Depressive Disorders

Assessment and Treatment

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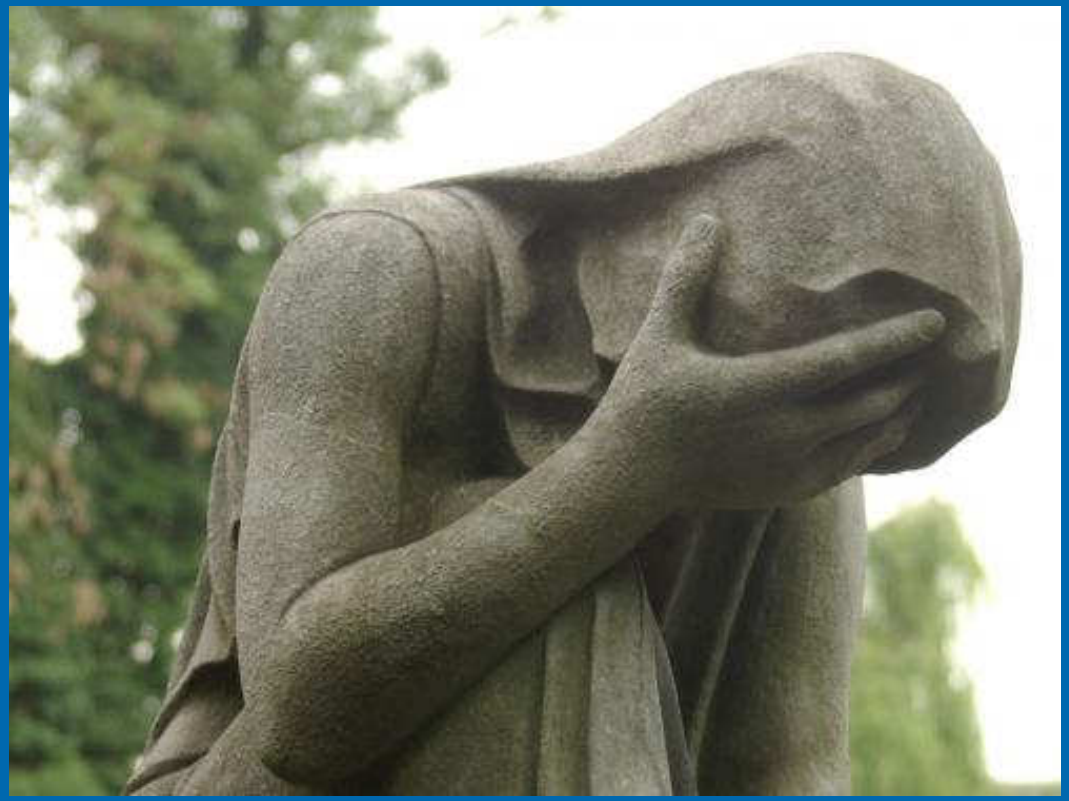
Who is Depressed?



Depressive Disorders

- Common
- Prevalence: 5-10% in primary care settings
- Rank fourth as causes of disability
- May rank second by the year 2020
- Prevalence of depressive symptoms : 30% in the general population
- Women twice as likely to be affected as men
- Has significant potential morbidity and mortality

Depression: Undiagnosed & Undertreated

- Are effective treatments not available?
- “Symptoms regarded understandable given current circumstances/background”

Comorbidity

About two-thirds of patients will also meet criteria for another psychiatric disorder

- *Anxiety disorders*
- *Substance misuse*
- *Alcohol dependency*
- *Personality disorders*

Mortality

- Suicide is the second leading cause of death in persons aged 20-35yrs
- Depressive disorder is a major factor in around 50% of these deaths

Social Impacts

- Relationships
- Families
- Productivity (through time off work)

Bear in Mind:

- Many patients will present to primary care
- Often with problems other than low mood
- Early interventions may be critical
- Prevention of major morbidity and mortality
- Reluctance to consider pharmacological interventions for emotional problems
- Overwhelming evidence of drugs‘ efficacy
- Drugs which improve mood considered addictive

Bear in Mind contd.

