MED441
KING SAUD UNIVERSITY

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REVIEWED BY

Mood Disorders Part II: Depressive Disorders

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Objectives:

- Become familiar with DSM-5 criteria for major depression and related disorders.
- List some of the differential diagnoses, risk factors, and comorbidities associated with depression.
- Identify pharmacological and non-pharmacological treatment modalities for depression.
- Recognize major depressive disorder as a high risk for suicide.

Color index:

- Important
- Golden
- Textbook
- Old notes (439/438)
- New notes (441)
- Extra

Major Depressive Disorder (MDD)

◀ DSM-5 Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms during the same two week period and represent a change from previous functioning, at least one of the symptoms is: **(1) depressed mood.** **or** **(2) loss of interest or pleasure.**	A. Must have at least **five** of the following symptoms for at least **two weeks** **(must include either number 1 or 2)** 1. Depressed mood most of the time. 2. Interest: Loss of interest (anhedonia). 3. Weight: Change in appetite or weight (↑ or ↓). 4. Sleep: Insomnia or hypersomnia 5. Motor: Psychomotor agitation or retardation 6. Energy: Fatigue or loss of energy 7. Guilt: excessive feeling of guilt or worthlessness[1] 8. Concentration: Diminished concentration[1] 9. Suicide: Recurrent thoughts of suicide and death Depression Is Worth Solidly Memorizing An Extremely Grueling Criteria. Sorry.
B. The symptoms cause significant distress or impairment in functioning.	
C. The episode is not attributable to the physiological effects of a substance or another medical condition.	
D. The occurrence is not better explained by another mental disorder.	
E. There has never been a manic episode or a hypomanic episode. (otherwise it will be bipolar disorder)	

◀ Symptoms of MDD

Noted:
Depressed mood, either;

- Subjective report (sad, depressed, empty, hopeless, discouraged, down in the dumps) or
- Observed by others (apparent tearful)

Other symptoms:
Boredom - Tearful - Irritability - Anxiety or phobia - Excessive worries about physical health - Pain - Menstrual problems - Sexual dysfunction, decrease interest in sex

Children & Adolescents	Elderly

1. Mood can be irritable mood.[2]
2. Children may refer to depressive feelings in terms of anger, or feeling “mad” rather than sad.
3. Children tend to present with somatic symptoms.
4. Can have failure to make expected weight gain rather than weight loss.
	• Symptoms of depression are not part of normal aging.
	• Symptoms compared to adult:
	  ○ Minimize sadness.
	  ○ More agitation.
	  ○ Higher rate of completed suicide and more lethal methods.

FOOTNOTES

1. May become fearful of going to work or taking examination or assuming any kind of responsibility. They might avoid answering calls or texts to avoid relationships or responsibility that they feel themselves inadequate to handle
2. An occasional presentation is of predominant irritability with only a small component of sadness. This might stem from the inability to experience pleasure.

◀ Specifiers with MDD

Specifiers are extensions of DSM-5 diagnoses

- They are used to further classify certain disorders into new subcategories
- Specifiers may indicate a specific treatment to an established diagnosis
- The same specifiers apply for bipolar with the exception of rapid cycling, which only applies for bipolar

1

"With Psychotic Features"

- **Delusions and or hallucinations are present:**
  - Mood-congruent psychotic features: content of the delusions and hallucinations consistent with depressive themes (guilt, inadequacy, nihilism, etc). (ex. Im hearing someone saying I'm a failure)
  - Mood-incongruent psychotic features: does not involve typical depressive themes. (ex. Im hearing someone saying Im the best)

2

"With melancholic Features" - formerly known as endogenous depression melancholic = anhedonia

- **One of the following:**
  - Loss of pleasure in all or almost all activities.
  - Lack of reactivity to usually pleasurable stimuli (does not feel better even temporarily when something good happens).
- **Three (or more) of the following:**
  - Distinct quality of mood (profound despondency, despair, empty mood).
  - Depression is worse in the morning.
  - Early morning awakening (at least 2 hours before usual awakening)(terminal insomnia)
  - Marked psychomotor agitation or retardation.
  - Significant anorexia or weight loss.
  - Excessive or inappropriate guilt.
- **Melancholic features are more frequent in:**
  - Inpatients.
  - More severe depressive episodes.
  - Those with psychotic features.
  - Older individuals.

