

DEPRESSION

Abraham Lincoln – 16th President of the United States. President Lincoln's first major episode of depression began in his 20s and he struggled with this illness for the remainder of his life.

John Keats – 19th Century English Romantic Poet most famous for his poetry series of "Odes." Keats experienced periods of severe depression.

Georgia O'Keeffe – Prominent American artist, painter since the 1920s. After her husband's affair, O'Keeffe became depressed and was hospitalized for a short period of time.

Buzz Aldrin – Astronaut who walked on the moon in 1969. Aldrin's depression began shortly after going to the moon and eventually was hospitalized. He recovered with the help of psychotherapy and depression medicines.

Terry Bradshaw – Former quarterback for the Pittsburgh Steelers. In the late 1990s, Bradshaw was diagnosed with clinical depression and began taking Paxil.

Diagnosis

DSM IV TR Criteria for Diagnosis of a Major Depressive Episode:

- Can not have a hx of manic/mixed/hypomanic episode(s)
- **Must have 5 of the 9 symptoms listed below for a minimum of 2 weeks. One of the symptoms has to be either depressed mood or loss of interest or pleasure. The symptoms must be a change from previous functioning. The symptoms must be present nearly every day.**
 - **Depressed mood**
 - **S**: insomnia (initial/middle/terminal) or hypersomnia
 - **I**: decreased interest or pleasure in all or almost all activities
 - **G**: feelings of inappropriate or excessive guilt or worthlessness
 - **E**: loss of energy or fatigue
 - **C**: decreased ability to concentrate or think or indecisiveness
 - **A**: change in appetite or weight, weight change over 1 month
 - **P**: psychomotor agitation or retardation
 - **S**: recurrent thoughts of death, recurrent SI w/o plan, suicide attempt or having a suicide plan.
- **Sx must be clinically significant and cause distress/impairment in social/occupational or other important areas of functioning.**
- **Specifiers:**
 - Mild: 5-6 depressive sx and either mild disability or the capacity to function normally but with substantial and unusual effort
 - Moderate: impairment or sx between mild and severe
 - Severe w/o psychotic features: several sx in excess of those needed to make the dx with a marked interference in function
 - Severe w psychotic features: delusions and hallucinations
 - a. mood congruent: c/w depressive themes (inadequacy, guilt, disease, nihilism, or deserved punishment)
 - b. mood incongruent: not c/w depressive themes (persecutory, thought insertion/deletion/broadcast, delusions of control)
 - Partial Remission: sx of MDE present but full criteria not met or a period w/o significant sx lasting <2mo following the end of MDE
 - Full Remission: no significant sx for ≥ 2 mo

- Post Partum: within 4 weeks of delivery
- With seasonal pattern: at least 2 discrete episodes in past 2 years, no non-seasonal episodes, no clear associated stressor
- With catatonic features: immobility, excessive motor activity, negativism, peculiarities of movement, echolalia or echopraxia
- With atypical features: mood reactivity, weight gain or increased appetite, hypersomnia, leaden paralysis, interpersonal rejection sensitivity
- With melancholic features: anhedonia, lack of reactivity, guilt, late insomnia ect
- Major Depressive Disorder, Recurrent: 2 episodes at least 2 months apart

Other Diagnoses to Consider

Dysthymic Disorder:

- Depressed mood for most of the day, more days than not, as indicated by subjective account or observation by others for at least 2 yrs.
- At least 2 of 6 sx
 - poor appetite or overeating
 - insomnia or hypersomnia
 - low energy or fatigue
 - low self-esteem
 - poor concentration or indecisiveness
 - feelings of hopelessness
- No MDE during the first 2 years
- No manic/mixed/hypomanic/cyclothymic Dx
- Think of it as a milder, longer lasting condition. See the glass "half empty most of my life", "I can't remember" the last time I was happy for an extended period of time

Adjustment Disorder with Depressed Mood:

- The development of depressive sx in response to an identifiable stressor occurring within 3 months of the onset of this stressor.
- The sx are clinically significant as evidenced by marked distress in excess of what would be expected or significant impairment of function
- Once the stressor is terminated the sx do not persist for more than 6 mo
- The sx are not due to bereavement

