Depressive Disorders

Mohammed Al-Sughayir

محمد بن عبد الله الصغيّر

Professor of Psychiatry

College of Medicine KSU, KSA

Objectives

- To understand what depression is.
- To know the various types of depression.
- To recognize features of depression.
- To be aware of pathophysiology/etiology of depression.

Ms. Amal is a 27-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.

- **Healthy people** have a wide continuum range of feelings with normal variations.

  [usual sadness **< < < - - - - - - - -> > >** usual happiness].

- **Patients with depression** have :

- Prolonged unusual sadness/lack of pleasure/others features that have adverse effect on functioning.
- Body physiology is adversely affected (HPT axis).

Depression secondary to:

- Medical d. (e.g., hypoth.).
- Medications (e.g., OCPs, steroids, anticancer Rx, beta blockers).
- Substance Abuse.
- Brain insult (e.g., CVA).
- Others.

Primary depression

- Persistent depressive d.
- Major depressive d.
- Depressive episodes of bipolar d.
- Adjustment d. with depressed mood.

Depressive features

Mood Changes:

- **Low mood** beyond the usual sadness (severity/duration).
- Lack of interest/pleasure (anhedonia).
- Feeling lonely
- Irritability.

Depressive features

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 (or agitation occurs):
    - Lack of motivation and initiation.
    - Slow movements/slow interactions.
- ❑ Social isolation and withdrawal.

Depressive features

Cognitive Functions & Thinking:

Deficit in attention, concentration, memory, & decision making.

In elderly this may be mistaken as dementia ***(pseudo dementia***).

Depressed thinking process

Pessimistic thoughts) 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**).

Depressive features

Biological Features (Neuro-vegetative Signs):

- Change in appetite, wt., and sleep (usually reduced but in some patients 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).
- Pain threshold becomes low (gate theory/serotonin).
- Several immunological abnormalities (e.g. low lymphocytes) increasing the risk to infection.

Etiology

- Bio-Psycho- Social.
- Neurotransmitters disturbances: 5HT-NE-DA.
- Genetic factors.

Persistent Depressive Disorder (Dysthymia)

Diagnostic Criteria

- ≥ 2 years history of chronic low mood.
- No remission periods more than two months.
- During low mood there should be ≥ 2 /6:

1. low energy or fatigue. 2. low self-esteem.

3. feeling of hopelessness. 4.insomnia (or hypersomnia).

5.poor appetite (or overeating). 6. poor concentration or difficulty in making decisions.

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

Treatment of dysthymic disorder

The most effective treatment is the combination of pharmacotherapy and cognitive or behavior therapy (CBT).

A. Pharmacological:

SSRI (e.g. fluoxetine 20 mg)

SNRIs(e.g. venlafaxine 150 mg.

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

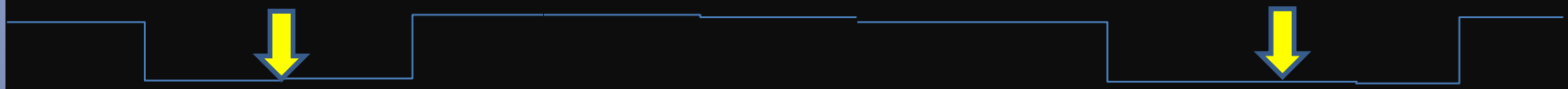
B. Psychological:

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.

Major Depressive Disorder (MDD)

Presence of major depressive episodes(MDEs).



There has never been a manic episode.

- Severity varies (mild-moderate- severe).

Epidemiology

- 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).

Prognosis of Depression (MDD)

- About 25 % of patients have a recurrence within a year.
- About 10 % will eventually develop a manic episode. *Be careful about antidepressants*
- A group of patients have chronic course with residual symptoms and significant social handicap.

Perinatal/Post-partum Depression

About 10 - 15 %.

In late pregnancy /within 6 weeks of childbirth (10–14 days after delivery).

If not treated may continue for 6 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.

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.

Adjustment Disorder with Depressed Mood

- Maladaptive psychological responses to usual life stressors resulting in impaired functioning (social, occupational or academic).
- Symptoms develop within 3 months of the onset of the stressor.
- There should be a marked distress that exceeds what would be expected from exposure to the stressor.
- There should be a significant functional impairment.

Etiology:

Abnormal personality traits:

Overprotection by family.

Low frustration tolerance.

High anxiety temperament.

Low self-esteem.

Less mature defense mechanisms.

Epidemiology:

Female : Males 2:1.

The prevalence of the disorder is estimated to be from 2 - 8 % of the general population.

It may occur at any age but most frequent in adolescents.

Common among college students & hospitalized patients for medical and surgical problems.

A. Psychological (treatment of choice):

Empathy, understanding, support, & ventilation.

Exploration (explore the meaning of the stressor to the patient).

Crisis Intervention: (Several sessions over 4 – 8 weeks) The patient, during crisis, is passing through emotional turmoil that impairs problem-solving abilities.

B. Medication: Short course of benzodiazepines in case of adjustment disorder with anxious mood. Small doses of antidepressants might be beneficial for adjustment disorder with depressed mood.