Good response to antidepressants and ECT

3

"With atypical Features" formerly known as exogenous or reactive depression

- Mood reactivity (mood brightens in response to positive events).
- **Two (or more) of the following:**
  - Significant weight gain or increase in appetite.
  - Hypersomnia.
  - Leaden paralysis (heavy, leaden feelings in arms or legs).
  - Long-standing pattern of interpersonal rejection sensitivity causing functional impairment.
- Criteria are not met for "with melancholic features" or "with catatonia".
- Atypical features may be more common in **Bipolar Depression** than MDD.
- Compared with patients with typical depression features, the patients with atypical features are; 1. found to have a younger age of onset, 2. have long-term course, 3. more frequent coexisting diagnosis of panic disorder, substance abuse or dependence, and somatization disorder.
- Difficulty in relationships, more frequent breakups

4 ***"With Catatonia Features"***

- **Three (or more) of the following symptoms:**
  - Stupor (no psychomotor activity).
  - Catalepsy (passive induction of a posture held against gravity). If you position the pt, they will stay in that position
  - Waxy flexibility (slight resistance to positioning by examiner).
  - Mutism.
  - Negativism (no response to instructions or external stimuli).
  - Posturing (spontaneous adoption of posture against gravity). If the pt position themselves in a certain position and freeze. Active not passive.
  - Mannerism (odd caricature of normal actions). Non goal directed movement.
  - Stereotypy (repetitive, abnormal non-goal directed movements).
  - Agitation.
  - Grimacing.
  - Echolalia.
  - Echopraxia (mimicking another's movements)
- Treat with benzodiazepines (first-line), ECT (2nd line)

5 ***"With peripartum Features"***

- If mood symptoms occur **during pregnancy** or in the **4 weeks** following delivery.

6 ***"With mixed features"***

- Coexistence of manic or hypomanic episodes
  - Does not fulfill the criteria of bipolar, though features of mania/hypomania are present

7 ***"With anxious distress"***

- 2 of the following 5 symptoms across an episode: 1) feeling keyed up or tense, 2) feeling unusually restless, 3) difficulty concentrating because of worry, 4) fear that something awful might happen, and 5) a feeling that one might lose control of himself/herself
- Higher suicidality, greater duration of illness and nonresponse to antidepressants

8 ***"With seasonal pattern"***

- Depression occurring only in winter months and remits in the spring
- Seasonal affective disorder triad: increased sleepiness, carbohydrate craving and irritability
  - Light therapy (2hrs a day of 2,500 lux [unit of luminance]). Bupropion for prophylaxis
  - Antidepressants can also be used

◄ Scales used in Diagnosis of MDD

- **Self-report Scales, such as:**
  - Beck Depression Inventory II (BDI-II).
  - Zung Self-Rating Depression Scale.
  - Patient Health Questionnaire (PHQ-9).
  - Quick Inventory for Depressive Symptomatology, Self- Rated (QIDS-SR).
- **Clinician-rated Scales, such as:**
  - Hamilton Depression (HAM-D).
  - Montgomery-Asberg Depression Assessment Scale (MADRAS).
  - Inventory for Depressive Symptomatology (IDS).

◄ Epidemiology of MDD

- MDD is among the leading causes of global disability. **Most common cause of suicide.**
- **Prevalence in adults:**
  - Lifetime: approximately 10 to 17 %.
  - 12-Month: approximately 4-7 %.
- **Gender:**
  - In adult: **1.5-3**:1 **F**:M ratio.
  - Age of Onset: Incidence peaks in **20s**, likelihood increases markedly **after puberty**, but can still have first onset in late life (onset later than for BAD "Bipolar Affective Disorder"). Bipolar starts earlier (teenage years). They come first with depression not mania or hypomania, with time we realize it is in fact bipolar.

