Depressive Disorders

- Introduction/Definitions.
- Major Depressive Episodes/Disorder.
- **Postpartum Depression.**
- Dysthymic Disorder.
- Others

Ms. Nouf is a 28-year-old single woman works as a teacher. She has a five-week history of low mood, chest tightness, poor appetite, disturbed sleep, excessive guilt feelings, and loss of interest in her social activities. Her father has a history of depression.

Healthy people have a sense of control over their moods, and experience a wide continuum range of feelings with normal variations **[** usual sadness **< < <** - - - - - - - - - - - - - - - - **> > >** usual happiness **]**.
Patients with mood(affective) disorders have a loss of that sense of control over feelings , a subjective experience of great distress and abnormality in the range of mood (e.g. depression, euphoria) and result in impaired interpersonal, social, and occupational functioning. Anxiety disorders are not considered as part of mood disorders in the modern classification, they are classified in a separate category although anxiety is a variant of normal mood.

Depressive Disorders (DSM-5)

1. Major Depressive Disorder, Single and Recurrent Episodes
2. Persistent Depressive Disorder (dysthymic Disorder & chronic major depressive disorder)
3. Disruptive Mood Dysregulation Disorder (in children).
4. Premenstrual Dysphoric Disorder
5. Substance/Medication-Induced Depressive Disorder
6. Depressive Disorder Due to another Medical Condition

Mood/Affect?!
Affect/Mood?!
Confusing terms !!

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.

Subjective affect: one's verbal expression of

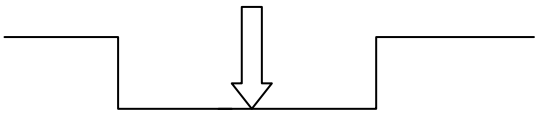
Objective affect: observer's evaluation of expression of affect, through nonverbal signs; facial expression, eye contact, tone of voice, posture & movements.

Episodes / Disorders! , These terms should not confuse me.

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

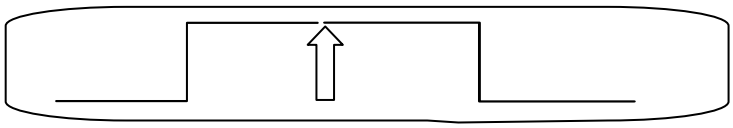
1.Major depressive episode (MDE):

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



2.Manic episode:

≥ 1 week of elevated, expansive, or irritable mood + other features



3.Mixed episode:

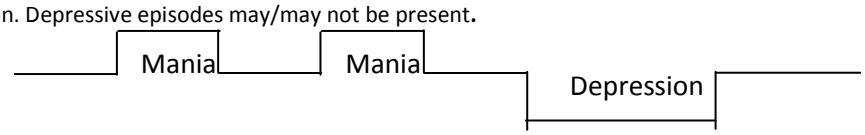
≥ 1 week of both depressed and manic mood + other features

4.Hypomanic episode:

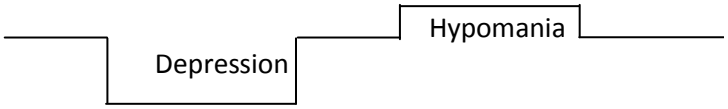
≥ 4 days less severe elevated mood + other features ------ --------

Disorders (longitudinal view / diagnostic term)

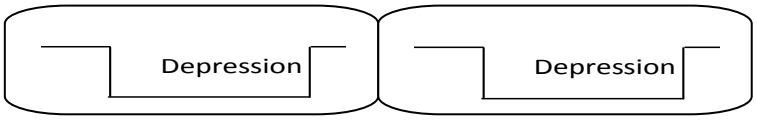
1.Bipolar I disorder: patient has met the criteria for a full manic or mixed episode, usually sufficiently severe to require hospitalization. Depressive episodes may/may not be present**.**



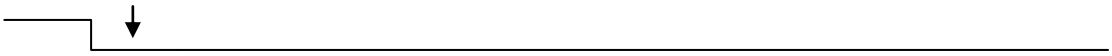
2.Bipolar II disorder: patient has at least one major depressive episode and at least one hypomanic episode, but ***NO*** manic episode.