Substance Induced Mood Disorder:

- Symptoms develop during or within a month of substance intoxication or withdrawal

Bereavement:

- Focus of clinical attention is the reaction to the death of a loved one in which a person presents w sx characteristic of MDE ("normal grief reaction").
- Not pathological unless lasts for >2mo or the sx include:
 - guilt about things other than actions taken or not taken by the survivor at the time of death
 - thoughts about death other than the survivor feeling like they'd be better off dead or should have died with the deceased
 - morbid preoccupation with worthlessness
 - marked psychomotor retardation
 - hallucinatory experiences other than thinking they heard the voice of or transiently sees the image of the deceased

Bipolar Depression or Mixed Episode

- h/o mania

Schizoaffective Disorder

- psychotic sx w/o mood sx

PTSD and Other Anxiety Disorders

Personality Disorders

Medical Disorders (hypothyroid, anemia, stroke, MS, dementia, epilepsy, ect)

- Labs: TSH, CBC, Chem, B12/Fol, UDS, BAL, Vit D level

EPIDEMIOLOGY:

- Mood disorders are common. In the most surveys, major depressive disorder has the highest lifetime prevalence (almost 17 percent) of any psychiatric disorder.
- Onset average age: 40, with 50% diagnosed between age 25 and 50
- more common in those w/o close interpersonal relationships or in those who are divorced or separated
- No link to SES
- precipitating event in at least 25%
- An almost universal observation, independent of country or culture, is the twofold greater prevalence of major depressive disorder in women than in men.
- Individuals with major mood disorders are at an increased risk of having one or more additional comorbid Axis I disorders. The most frequent disorders are alcohol abuse or dependence, panic disorder, obsessive-compulsive disorder (OCD), and social anxiety disorder.

CLINICAL FEATURES:

- Depressed mood and a loss of interest or pleasure are the key symptoms of depression. Patients may say that they feel blue, hopeless or worthless. For a patient, the depressed mood often has a distinct quality that differentiates it from the normal emotion of sadness or grief.
- Almost all depressed patients (97 percent) complain about reduced energy; they have difficulty finishing tasks, are impaired at school and work, and have less motivation to undertake new projects.
- About 80 percent of patients complain of trouble sleeping, especially early-morning awakening and multiple awakenings at night, during which they ruminate about their problems.
- Many patients have decreased appetite and weight loss, but others experience increased appetite and weight gain and sleep longer than usual. These patients are classified in DSM-IV-TR as having atypical features.
- 90% report anxiety
- The various changes in food intake and rest can aggravate coexisting medical illnesses such as diabetes, hypertension, chronic obstructive lung disease, and heart disease.
- About 50 percent of all patients describe a diurnal variation in their symptoms, with increased severity in the morning and lessening of symptoms by evening.
- Cognitive symptoms include subjective reports of an inability to concentrate (84 percent of patients in one study) and impairments in thinking (67 percent of patients in another study).
- Two thirds contemplate suicide and 10-15% commit suicide, Those recently hospitalized with a suicide attempt or suicidal ideation have a higher lifetime risk of successful suicide than those never hospitalized for suicidal ideation.

MENTAL STATUS EXAM:

- General appearance and behavior: psychomotor retardation or agitation, poor eye contact, tearful, downcast, inattentive to personal appearance
- Affect: constricted

- **Mood:** depressed, irritable, frustrated, sad
- **Speech:** little or no spontaneity, monosyllabic, long pauses, soft, low, monotone- Many depressed patients have decreased rate and volume of speech; they respond to questions with single words and exhibit delayed responses to questions. The examiner may literally have to wait 2 or 3 minutes for a response to a question.
- **Thought Content:** SI, obsessive rumination; pervasive feelings of hopelessness, worthlessness, and guilt; somatic preoccupation; indecisiveness; mood congruent hallucinations and delusions.
 - Depressed patients with delusions or hallucinations are said to have a major depressive episode with psychotic features.
 - Delusions and hallucinations that are consistent with a depressed mood are said to be mood congruent. Mood-congruent delusions in a depressed person include those of guilt, sinfulness, worthlessness, poverty, failure, persecution, and terminal somatic illnesses.
 - The content of mood-incongruent delusions or hallucinations is not consistent with a depressed mood. For example, a mood-incongruent delusion in a depressed person might involve grandiose themes of exaggerated power, knowledge, and worth. When that occurs go through your ddx.
- **Cognition:** distractible, difficulty concentrating, complaints of poor memory, apparent disorientation. Most depressed patients are oriented to person, place, and time, although some may not have sufficient energy or interest to answer questions about these subjects during an interview. Some depressed patients have a cognitive impairment, sometimes referred to as pseudodementia.
- **Insight and judgment:** impaired because of cognitive distortions of personal worthlessness