◀ Differential Diagnosis of MDD

Medical Conditions

- Hypothyroidism.
- Cushing's Disease or Addison's disease.
- Anemia, Vitamin B12 or Folate Deficiency.
- Infectious Etiology: Mononucleosis, HIV, etc.
- Pancreatic cancer, brain tumors and other neoplasms.
- Epilepsy.
- CVA.
- Multiple Sclerosis.
- Parkinson's Disease.

Substance Induced

- Stimulants withdrawal: Amphetamine, MDMA (ecstasy, discussed in substance abuse lecture), Cocaine.
- Sedatives: Alcohol, benzodiazepines, barbiturates.
- Medications induced. Like Corticosteroids and Immunosuppressants.

Others

- Normal Sadness[1], Grief, Adjustment Disorder with Depressed Mood, Dysthymia, Bipolar I and Bipolar II Disorder, Schizoaffective Disorder, ADHD (Attention deficit hyperactivity disorder).
- In elderly: also consider: electrolyte imbalance, glucose abnormality, and pain.

◀ Risk Factors of MDD

- Early-Onset Adversity.
- Stressful Life Events.
- Family History (first degree relatives have 2-4x greater chance of having MDD).
- Female Gender.
- Neuroticism (negative affectivity).
- Chronic Medical Conditions.
- Substance use.
- Anxiety Disorders.
- Certain personality disorders

FOOTNOTES

1. it should be on your differential diagnosis, as everyone grieve in a different way it might be similar to MDD.

◄ Comorbidities of MDD

- Substance Use Disorders.
- Anxiety Disorders.
- Eating Disorders.
- Borderline Personality Disorder.
- Attention-deficit/hyperactivity disorder (ADHD), Learning disabilities, oppositional defiant disorder, and conduct disorder.
- **Men** more frequently present with substance use disorders, **women** more frequently present with comorbid anxiety and eating disorders.

◄ Prognosis of MDD

- Untreated depressive episodes last **6 to 13 months**, treated episodes last **3 months.**
- Course is quite variable, but 80% will recover within 1 year.
- Can get both absenteeism and presenteeism at work.
- MDD increases the risk of Type II diabetes (HPA axis hyperfunction, thyroid hypofunction and increased levels of TNF-alpha and IL-1 in depressed individuals → predispose ectopic fat formation → insulin resistance) and is an independent risk factor for cardiovascular disease and mortality.
- Increased rates of emphysema, COPD, migraine, multiple sclerosis, back problems, cancer[1], epilepsy, asthma, stroke, thyroid disease, diabetes, and heart disease in patients with MDD.
- **Low recovery rates with:**
  - Long duration of current episode.
  - Symptom Severity.
  - Psychotic features.
  - Prominent anxiety.
  - Personality Disorders (psychotherapy is particularly indicated)
- **Risk of Recurrence with:**
  - Multiple prior episodes.
  - Previous severe episode.
  - Mild depressive symptoms persist during remission.
  - Younger individuals.
- Residual symptoms:
  - The least common residual symptoms are depressed mood, suicidality, and psychomotor retardation.

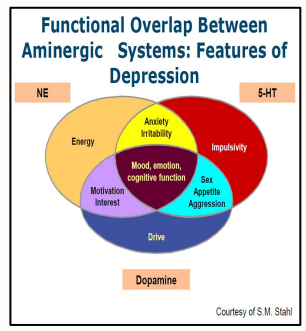
◄ Depression and its Relation to Suicidality

- About two-thirds of all depressed patients contemplate suicide and 10 to 15 percent commit suicide.
- Low concentrations of 5-HIAA (5-Hydroxyindoleacetic acid), which is a serotonin metabolite, have been associated with suicidal behavior. Furthermore, low concentrations of 5-HIAA in the CSF also predicts the presence of future suicidal behavior.
- Several risk factors for suicide exist; prior suicidality is the most significant risk factor.