3.Major depressive disorder (MDD): patient has major depressive episodes (MDEs) but no manic or hypomanic episodes.



4.Dysthymic disorder: ≥ 2 year-history of chronic less severe low mood.



5.Cyclothymic disorder: Less severe bipolar mood disorder with continuous mood swings; alternating periods of hypomania and moderate depression**.**

Majed, what is Ms. Nouf's condition?

Well, Bader, I think she has **MDE**, which can be a presentation of **MDD, Bipolar I or Bipolar II disorders.**

Uhhaa ! this means MDE≠MDD. Okay, how one would proceed in such a case?

Take a detailed past psychiatric history especially **previous manic, mixed, or depressive episodes.**

This is very essential in such a case.

Why?

Not only to reach a proper **diagnosis** , but also to **treat her properly.** If she had previous manic or mixed episodes and you treat her with **antidepressants** without careful observation she may **swing into a manic or a mixed episode** with serious behavioral problems.

Major Depressive Episode (MDE)

A. ≥ 5 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 no.1 or no.2:

1. Low mood. 2. Loss of interest in pleasurable activities (anhedonia).
3. Appetite or body weight change (increased or decreased).
4.Insomnia or hypersomnia**. 5**. Psychomotor agitation or retardation.
6. Fatigue or loss of energy. **7.** Feelings of worthlessness or excessive guilt.
8. Diminished concentration. **9.** Recurrent thoughts of death or suicide.

B. Significant distress or impairment in functioning.
C. The symptoms do not meet criteria for a mixed episode.
D. Not due to substance abuse , a medication or a medical condition(e.g., hypothyroidism).

Depressive features; range / analysis

Appearance & Behavior:
Neglected dress and grooming.
Facial appearance of sadness:
Turning downwards of corners of the mouth.
Down cast gaze**/**tearful eyes/reduced rate of blinking.
Head is inclined forwards.
Psychomotor retardation (in some patients agitation occurs):
Lack of motivation and initiation.
Slow movements**/**slow interactions.
Social isolation and withdrawal.
Delay of tasks and decisions.

Biological Features (Neurovegetative Signs): Change in appetite (usually reduced but in some patients increased).
Change in sleep (usually reduced but in some patients increased)
Early morning (terminal) insomnia; waking 2 - 3 hours before the usual time, this is usually associated with severe depression.
Change in weight (usually reduce but may be increased).
Fatigability, low energy level (simple task is an effort). Low libido and /or impotence. Change in bowel habit (usually constipation).
Change in menstrual cycle (amenorrhea).
Diurnal variation of mood (usually worse in the morning).
Several immunological abnormalities (e.g. low lymphocytes) increasing the risk to infection.

Mood (Affective) Changes:
Feeling low (more severe than ordinary sadness).
Lack of enjoyment and inability to experience pleasure (anhedonia).
Irritability /Frustration/Tension

Cognitive Functions & Thinking:
Subjective poor attention, concentration and memory.
In elderly this may be mistaken as dementia ***(pseudo dementia***).
Depressive cognitive triad (pessimistic thoughts) as suggested by Beck;
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**).

Psychotic Features Associated with Severe Depression.

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.

B. Delusions (mood-congruent)

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).

Diagnostic Criteria for Major Depressive Disorder (MDD)

A. Presence of major depressive episode (s).
B. Not better accounted for by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.
C. There has never been a manic episode, a mixed episode, or a hypomanic episode.

If the full criteria are currently met for a major depressive episode, specify its current clinical status and/or features:
Mild, moderate, severe without psychotic features/severe with psychotic features
Chronic - With catatonic features - With melancholic features
With atypical features - With postpartum onset

Ms. Nouf, I am Abdulrahman, a 4th year medical student. I would appreciate allowing me to ask some pertinent questions to reach a proper diagnosis and treatment of you condition.

☐ **Differential Diagnosis of Major Depressive Disorder (MDD) :**

- Depression secondary to ***medical diseases***:

- Hypothyroidism - Diabetes mellitus - Cushing's disease - Parkinson's disease.
- Stroke; see post stroke depression (PSD) p 46.
- Carcinoma (especially of the pancreas and lungs).
- Autoimmune diseases; SLE, multiple sclerosis.

