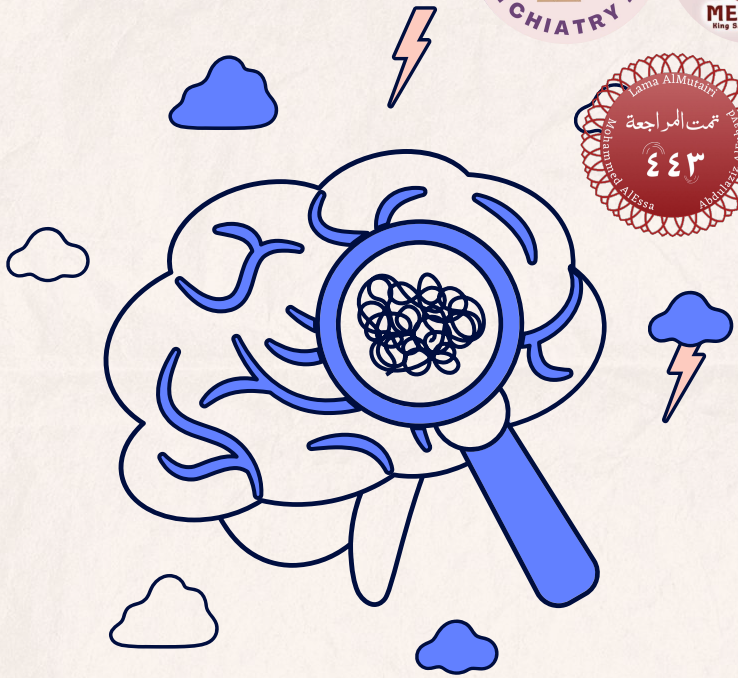
L2:
Depression



Editing file

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Main Text
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Extra Info

Objectives :

- To understand depression and its main features .
- To know the various types of depressive disorders .
- To be aware of the etiology, complications, epidemiology, course ,and prognosis.
- To have a background about treatment plan.

*Female Slides

Depression

- **The most common psychiatric illness.**
- **Lifetime prevalence of nearly 17% for major depression and about 2% for bipolar I**

and II disorders

- **More common in women than in men**
- **Mean age is around 32 yrs**

Mood:

is the sustained and pervasive feeling tone that influences a person's behavior and perception of the world. It is internally experienced. Mood can be normal, depressed, or elevated.

Affect:

is the person's present transient emotional state. It represents the external expression of mood.

*Male Slides

Depressive disorders

Main features:

- Low mood
- Loss of interest

It adversely effects :

- Thinking
- Behavior
- Body physiology
- Functioning

Differential diagnosis of depressive disorders:

1. Normal sadness (e.g., bereavement).
2. Depressive disorder due to a physical disease (e.g., hypothyroidism, vitamin deficiencies, Parkinson's disease, SLE, multiple sclerosis, cancer, CVA, epilepsy).
3. Depressive disorder due to medications (e.g., antihypertensive drugs, steroids, bromocriptine, L-dopa, indomethacin, isotretinoin, progestin-containing contraceptives (compared to estrogen- containing contraceptives, which can reduce depression risk), tamoxifen (estrogen-receptor antagonist used in breast cancer; it may induce depression that can be difficult to treat with antidepressants), chemotherapy agents e.g. vincristine, interferon (may induce severe depression with suicidal ideas), and antipsychotics.
4. Depressive disorder due to substance abuse.
5. Persistent depressive disorder (dysthymia). Premenstrual dysphoric disorder.
6. Adjustment disorder with depressed mood.
7. Bipolar disorder (past history of manic or hypomanic episode).
8. Schizoaffective disorder.
9. Schizophrenia.

*Male Slides

Biological features (Neuro-vegetative Signs):

- Change in appetite, wt., and sleep (usually reduced but in some patients increased).
- Fatigability, low energy level (a simple task is an effort).
- Change in bowel habit (usually constipation).
- Change in menstrual cycle (amenorrhea)
- Pain threshold becomes low (gate theory/serotonin).
- Low libido and /or impotence.
- Several immunological abnormalities (e.g. low lymphocytes) increasing the risk to infection.