FOOTNOTES

1. Depressed patients have reduced levels of circulating natural killer lymphocytes (NK cells). These cells function in cancer surveillance as they sense the decrease in expression of MHC=I in cancer cells (a common feature of tumor) and attack these MHC-1 lacking cancer cells

◄ Etiological Theories



1. **Monoamine hypothesis (NE, serotonin and dopamine)**
   - Most antidepressants work effectively on these neurotransmitters
   - Depletion of tryptophan (5-HT precursor) from diet leads to relapse in patients taking SSRIs
   - Depletion of catecholamines leads to relapse in patients taking noradrenergic agents
   - Reserpine (which can cause depletion of monoamine transmitters after long-use) is associated with depression
   - Reduction of 5-HIAA (serotonin metabolite) in CSF is associated with increased suicidality and impulsive behavior, in both depression and other disorders
2. **Neurotrophic hypothesis (brain-derived neurotrophic factor [BDNF])**
   - BDNF enhances neurogenesis, synaptogenesis and consequently neuroplasticity
   - Stress and depression are associated with reduced levels of BDNF→ hippocampal and anterior cingulate atrophy → reduced emotional regulation, concentration and memory defects
   - Infusion of BDNF has antidepressant effects in animal models
   - Antidepressants enhance BDNF levels (Especially SSRIs, enhance neuroplastic potential of frontal and hippocampal neurons)
3. **Neuroendocrinology**
   - HPA hyperfunction → cortisol decreases BDNF synthesis
   - Thyroid hypofunction → brain less sensitized to catecholamines
   - Estrogen and testosterone have also been implicated in the etiology

◄ Difference between MDD & Grief (Bereavement)

- **In Grief:** will be explained in anxiety lecture
  - Affect is feelings of emptiness and loss.
  - Dysphoria likely decrease in intensity over days to weeks.
  - Functional impairment is usually transient.
  - **May be accompanied by positive emotions and humor.**
  - **In grief, self-esteem is usually preserved.**
  - If thoughts about death and dying, limited to thoughts of joining the deceased but not on ending one's life because of worthlessness or pain of depression.
  - Survivor does not have morbid feelings of guilt and worthlessness, suicidal ideation, or psychomotor retardation.

◄ Difference between MDD & Adjustment Disorder

- **In Adjustment disorder:**
  - Some symptoms overlap.
  - Doesn't involve as many of the physical and emotional symptoms of clinical depression.
  - Less levels of severity.

◄ Difference between MDD & Attention Deficit Hyperactivity Disorder

- **In ADHD:**
  - Onset of clear-cut symptoms before age 7.
  - Onset of hyperactivity or disruptive behaviors.
  - Continuous.
  - Family history of disruptive disorders.

◄ Schizoaffective Disorder Vs. MDD

DSM-5 criteria for schizoaffective disorder:
A. An uninterrupted duration of illness during which there is a major mood episode (manic or depressive) in addition to criterion A for schizophrenia; the major depressive episode must include depressed mood.
Criterion A for schizophrenia is as follows: Two or more of the following presentations, each present for a significant amount of time during a 1-month period (or less if successfully treated). At least one of these must be from the first three below.
1. Delusions
2. Hallucinations
3. Disorganized speech
4.Grossly disorganized or catatonic behavior 5. Negative symptoms
B. Hallucinations and delusions for two or more weeks in the absence of a major mood episode (manic or depressive) during the entire lifetime duration of the illness.
C. Symptoms that meet the criteria for a major mood episode are present for the majority of the total duration of the active as well as residual portions of the illness.
D. The disturbance is not the result of the effects of a substance (e.g., a drug of misuse or a medication) or another underlying medical condition.

◄ Management of MDD

Phases of Treatment	
Acute Phase	**Maintenance Phase**

• **Goals:**
  ○ Remission of symptoms.
  ○ Restoration of functioning.
• **Activities:**
  ○ Establish therapeutic alliance.
  ○ Educate and support.
  ○ Select and deliver evidence based treatment.
	• **Goals:**
	  ○ Return to full functioning and quality of life.
	  ○ Prevention of recurrence.
	• **Activities:**
	  ○ Educate.
	  ○ Treat comorbidities.
	  ○ Monitor for recurrence.