COURSE:

- Chronic, relapsing and remitting nature
- Untreated episodes last 6-13 mo
- Treated episodes last ~ 3 mo
- Over 20 yrs will have 5-6 episodes on average
- Relapse rates 25% in first 6 mo after d/c, 30-50% in 2yr, and 50-75% in 5 yr

TREATMENT:

- Therapy and pharmacotherapy in combo most effective
- SSRI 1st line – have a “go to”, options include: fluoxetine (longest half life if missing days an issue), sertraline, citalopram (fewest drug interactions), paroxetine, fluvoxamine, escitalopram.
- 4-6 week onset of action
- Should remain on medication for minimum of 6-12mo after remission
- Patients with depressive disorders are at increased risk of suicide as they begin to improve and regain the energy needed to plan and carry out a suicide (paradoxical suicide). It is usually clinically unwise to give a depressed patient a large prescription for a large number of antidepressants, especially tricyclic drugs, at the time of their discharge from the hospital.
- ECT
- Vit D replacement, light box, Omega 3
- Behavioral Activation, avoid alcohol and illicit drugs, address stressors

Case 1:

A.H. is a 46 yo married woman who is brought to the ER by her husband. She is psychomotorically slowed, very suspicious and basically mute. Her husband reports that she had been depressed, amotivated, withdrawn and anhedonic for a number of months and that in the last few weeks her behavior has changed dramatically. She had begun to accuse him of being unfaithful to her. She appeared to be responding to conversations when alone and would yell out as if in response to auditory hallucinations. Her self-care had deteriorated markedly. She had not eaten or drank in the last 2 days as she is concerned her food is contaminated. She has been noncompliant with her sertraline. She has a hx of MDD. She is placed on a hospital hold and admitted to the inpatient psychiatric ward.

Case 2:

W.K. is a 65 yo married man with a hx of depressed mood dating back to "since I was a kid". He reports that he rarely feels happy for more than an hour or two. He has a very negative outlook on the world, often coming in and feeling victimized by family/acquaintances. He often reports low energy, low self esteem and feeling hopeless. He has no history of major depressive episodes or other mood disorder and he has never been hospitalized psychiatrically. Over the years he has had numerous failed trials of antidepressants including fluoxetine, citalopram, venlafaxine and bupropion.

Case 3:

A.S. is a 20 yo single woman. She is a college student majoring in biochemistry. She has a hx of numerous hospitalizations for mania and was diagnosed with bipolar disorder in her late teens. She is currently home for the holidays and reports that her mood had deteriorated significantly. She presents as profoundly depressed with anhedonia and SI. She reports low energy, decreased appetite, poor concentration, anhedonia, decreased libido and feeling hopeless. She has thoughts of overdosing. She reports that her depressive episodes are becoming more frequent and lasting longer. She does not plan to stay on her medications long-term b/c she "loves the feeling" of her manic highs.

Case 4:

M.P. is a 37 yo woman who presents with depressed mood with neurovegetative changes and vague S.I. She has a hx of similar episodes and has responded only partially to being on sertraline. She reports consuming a bottle of wine a night and has done so for the last 5 years. Her depressive sx do not predate this level of alcohol use. She has not had a period of sobriety lasting more than 2 weeks during this time.

Case 5:

R.G. is a 55 yo man with no previous psychiatric history. He reports that his wife asked for a divorce one month ago and that since then he has felt increasingly depressed with low energy, poor sleep and decreased appetite. He denies SI.