increased fatigue; restlessness or irritability; feelings of worthlessness or inappropriate guilt; difficulty thinking, concentrating, or making decisions; and thoughts of death or suicide, or attempts at suicide. Thought processes may also be affected, with impaired memory, and diminished ability to think, concentrate, or make decisions. Other symptoms may include increased anxiety and ruminations on death or suicide.

A depressive episode is diagnosed only if the above symptoms are not due to any other psychiatric conditions (such as bipolar disorder), medical conditions (such as neurological or hormonal problems), or physical illnesses (such as cancer or heart attack). Symptoms must not be due to unexpected side effects of medications or substance abuse.

The DSM-IV-TR divides major depressive disorder into two subtypes based on whether or not the individual has experienced a single depressive episode or recurrent depressive episodes. The DSM-IV-TR also adds specifiers to a diagnosis, rating severity along a continuum of mild, moderate, severe, and severe with psychotic features. The latter is sometimes known as depressive psychosis. Partial and full remissions are additional specifiers.

Major depression can afflict anyone, regardless of age, race, class, or sex. Only a third of depressed individuals receive proper treatment. Recently, a study showed that of bereaved spouses who meet major depression criteria, 83% received no antidepressant medication. One explanation for the low percentage of treatment of depressed individuals is that society has stigmatized mental illness for so long that people with depression, and sometimes their families, feel too ashamed to acknowledge the disease and to seek treatment.

It is estimated that up to 25% of individuals experiencing severe medical conditions will experience a concurrent major depressive disorder (DSM-IV-TR 372-73).

**Risk:** Major risk factors are female sex, age, family history, bereavement, and brain injury. Women suffer from the disorder at least twice as often as men in societies around the world. The peak age at onset is between 20 and 25 years, and 40 and 45 years. Although older individuals frequently seek treatment, there is no evidence that major depression is more common in older than in younger adults. Individuals who have parents or siblings with major depression have a 1.5 to 3 times greater risk of developing this disorder. Grief is a risk factor because it may turn into major depression, especially in bereaved spouses, who often meet the criteria for major depression.

**Incidence and Prevalence:** In the US, lifetime risk is 10% to 25% for women, and 5% to 12% for men. An international study (17 researchers, 38,000 individuals from 10 countries) reported that the lifetime risk of depression ranged from 1.5% in Taiwan to 19% in Lebanon. Risks in other countries, in ascending order, were 2.9% in Korea, 4.3% in Puerto Rico, 5.2% in the US, 9.2% in Germany, 9.6% in Canada, 11.6% in New Zealand, and 16.4% in France.

### Diagnosis

**History:** A thorough history includes taking an account of current and previous symptoms, questions about mood, memory, and changes in relationships, and corroborative history from friends, family members, or employers. It is important to determine whether there is a family history of depression or of suicides. A careful, non-judgmental inventory of substance abuse should be made in every case, as this requires specific treatment measures of its own. A general history of psychological problems could predispose an individual to depression. Because physical conditions have been associated with depression, a thorough history should include an account of diseases such as neurologic disorders (stroke, Parkinson’s, and Alzheimer’s disease, multiple sclerosis, epilepsy, encephalitis, brain tumors); endocrine disorders (diabetes mellitus, hypothyroidism, and hyperparathyroidism); and other disorders (coronary artery disease, cancer, and

chronic fatigue syndrome). Conversely, individuals with major depression may see a medical doctor for physical complaints of headache, abdominal pain, body aches, low energy, feeling poorly, or problems with sexual function.

It is also important to obtain a complete history of medications the individual is taking because major depression has been shown to be a side effect of some medications, especially antihypertensive agents such as calcium-channel blockers, beta blockers, analgesics, and some anti-migraine headache preparations.

**Physical exam:** Complete physical examination and medical workup are indicated to rule out medical causes. Illnesses that frequently cause depression include hyperthyroidism and other glandular disturbances, cancer, stroke, and heart attack. As these illnesses are usually associated with dramatic symptoms, individuals are likely to have already sought medical attention. When the disease process is less acute and without many outward signs, however, depression may be the only complaint.