◄ Treatment Modalities of MDD

Pharmacotherapy

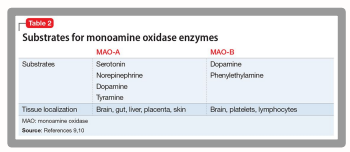
- **Antidepressant (SSRIs, MAOIs, TCAs)** choice based on multiple factors:
  - Patient preference, Past response, Drug-drug interaction, Comorbid Disorders, Side-effect profile and tolerability, Cost & Availability.
- **Length of Treatment:**
  - Risk factors **supporting** long-term (2 years to lifetime) antidepressant maintenance:
    - Older age, Recurrent episodes, Chronic episodes, Psychotic Episodes, Severe episodes, Difficult to Treat Episodes, Significant Comorbidity (psychiatric or medical), Residual Symptoms, History of recurrence during discontinuation of antidepressant.

Psychotherapy

- **CBT (cognitive behavioural therapy).**
- IPT (interpersonal therapy).
- Behavioural activation.

Neurostimulation

- **ECT (electroconvulsive therapy).**
- rTMS (repetitive transcranial magnetic stimulation).

Class	SSRIs	MAOIs	TCAs
MOA	Selectively block reuptake of 5-HT	Inhibit the metabolism of neurotransmitters DA, NE, 5-HT	Affect multiple receptor systems (inhibit the reuptake of NE and 5-HT)
Notes	Include: • **Fluoxetine (longest half-life, less withdrawal side effect)** • Sertraline. • Paroxetine. (shortest half-life, more withdrawal effects) • Fluvoxamine (investigated for the treatment of COVID-19 → markedly reduced rates of hospitalization among users) • Citalopram. • **Escitalopram.** (least likely to cause adverse effects, including drug interactions) Compared to MAOIs and TCAs; • Less cardiotoxicity. • More sexual dysfunction. • Lack side-effects of TCAs (anticholinergic, antihistaminic, antiadrenergic)	• MAO A inhibitors (e.g., moclobemide) • MAO B (e.g., selegiline) • Non-selective (e.g., tranylcypromine) Common uses: • **Atypical** depression (SSRIs are first-line). • **Refractory** patients. Most of the medications in this class needs dietary monitoring (especially types of cheese). Persons taking MAOI antidepressants are cautioned to avoid foods that are rich in **tyramine** so that the hypertensive crises can be avoided. (except users of selegiline) **Not** used as first line because many side effects and drug Interactions. 	• Tricyclics (e.g., clomipramine [most serotonin-selective]. imipramine, nortriptyline) • Tetracyclics (e.g., amoxapine)(may cause extrapyramidal effects) • Multiple side effects (not 1st line). • Several drug-drug interactions. • **Lethal in overdose** (arrhythmias; seizures) (Avoid TCAs in suicidal patients). • Helpful in cases of (physical symptoms): • Pain, Fibromyalgia, Migraine, Sedative/hypnotic, **Severe depression** • **Treatment of overdose: IV sodium bicarbonate.**
Common Side Effects	• GI side effects (nausea, vomiting, diarrhea, appetite, weight). • Headache. • Insomnia. • **Sexual dysfunction (treats premature ejaculation)** → if bothersome, switch class, reduce dose or co-administer bupropion or cyproheptadine as antidotes or silddenafil • Agitation. • Restlessness. • Anxiety. • Weight gain (paroxetine) • Weight neutral (fluoxetine and sertraline)	• **Cardiovascular** (orthostatic hypotension [if severe, add fludrocortisone or elastic stockings], peripheral edema). • Weight gain. • **Sexual side effects.** • Neurological (headache, insomnia, sedation, paresthesias). • Other (dry mouth, constipation, urinary hesitancy)(anticholinergic side effects).	• Drowsiness, dizziness, falls, fracture. • **Cardiac side effects.** • Blurred vision, mydriasis (pupillary dilation). • Dry mouth. • Constipation. • Urinary retention. • Memory impairment. • **Sexual dysfunction.** • Fever. • Weight gain. • Neurological side effects (myoclonus, confusional state, seizure in overdose). **Summary: HAM + life-threatening effects** - **Antihist**aminic (e.g., sedation, weight gain) - Antiadrenergic (e.g., hypotension) - Antimuscarinics (e.g., can't see, can't pee, can't defecate, dry mouth, and sexual dysfunction) - Life-threatening: (e.g., cardiotoxicity, seizure)
Other Side Effects	• **Serotonin syndrome.** • Abnormal bleeding (Caution with anticoagulants, NSAIDs, ASA). (Serotonin does not cross BBB, yet SSRIs work peripherally on platelets to decrease serotonin uptake) • **Cardiotoxicity** (citalopram, escitalopram, dose-dependant). • The syndrome of inappropriate antidiuretic hormone secretion (SIADH). SIADH = SSRI • Do not use with MAOI → wait 6 weeks • All are pregnancy risk category C, except paroxetine (D)	• **Hypertensive crisis (tyramine-rich foods):** • Hypertension, neurological symptoms, fever, nausea, palpitations, tachycardia, cardiac arrhythmias, confusion. • Possibly CVA and death. • **Serotonin syndrome (if taken with other antidepressants):** Neurological symptoms, GI symptoms, restlessness, MSE changes, confusion, tachycardia, hypertension, fever. ○ In severe form: Hyperthermia, rhabdomyolysis, renal failure, cardiovascular shock, coma, seizures, death.	