Depressed thinking process:

Pessimism about:

- **Present**: patient sees the unhappy side of every event (discounts any success in life, no longer feels confident, sees himself as failure).
- **Past**: unjustifiable guilt feeling and self-blame.
- **Future**: gloomy preoccupations; hopelessness, helplessness, death wishes (may progress to suicidal ideation and attempt).
- **Guilt/Self-blame.**

Depressive Disorders (DSM-5)

(Diagnostic and Statistical Manual of Mental Disorders) :

- 1-Persistent Depressive Disorder (Dysthymia , dysthymic Disorder & chronic major depressive disorder)
- 2-Major Depressive Disorder (MDD) Single and Recurrent Episodes
- 3-Depressive Disorder Due to Another Medical Condition
- 4-Substance/Medication-Induced Depressive Disorder
- 5-Premenstrual dysphoric disorder
- 6-Disruptive Mood Dysregulation Disorder (in children)
- 7-Other Specified Depressive Disorder
- 8-Unspecified Depressive Disorder

- Adjustment Disorders with depressed mood.
- Depressive episodes in bipolar disorders/schizoaffective d.

Etiology and Pathophysiology

Mood Disorders

- Genetics
- Social and Environmental Factors
- Neurobiology (catecholamine hypothesis, decrease of
- norepinephrine) \ serotonin ?
- Neuroimaging Studies (subgenual prefrontal cortex (SGPFC)
- ↓ blood flow
- Abnormalities in Neuroendocrine Function (abnormal diurnal variation in cortisol production , hypothalamic-pituitary-adrenal axis , GH ?

Depressive Disorders

- Biological factors: Neurotransmitters=↓ Serotonin,↓ Norepinephrine↓ Dopamine
- Psychological factors: Loss of a parent before 11 years old Loss of spouse Personality factors : OCD, histrionic, and borderline
- Social factors: Social stressors such as unemployment or financial stressors.

Complications of Depressive Disorders : suicide, risk of serious d., substance abuse, under achievement/family/ financial...etc.

*Female Slides

Episodes

(discrete periods of abnormal mood; low, high, or mixed mood)

1.Major depressive episode (MDE):

≥ 2 weeks of low mood/loss of interest + other features.

2. Mixed episode :

≥ 1 week of both depressed and manic mood + other features

Box 6–3. DSM-5 Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Clinical Findings:

- Alteration of mood
- Vegetative (or somatic) symptoms, such as decreased appetite or insomnia, wt loss
- Feeling chronically tired \ lack of energy
- Psychomotor retardation\ agitation
- Feelings of worthlessness and guilt \ hopeless
- Complaints of difficulty in concentrating or thinking clearly
- Depressed patients may think a great deal about death or dying
- Diurnal variation
- Decrease sex drive

*Female Slides

Mood-congruent psychotic features:

Psychotic Features associated with severe depression (In one fifth of cases):

A. Hallucinations (mood-congruent)

1. Usually second person auditory hallucinations (addressing derogatory repetitive phrases).
2. Visual hallucinations (e.g. scenes of death and destruction) may be experienced by a few patients.

Congruent :الهلوسات تتماشى مع الاكتئاب
مثل: الناس تكرهني، مامني فايده

second person auditory hallucinations: يكلمه واحد

hallucinations auditory person third:ناس حوله تتكلم عنه

B. Delusions (mood-congruent)

فى واحد يلاحقني ويبغى يضربني

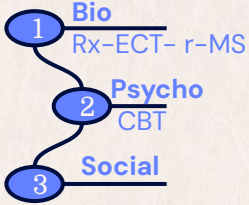
1. Delusion of guilt (patient believes that he deserves severe punishment).
2. Nihilistic delusion (patient believes that some part of his body ceased to exist or function, e.g. bowel, brain...).
3. Delusion of poverty and impoverishment.
4. Persecutory delusion (patient accepts the supposed persecution as something he deserves, in contrast to schizophrenic patient).

Course & Outcome

- A depressive episode may begin either suddenly or gradually
- Duration of an untreated episode may range from a few weeks to months or even years (6 months)
- 20% will develop a chronic form of depression
- suicidal risk↑

-being divorced or living alone,
- having a history of alcohol or drug abuse,
-being older than 40,
- having a history of a prior suicide attempt,
-expressing suicidal ideation (particularly when detailed plans have been formulated)

Depressive Disorders treatment plan



Treatment

1-Antidepressants have proven to be very useful in the treatment of severe depression. They shorten the duration in most cases (see antidepressants later).

2-Avoid Tricyclics / Tetracyclics in suicidal patient because of cardiotoxicity in Overdose.

3- Selective Serotonin Reuptake Inhibitors (SSRIs) e.g. fluoxetine, paroxetine.

4-Selective serotonin – Norepinephrine Reuptake Inhibitors (SNRIs) e.g. venlafaxine, duloxetine. Other new agents e.g. mirtazapine.