**Tests:** Besides routine laboratory tests, more specialized endocrine tests may be helpful in establishing the diagnosis. A CT may also be requested to test for relatively rare causes such as brain tumor or a clinically silent stroke. Psychological tests such as the MMPI-2 and the BDI may be useful in establishing a baseline of reported symptoms and monitoring response to treatment.

## Treatment

Treatment choice depends on the outcome of the evaluation (history, physical exam, and tests). Treatment usually consists of psychotherapy, medications, or both. Today, there are a number of effective antidepressant medications that work by correcting imbalances in the levels of brain chemicals (neurotransmitters). About two-thirds of individuals treated will respond to one or more medications. Generally, these medications take full effect 3 to 6 weeks after treatment has begun. Psychiatrists usually recommend that individuals continue to take the medication for five or more months after symptoms have improved.

Treatment of depression consists of three phases. Acute treatment, lasting 6 to 12 weeks, is aimed at remission of symptoms. Continuation treatment, lasting 4 to 9 months, is aimed at preventing relapse. During this phase, medication should be continued at full dosage. Psychotherapy may also be helpful. Maintenance treatment is aimed at preventing new episodes (recurrence) in individuals with prior episodes. Both maintenance medication and maintenance psychotherapy can prevent relapse or delay the next episode. Individuals and their families should be educated before treatment about the diagnosis, likely outcome, treatment options, costs, and side effects.

Psychotherapy or talk therapy may be used alone for treatment of mild depression. Antidepressant medications in combination with psychotherapy are used for moderate to major depression. Different types of psychotherapy include cognitive-behavioral therapy, psychodynamic psychotherapy, interpersonal therapy, and supportive psychotherapy. In a major analysis of four randomized comparative studies, cognitive-behavioral therapy was

shown to be as effective as antidepressants in treating severe or major depression, but not dysthymia. Much of the success of psychologic therapy, in any case, depends on the skill of the therapist.

Research indicates that using a combination of antidepressants and therapy is more effective than either treatment alone for most individuals, possibly because most individuals are more likely to take their medication regularly when they are also undergoing therapy.

For those for whom neither medications nor psychotherapy are effective, other techniques, such as electroconvulsive therapy (ECT), are safe and effective. Although ECT has received bad press since it was introduced in the 1930s, it has been refined over the years, and is now successful in treating more than 90% of individuals suffering from mood disorders.

Psychiatric hospitalization is warranted in instances when there is indication of personal neglect or high-risk of self-harm.

## Prognosis

Most individuals with a major depressive episode will get better. As the number of available antidepressant medications continues to grow, most individuals will respond to at least one of these. Individual may also benefit from psychotherapy. With time, recovery is usually complete, though risk of relapse increases with each episode. More than half of all individuals with one episode of major depression will have another, while those individuals with a history of three previous episodes have a 90% likelihood of having a fourth. Because of this high relapse rate, it is now recommended that individuals with a history of multiple depressive episodes receive medication for the rest of their lives.

Spontaneous recovery may take months. During that time the individual is at such a great risk of complications that it would be unthinkable not to intervene. Risk of recurrence is about 70% at 5 years, and at least 80% at 8 years. For individuals with severe major depression, 76% on antidepressants recover, whereas only 18% on sugar pills (placebo) or on psychotherapy without medication recover.

Poor outcome is associated with inadequate treatment, severe initial symptoms (including psychosis), early age of onset, greater number of previous episodes, only partial recovery after 1 year, having another severe mental or medical disorder, and family dysfunction.

Major depression causes more physical and social dysfunction than many chronic medical conditions.