Class	SNRIs	Serotonin Modulators	NDRIs
MOA	Selectively block reuptake of 5-HT and NE	5-HT2 receptor antagonists (trazodone and nefazodone) or 5-HT1A partial agonists (vilazodone) and reuptake inhibitors	Inhibit the reuptake of NE and dopamine
Notes	Include: Duloxetine, venlafaxine, desvenlafaxine and levomilnacipran	Include: Trazodone, nefazodone and vilazodone - Commonly used in insomniac patients (sedative, evential switch to SSRIs when insomnia improves)	• Include: Bupropion • Approved for the treatment of smoking cessation, major depression and the prophylaxis of seasonal depression • Not effective in anxiety disorders
Important Side Effects	• Side effects are similar to SSRIs • Hepatotoxicity **(especially doluxetine)** • Anticholinergic (especially doluxetine) • **Dose-dependent increase in DBP (especially venlafaxine and desvenlafaxine - monitoring is recommended)**	• **Priapism (trazodone)** • **Anticholinergic side effects (nefazodone)** • **Hepatotoxicity (nefazodone, rarely used)** • **No sexual side-effects**	• Most important side effect is reduced seizure threshold (contraindicated in seizure disorder and eating disorders) • Tremors (subside with time, can be treated with propranolol) • **No sexual side-effects**
Other Side Effects	• **Serotonin syndrome.** • **Do not combine with MAOI**	• **Serotonin syndrome.** • **Do not combine with MAOI**	

Other medications

- Mirtazapine: Increases the levels of serotonin and NE in the synaptic cleft.
- Highly sedative (a choice for highly insomniac patients)
- In cancer patients (increases weight). Should not be used within 14 days of using MAOI

◄ Treatment Essentials

- Treatment should start with an SSRI (especially in patients with cardiac defects, preferably avoid citalopram)
- When TCAs are used, amitriptyline, imipramine and desipramine are the drugs of choice
- Patient treated for their first episode should continue treatment for 6-9 months after remission
- If there is no response after 4 weeks of treatment, either increase the dose or switch medication classes
  - If there is still no response, augmentors may be used such as; lithium (effective within a week)
  - ECT is another option

◄ Serotonin Syndrome "discussed thoroughly in pharma lecture"

- A triad of neuromuscular excitability, autonomic dysfunction and an altered mental status
- Neurological symptoms (signs of sympathetic activation + cerebellar signs + myoclonus)

Treatment

- **Immediate discontinuation of SSRIs**
- Supportive care
  - **Antihypertensives**, fluid replacement
  - **Benzodiazepines** for sedation