- Depression secondary to ***medications:***

- Antihypertensives (e.g. beta-blockers, methyldopa, reserpine & Ca-channel blockers).
- Steroids.
- Bromocriptine & L - dopa.
- Indomethacin.
- Isotretinoin (Roaccutane); treatment of acne.
- 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).
- Antipsychotics.

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

☐ **Etiology of MDD:**

The causative factors are multifactorial (interacting together);

GENETIC FACTORS

As supported by family and twin studies

BIOLOGICAL

Reduced level of NE.5HT. &DA.

PSYCHOLOGICAL

- Stressful events.
- Premorbid personality factors.
- Cognitive distortions.

Epidemiology of Major Depressive Disorder (MDD)

- It is more prevalent than bipolar mood disorder (more in women).
- Lifetime risk is in the range of 10 - 15 %.
- Lifetime prevalence is in the range of 15 - 25 %.
- The mean age of onset is about 40 years (25 - 50 years).

- It may occur in childhood or in the elderly.
- In adolescents, it may be precipitated by substance abuse.
- More common in those who lack confiding relationship (e.g. divorced, separated, single…).

☐ Management of Major Depression: Bio-Psycho-Social Approach.

Hospitalization is indicated for:

- Suicidal or homicidal patient.
- Patient with severe psychomotor retardation who is not eating or drinking (for ECT).
- Diagnostic purpose (observation, investigation…).
- Drug resistant cases (possible ECT).
- Severe depression with psychotic features (possible ECT).

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.

Psychosocial: Supportive therapy. Family therapy. Cognitive-behavior therapy- CBT- ; for less severe cases or after improvement with medication (see later;)

Prognosis of Unipolar Depressive Disorders; About 25 % of patients have a recurrence within a year. Ten percent will eventually develop a manic episode. A group of patients have chronic course with residual symptoms and significant social handicap.

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

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

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

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

- Desirable therapeutic antidepressant effect requires a period of time, usually 3-5 weeks. Side effects may appear within the first few days.
- 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.
- 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.
- Lithium Carbonate can be used as prophylaxis in recurrent unipolar depression.

Post-partum Depression

– About 10 - 15 % recently delivered women develop disabling depression within 6 weeks of childbirth (10–14 days after delivery) which if not treated may continue for six months or more and cause considerable family disruption. 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.
– Depressed mood may be associated with irritability, self-blame and doubt of being a good mother, excessive anxiety about the baby's health and death wishes.
– Counseling, additional help with child-care may be needed. Antidepressants or ECT are indicated if there are biological features of depression.

DYSTHYMIC DISORDER (*Persistent Depressive Disorder* in DSM-5)

- Dysthymia (ill-humored) was introduced in 1980 and changed to dysthymic disorder in DSM-IV.
- It was also called "**depressive neurosis**" and "**neurotic depression**" compared to major depression (psychotic or endogenous depression)
- Dysthymic disorder is a chronic depressed mood that lasts most of the day and presents on most days.

Diagnostic Criteria

- ≥ 2 years history of chronic low mood.
- No remission periods more than two months.
- During low mood there should be ≥ 2 out of the following:

2. low energy or fatigue.
3. low self-esteem.
4. feeling of hopelessness.
5. insomnia (or hypersomnia).
6. poor appetite (or overeating).
7. poor concentration or difficulty in making decisions.

- Not better accounted for by any other psychiatric or medical diseases (e.g. major depression, hypothyroidism).
- It leads to impairment in functioning or significant distress.

Differential Diagnosis

This is essentially identical to that of major depression. However, two disorders require consideration:

1. Chronic Fatigue Syndrome / Neurasthenia

• Disabling chronic fatigue of uncertain etiology associated with variable extent of somatic and / or psychological symptoms.

2. Recurrent Brief Depressive Disorder:

Brief (less than two weeks) periods during which depressive features are present with greater severity than that of dysthymic disorder. The course is episodic and recurrent.

Treatment: The most effective treatment is the combination of pharmacotherapy and 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.

3. 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.

Course and Prognosis

The onset is usually insidious before age 25; the course is chronic. Some patients may consider early onset dysthymic disorder as part of life. Patients often suffer for years before seeking psychiatric help.

About 25 percent never attain a complete recovery