## Differential Diagnoses

- Adjustment disorder with depressed mood
- Bipolar disorder
- Dementia
- Dysthymic disorder
- Mood disorder due to general condition
- Schizoaffective disorder
- Substance-induced mood disorder

## Specialists

- Clinical Psychologist
- Psychiatrist

## Comorbid Conditions

- Alcohol/substance abuse
- Anxiety disorders
- Cardiac conditions
- Other general medical conditions
- Personality disorders

## Complications

Substance abuse, especially alcohol, frequently complicates a diagnosis for depression, although in some cases it may be difficult to determine which problem is primary. About 80% to 90% of individuals with major depression also have anxiety symptoms, such as anxiety, obsessive preoccupation, panic attacks, phobias, and excessive health concerns, and about one-third also have a full-blown anxiety disorder—usually panic disorder, obsessive-compulsive disorder, or social phobia. Anxiety symptoms may require special treatment, but frequently respond to antidepressant medications, reinforcing the view that the two disorders share common brain chemistry imbalances. Approximately 1 in 10 individuals who has experienced a major depressive episode will subsequently be diagnosed as having bipolar mood disorder, a chronic condition with episodes of both depression and mania, that may only partly respond to treatment. In some cases, an episode of bipolar mood disorder may emerge as the result of antidepressant medication use.

In extremely severe cases of major depression, psychotic symptoms may be present, such as hearing voices (auditory hallucinations) or having false beliefs (delusions).

Up to 15% of individuals with severe major depression die by suicide. Death rate is 4 times higher over age 55. Suicide attempt may paradoxically occur as the individual begins to respond to therapy because the extreme apathy sometimes seen in major depression before treatment may actually prevent them from committing suicide due to lack of motivation or energy.

## Factors Influencing Duration

Length of duration might be influenced by the severity of the illness, the presence of complicating factors such as substance abuse or suicide attempts, response to therapy, and the occupa-

tion requirements. Only in the most severe and unusual cases should this result in permanent disability.

Substance abuse will complicate treatment and may significantly delay returning to work. Suicide attempts that lead to hospitalization will also be associated with longer periods of disability.

## Length of Disability

Psychotherapy and/or pharmacotherapy, major depressive disorder (single episode).

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Any Work	14	28	56

Psychotherapy and/or pharmacotherapy, major depressive disorder (recurrent episode).

DURATION IN DAYS			
Job Classification	Minimum	Optimum	Maximum
Any Work	14	28	70

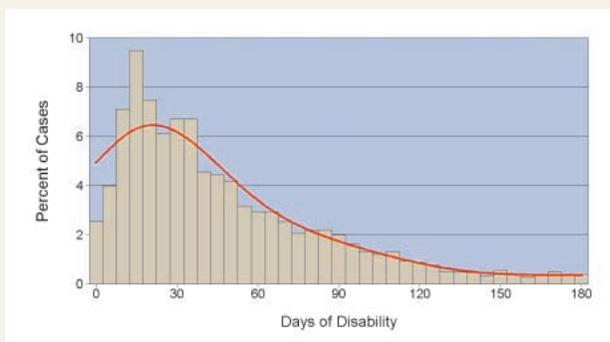
## Return to Work

Temporary work accommodations may include the avoidance of stressful situations and may include reducing or eliminating activities where the safety of self or others is contingent upon a constant and/or high level of alertness, such as driving motor vehicles, operating complex machinery, or handling dangerous chemicals; introducing the individual to new or stressful situations gradually under individually appropriate supervision; allowing some flexibility in scheduling to attend therapy appointments (which normally should occur during employee's personal time); promoting planned, proactive management of identified problem areas; and offering timely feedback on job performance issues. It will be helpful if accommodations are documented in a written plan designed to promote timely and safe transition back to full work productivity. Daytime work hours may be necessary for a period of time.

## Reference Data

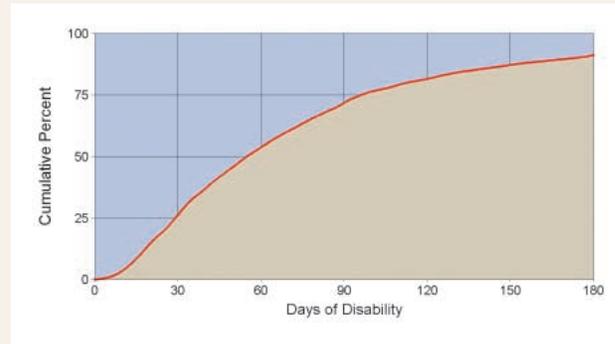
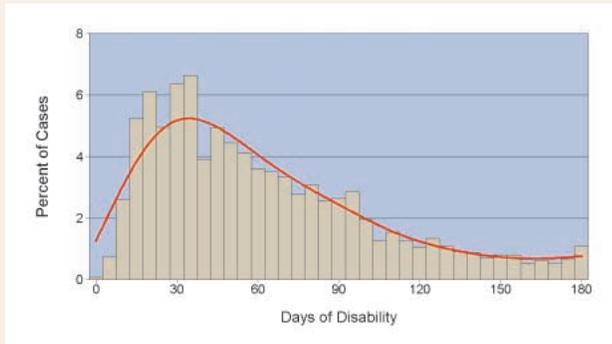
### DURATION TRENDS - ICD-9-CM: 296.2