Cyproheptadine (5HT-1A, 5-HT2A): Used for serotonin syndrome if no response to supportive care

◄ Neurostimulation of MDD

Electroconvulsive Therapy (ECT)	Repetitive Transcranial Magnetic Stimulation (rTMS)

• A medical procedure that is delivered under controlled conditions (general anesthesia). It involves the use of electrical stimulus to depolarize cerebral neurons thereby produce a generalized seizure Helpful in: (strong tx used in severe cases).
• Elderly.
• Psychotic depression.
• Catatonia.
• Severe depression.
• Treatment <u>resistant</u> depression.
• **Important note: ECT has other uses in psychiatry such as in schizophrenia.**
	• <u>Compared to ECT:</u>
	  ○ No anesthesia.
	  ○ No negative effects on neurocognitive functioning.
	  ○ No driving restrictions.
	  ○ Doesn't affect memory (unlike ECT).
	  ○ Used mainly for treatment **resistant depression** & OCD. (Used if failure to respond to 1 or 2 antidepressant medications)

◄ Other Therapies of MDD

- Exercise.
- Light therapy.
- Others: e.g. St. John's Wort- mild to moderate depression (a plant used for the treatment of depression, should not be combined with antidepressants)
- Thyroid hormone.

◀ DSM-5 criteria for Schizoaffective Disorder (SAD)

A. An uninterrupted duration of illness during which there is a major mood episode (manic or depressive) in addition to criterion A for schizophrenia; the major depressive episode must include depressed mood. **Criterion A** for schizophrenia is as follows: Two or more of the following presentations, each present for a significant amount of time during a 1-month period (or less if successfully treated). At least one of these must be from the first three:	1. Delusions. 2. Hallucinations. 3. Disorganized speech. 4. Grossly disorganized or catatonic behavior. 5. Negative symptoms. - E.g. Lack of interest in the world, social withdrawal, anhedonia, avolition, not talking much.
B. Hallucinations and delusions for two or more weeks in the absence of a major mood episode (manic or depressive) during the entire lifetime duration of the illness. (Distinguishes schizoaffective from MDD with psychosis)	
C. Symptoms that meet the criteria for a major mood episode are present for the majority of the total duration of the active as well as residual portions of the illness.	
D. The disturbance is not the result of the effects of a substance (e.g., a drug of misuse or a medication) or another underlying medical condition.	

◀ Persistent Depressive Disorder (Dysthymia)

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.	
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 other mental illnesses such as schizoaffective disorder, etc.	
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.	

Coexistence of PDD and MDD = Double depression

- Most effective treatment = pharmacotherapy + psychotherapy (main treatment)
- Psychotherapy (cognitive, behavior, interpersonal or insight-oriented [psychoanalytic], the latter is the most common option)
- Pharmacotherapy: SSRIs (first-line) , venlafaxine and bupropion (alternatives)

Other Depressive Disorders

◀ Substance/Medication-Induced Depressive Disorder

A. A prominent & persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.	
B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):	1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication. 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced.	
D. The disturbance does not occur exclusively during the course of a delirium.	
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	

◀ Depressive Disorder Due to Another Medical Condition

A. A prominent and persistent period of depressed mood or markedly diminished interest or pleasure in all, or almost all, activities that predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Examples: • Neurological: (stroke, Huntington's disease, multiple sclerosis, Parkinson's disease, traumatic brain injury). • Endocrinological: (Cushing's disease, hypothyroidism). • Others.

◀ Other Specified & Unspecified Depressive Disorders

Specified	Unspecified
This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but **do not meet the full criteria for any of the disorders** in the depressive disorders diagnostic class. The other specified depressive disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder.	This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but **do not meet the full criteria for any of the disorders** in the depressive disorders diagnostic class. The unspecified depressive disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific depressive disorder, and includes presentations for which there is insufficient information to make a more specific diagnosis.
Examples: • Short-duration depressive episode. • Depressive episode with insufficient symptoms.	**Example:** • In emergency room settings.