5- Desirable therapeutic antidepressant effect requires a period of time, usually 3-5 weeks. Side effects may appear within the first few days.

6- After a first episode of a unipolar major depression, treatment should be continued for six months after clinical recovery, to reduce the rate of relapse.

7- If the patient has had two or more episodes, treatment should be prolonged for at least a year after clinical recovery to reduce the risk of relapse.

8- Lithium Carbonate can be used as prophylaxis in recurrent unipolar depression.

*Male Slides

1-Persistent Depressive Disorder (Dysthymia)

Persistent Depressive Disorder (PDD) and Major Depressive Disorder (MDD) are very similar. However, in MDD, depressive episodes are SEVERE

Diagnostic criteria (DSM-5)

A. Depressed mood for most of the time for at least 2 years.
B. Presence, while depressed, of at least 2 of 6:
   1. Poor appetite or overeating.
   2. Insomnia or hypersomnia.
   3. Low energy or fatigue.
   4. Low self-esteem.
   5. Poor concentration or difficulty making decisions.
   6. Feelings of hopelessness.
C. Never been without the symptoms in Criteria A & B for more than 2 months at a time.
D. Criteria for a major depressive disorder *may be* continuously present for 2 years.
E. There has never been a manic episode or a hypomanic episode.
F. Not better explained by a another psychiatric disorder.
G. Not attributable to a physical disease, a medication, or substance abuse.
H. Significant distress or functional impairment.

PDD course and prognosis:

- The onset is usually insidious before age 25 yrs.
- the course is chronic with risk of major depressive d.

Some patients may consider early-onset dysthymic disorder as part of normal life.

- Patients often suffer for years before seeking psychiatric help.
- About 25 percent never attain a complete recovery.

*Female Slides

PDD

Box 6–4. DSM-5 Diagnostic Criteria for Persistent Depressive Disorder (Dysthymia)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

   Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

   1. Poor appetite or overeating.
   2. Insomnia or hypersomnia.
   3. Low energy or fatigue.
   4. Low self-esteem.
   5. Poor concentration or difficulty making decisions.
   6. Feelings of hopelessness.

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

PDD-Treatment

Treatment: The most effective treatment is the combination of

1. **Bio**: Pharmacotherapy and 2. **Psycho**: cognitive or behavior therapy (CBT).

A. Pharmacological:

Selective serotonin reuptake inhibitors (SSRI).

Selective serotonin – Norepinephrine Reuptake Inhibitors(SNRIs) e.g. venlafaxine,duloxetine.

Or Monoamine oxidase inhibitors (MAOI). Avoid combining with SSRI or tricyclic antidepressants.

These groups may be more beneficial than tricyclic drugs in the treatment of dysthymic disorders.

B. Psychological:

Supportive therapy.

Cognitive therapy; to replace faulty negative self-image, negative attitudes about self, others, the world, and the future.

Behavior therapy; to enable the patient to meet life challenges with a positive sense by altering personal behavior through implementing positive reinforcement.

*Male Slides

2-Major Depressive Disorder (MDD)

1. Presence of major depressive episodes (MDEs).
2. There has never been a manic episode.
3. Severity varies (mild-moderate- severe).

MDD is a unipolar disorder in which the patient has only MDEs. Whereas, in bipolar disorder, the patient may have MDEs along with manic or hypomanic episodes (see bipolar disorders). Many bipolar disorders begin with one or more MDEs, especially in adolescence & in individuals with a family history of bipolar d.

MDD- Single Episode	MDD- Recurrent
One major depressive episode (MDE) not preceded by major depressive, hypomanic, or manic episodes.	At least 2 MDEs separated by at least 2 months during which a patient has no significant symptoms of depression and not preceded by hypomanic or manic episodes.

Diagnostic criteria for Major Depressive Episode (MDE) (DSM-5)

A. At least a 2-week period of ≥ 5 of the following 9 symptoms (at least one of the symptoms is either) (1) depressed mood or (2) diminished interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Anhedonia in most of the previously pleasurable activities.
3. Marked changes in appetite/weight (decrease or increase).
4. Marked changes in sleep (insomnia or hypersomnia).
5. Psychomotor changes (slowness or agitation).
6. Fatigability or loss of energy.
7. Feelings of excessive guilt or worthlessness.
8. Diminished ability to think, concentrate or make decisions.
9. Recurrent thoughts of death, recurrent suicidal ideations, suicidal attempt or plan.

B. Significant distress or functioning impairment.
C. Not induced by substance or medication.
D. The occurrence of the MDE is not better explained by other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.