Cases	Mean	Min	Max	No Lost Time	Over 6 Months	Percentile:	5th	25th	Median	75th	95th
6347	52	0	266	2.5%	4.1%	Days:	4	17	35	71	167



### DURATION TRENDS - ICD-9-CM: 296.3, 296.32, 296.33

Cases	Mean	Min	Max	No Lost Time	Over 6 Months	Percentile:	5th	25th	Median	75th	95th
3693	74	0	360	0.1%	9.2%	Days:	12	30	55	97	189



### Failure to Recover

#### Regarding diagnosis:

- Was a thorough history obtained?
- Does family have history of depression or of suicides?
- Was substance abuse identified or ruled out?
- Does individual have history of psychological problems? Does individual have any physical conditions such as neurologic disorders (stroke, Parkinson's, epilepsy), endocrine disorders (diabetes mellitus, hypothyroidism, or hyperparathyroidism), or other disorders (cancer, coronary artery disease)?
- Were endocrine tests done?
- Is the physician an expert in diagnosis and psychopharmacology?
- Was diagnosis confirmed?
- Is it possible that individual was misdiagnosed?
- Would individual benefit from a second opinion?

#### Regarding treatment:

- Since major depression is the result of biochemical imbalances in the brain, is the physician adequately trained in psychopharmacology?
- Even though the right medication is prescribed, does the dosage need to be increased in order to achieve an adequate level of therapeutic benefit?
- Is individual beginning to feel any positive response from current medication(s)? Because responses differ and several trials of medicine may be needed before an effective treatment is found, is change of medication warranted at this time?
- If individual is experiencing side effects from current medication, is individual comfortable with and diligent in reporting side effects to doctor? If not, does individual trust family member or caregiver to share this information with physician?
- Is psychotherapy being used as part of individual's treatment regimen?
- Is individual learning to recognize and change behaviors, thoughts, or relationships that cause or maintain depression? Is therapy helping individual to develop more healthful and rewarding habits?

- Are underlying medical conditions that may complicate treatment or impact recovery being effectively addressed?
- If individual's depression is incapacitating, severe and life-threatening, or if he/she cannot take or does not respond to antidepressant medications, is electroconvulsive therapy (ECT) being considered at this time?
- Is individual seriously contemplating suicide or previously attempted it? Does the threat of self-harm or personal neglect put individual at risk?
- Is individual frail because of weight loss or at risk for heart problems because of severe agitation?
- Would individual benefit from hospitalization until self-care is possible?

#### Regarding prognosis:

- Assuming diagnosis and treatment are accurate, can individual comprehend and follow medication treatment regimen including proper dose to be taking, what time of day to take medication, and how to increase dosage when ordered? If individual is not capable, is another responsible individual available to oversee treatment? If not, would individual benefit from hospitalization until self-care is possible?
- Was individual made aware of possible side effects and what to do if a side effect is experienced?
- Does individual have a good working rapport with his/her physician?
- Does individual know how often to see physician and is transportation available? Is individual diligent about keeping appointments?
- Has the physician informed individual as to what to do to improve response to treatment and which activities to avoid to increase the likelihood of improvement? Is individual engaged in psychotherapy?
- What other support is available to individual? Family? Friends? Church? Support group?

### Cited References

Frances, Allen, ed. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. 4<sup>th</sup> ed. Washington, DC: American Psychiatric Association, 2000.