◀ Premenstrual Dysphoric Disorder

Mood lability, irritability, dysphoria, and anxiety that occur repeatedly during the premenstrual phase of the cycle.

Diagnosis and DSM-5 Criteria

- In most menstrual cycles, at least five symptoms (below) are present in the final week before menses, improve within a few days after menses, and are minimal/absent in the week postmenses (should be confirmed by daily ratings for at least two menstrual cycles).
- At least one of the following symptoms is present: affective lability, irritability/anger, depressed mood, anxiety/tension.
- At least one of the following symptoms is present (for total of at least five symptoms when combined with above): anhedonia, problems concentrating, anergia, appetite changes/food cravings, hypersomnia/insomnia, feeling overwhelmed/out of control, physical symptoms (e.g., breast tenderness/swelling, joint/muscle pain, bloating, weight gain).
- Symptoms cause clinically significant distress or impairment in functioning.
- Symptoms are not only exacerbation of another disorder (e.g., MDD, panic disorder, persistent depressive disorder).
- Symptoms are not due to a substance (medication or drug) or another medical condition.

Onset can occur at any time after menarche. May worsen prior to menopause but cease after menopause.

Treatment

- SSRIs are first-line treatment, either as daily therapy or luteal phase-only treatment (starting on cycle day 14 and stopping upon menses or shortly thereafter).
- Oral contraceptives may reduce symptoms.
- Gonadotropinreleasing hormone (GnRH) agonists have also been used, and, in rare, severe cases, bilateral oophorectomy with hysterectomy will resolve symptoms.

◄ Masked Depression

- Full depressive syndrome is not obvious because **the patient does not report a depressed mood**
- An older person may come in complaining primarily of somatic symptoms (e.g., insomnia, loss of energy and appetite) so troubling that he or she is unable to concentrate, work, and sleep.
- **Although a careful medical workup reveals no physical abnormalities**
- Treated with antidepressants

◄ Summary & Other Notes

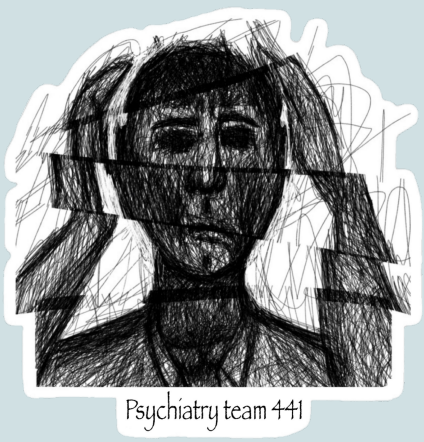
- **Major depressive disorder:**
  - Is a major psychiatric illness that can affect several life domains.
  - In adults, it tends to occur more in female than males.
  - Its onset is later than for BAD (bipolar disorder).
  - Psychiatric and medical comorbidities are common.
  - About 10 to 15 percent of depressed patients commit suicide.
  - Several pharmacological and non-pharmacological treatments exist.
- **Depressed mood, either:**
  - Subjective report (sad, depressed, empty, hopeless, discouraged, down in the dumps) or Observed by others (apparent tearful).
- **General Other Symptoms of MDD:**
  - Boredom.
  - Tearful.
  - Irritability.
  - Anxiety or phobia.
  - Excessive worries about physical health.
  - Pain.
  - Menstrual problems.
  - Sexual dysfunction, decrease interest in sex.

Team leader

- **Saleh Aloraini**

Team members

- **Abdulrahman Aljofan**
- **Faisal Alhussaini**
- Alwaleed Bin shaya
- Faisal Bin moammar
- Mishari Alzoubi
- Abdulmajeed Namshah
- Abdulrahman bawazir
- **Abdulmalik Alduraibi**
- Hamad Alothman
- Sultan Alkassim
- Faisal Alshuaibi
- Abdullah Alyamani
- Talal Alanazy
- Yahya Alghamdi
- Osama Alsaaid



Good luck!!

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Special thanks to 439 & 438 psychiatry teams