DEPRESSIVE DISORDERS

NOOR AL-MODIHESH
CONSULTANT psychistry
CHILD & ADOLESCENT unit

About 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.

Depressive disorders (DSM-V) :

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

Etiology and Pathophysiology of 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 ?

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.

- 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

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

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.

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).

Course and 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).

TREATMENT :

- 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.

- 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.

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.

Persistent Depressive Disorder (Dysthymia)

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.

- **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.

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.

Peripartum DEPRESSION :

- 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
- 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.
- accompanied by severe anxiety and even panic attacks AND irritable mood
- Counseling, additional help with child-care may be needed. Antidepressants or ECT are indicated if there are biological features of depression.


قَالَ رَسُولُ اللهِ صَلَّى اللهُ عَلَيْهِ وَسَلَّمَ:
" مَنْ أَصْبَحَ مِنْكُمْ آمِنًا فِي سِرْبِهِ
مُعَافًى فِي جَسَدِهِ
عِنْدَهُ قُوتُ يَوْمِهِ
فَكَأَنَّمَا حِيزَتْ لَهُ الدُّنْيَا ".
حسنه الألباني

Thank you

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