*Male Slides

MDD-Epidemiology

01 Lifetime prevalence is in the range of 15 – 25 %.

02 The mean age of onset is about 40 years (25 – 50 years).

03 It may occur in childhood or in the elderly.

04 In adolescents, it may be precipitated by substance abuse.

05 More common in those who lack confiding relationship (e.g. divorced, separated, single…).

MDD-Management

Bio-Psycho-Social Approach.

Hospitalization is indicated for:

01

Suicidal or homicidal patient.

02

Patient with severe psychomotor retardation who is not eating or drinking (for ECT).

03

Diagnostic purpose (observation, investigation...).

04

Drug resistant cases (possible ECT).

05

Severe depression with psychotic features (possible ECT)

MDD- Management

- **Electroconvulsive therapy (ECT)**:. The effect of ECT is best seen in severe depression especially with marked biological (neurovegetative), suicidal and psychotic features. It is mainly the speed of action that distinguishes ECT from antidepressant drug treatment. In pregnant depressed patient ECT is safer than antidepressants.

- **Transcranial magnetic stimulation (TMS):**
  It is a neurostimulation treatment modality that is performed as an outpatient treatment. The length of the treatment session varies depending on the protocol used, with an average being 30 min. The patient remains awake during the procedure. The treatment is administered daily for 4 weeks to produce electrical stimulation of targeted cortical regions. It has a safe side effect profile (mild headache) and is not associated with cognitive side effects. TMS therapy is contraindicated in patients with non removable metallic objects in or around the head. (it's usually used for the treatment of Parkinson's and Depression)

- **Psychological treatment (psychosocial) :**
  Family therapy, Supportive therapy and in less severe cases cognitive-behavior therapy (CBT). Other useful treatments for depression, depending on the severity and the clinical presentation, could include exercise and light therapy

MDD-Prognosis

01 About 25 % of patients have a recurrence within a year.

02 About 10 % will eventually develop a manic episode. Be careful about antidepressants.

03 A group of patients have chronic course with residual symptoms and significant social handicap.

Depressive Disorder Due to Another Medical Condition

01 **Endocrine D. :**
Hypothyroidism - Diabetes Mellitus - Cushing's disease

02 **Neurological D.:**
Traumatic brain injury (TBI) - Parkinson's disease- Huntington disease

03 **Autoimmune D. :**
SLE / Multiple sclerosis

04 Carcinoma (especially of the pancreas and lungs)

05 Stroke; post stroke depression (PSD)

- Psychiatric disorders:
  - Dysthymic disorder (chronic& less severe depression- see later-).However, both may occur together; dysthymic disorder complicated by major depressive episodes (double depression).
  - Adjustment disorder with depressed mood (see later).
  - Schizophrenia, schizoaffective disorder.
  - Somatization disorder
  - Anxiety disorder.

"Female Slides"

Medication-induced depressive d.

01 **Chemotherapy agents** e.g., vincristine, interferon (may induce severe depression with suicidal ideas).
Tamoxifen: (estrogen-receptor antagonist used in breast cancer): it may induce depression that can be difficult to treat with antidepressants

02 **Progestin-containing contraceptives** (compared to estrogen- containing contraceptives, which can reduce depression risk).

03 -Steroids,
-Indomethacin,
-Bromocriptine & L - dopa.

04 Antihypertensive Rx (e.g. beta-blockers, methyldopa, reserpine & Ca-channel blockers).

05 -Isotretinoin (Roaccutane); treatment of acne.
-Certain antibiotics and antiviral medications.
-Varenicline (smoking cessation agent)

06 -Antipsychotics

Depression secondary to substance abuse (upon discontinuation of stimulants / cannabis).

Perinatal/Post-partum Depression

01 About 10 - 15%
In late pregnancy /within 6 weeks of childbirth (10–14 days after delivery)

02 If not treated may continue for 6 months or more and cause considerable family disruption

03 It is associated with increasing age, mixed feelings about the baby, physical problems in the pregnancy and prenatal period, .family distress and past psychiatric history

04 May be associated with irritability, panic attack, self-blame and doubt of being a good mother, excessive anxiety about the baby's health and death wishes

05 Counseling, additional help with child-care may be needed. Antidepressants or ECT are indicated if there are biological features of depression

"Female Slides"

- The peripartum onset specifier identifies those patients who experience a depressive, manic, or hypomanic episode during pregnancy or within the first 4 weeks postpartum
- 50% of "postpartum" depressive episodes actually begin prior to delivery

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