- Stigma attached to psychiatric illness
- A recent study examined the lives of almost 300 world-famous men
- Over 40% had experienced some type of depression during their lives

Depression amongst the famous

- Leonard Cohen
- Anthony Hopkins
- Barbara Bush, former First Lady (US)
- Marlon Brando
- Elton John
- Harrison Ford
- Jim Carrey
- Winona Ryder, actress

Other famous people (deceased)

- Ernest Hemingway
- Franz Kafka
- Richard M. Nixon

Depression amongst the famous contd.

Kurt Donald Cobain

"Lead singer and guitarist of Nirvana band"

- *Family History*
- *Parents' Divorce*
- *Depression*
- *Heroin addiction*
- *Suicide*

Risk Factors

- Genetic Heritability (40-70%)
  - *High rates of anxiety disorders in families*
- Childhood experiences
  - *Loss of a parent, lack of parental care, parental alcoholism/antisocial traits, childhood sexual abuse*
- Personality traits
  - *Neuroticism/anxiety, impulsivity, obsessionality*

Risk Factors contd.

- Social circumstances

  -Marital status

  -Adverse life events

  Loss events (increased risk 2-3 months after event) in vulnerable individuals

- Physical illness (chronic, severe, or painful)

  -Neurological disorders (Parkinson's disease, MS, stroke, epilepsy)

  - Post-MI, diabetic, and cancer patients

- Family or personal history of depression

Marital Status and Depression

Men

- *Low rates associated with marriage*
- *High rates with separation or divorce*

women

- *Probably similar, but less clear-cut*
- 3 or more children under the age of 11?
- *Lack of paid employment?*
- *Lack of a confiding relationship*

Aetiology

Interplay of

- *Neurobiological factors*
- *Genetic factors*
- *Personality/temperament factors*
- *Psychological factors*
- *Gender*
- *Social factors*

In the lifespan of an individual

Neurobiological Factors

- Structural brain changes in chronic cases

  - Parietal, frontal Cortices

- Functional brain changes

  - *Hypo-perfusion in frontal, temporal, and parietal areas (esp. older patients)*

  - *Increased perfusion in frontal and cingulate cortex (in younger patients, associated with good treatment response)*

Neurobiological factors contd.

- Neurotransmitter abnormalities
  - *Monoamine theory of depression*
- Endocrine changes
  - *Reduced monoamine functioning*
  - *Increased cholinergic functioning*
- Changes in sleep pattern
  - Reduced total slow wave sleep (SWS)
  - Shortened REM latency (secondary to increased cholinergic and/or reduced serotonergic/noradrenergic drive

Genetic Factors

- Altering individual sensitivity to the effects of life stressors
- Association between the serotonin transporter gene (17q11.1-12), depression, treatment response, and, possibly, suicidal behaviour

Monoamine Theory

Antidepressants

- *Increase monoamine release (5HT, NA)*

and/or

- *Reduce their reuptake in the synaptic cleft*

Serotonin or **5-Hydroxytryptamine (5-HT)**

Personality/temperament factors

- Enduring traits with a biological basis

- Certain temperaments (e.g. neuroticism) may increase vulnerability to depression
  - *autonomic hyperarousal*

    (heightened responses to emotional stimuli)

OR

  - *lability*

    (unpredictable responses to emotional stimuli)

Psychological factors

- Disruption in social, marital, parental, or familial relationships
- Adverse childhood experiences/chronic stressors
  - *Sensitivity of individuals to later stressful events*
- Low self-esteem
  - Negative view of self, the past, current events and the future

- Causal factor ?

OR

- Symptom of depression?

Gender

Increased prevalence of depression in women

- Restricted social and occupational roles
- Being over or under-occupied
- Endocrine factors

  - ***Increased risk of depression in the premenstrual & post-partum periods***

Gender Difference

- ***Women are more likely to admit to depressive symptoms***
- ***Men tend to express their symptoms differently***

(alcohol abuse and antisocial behaviour)

Social factors

- Low socio-economic status (i.e. low levels of income, employment, and education)

  - social causation

    stress associated with such problems leads to depression

    (i.e. an environmental argument)

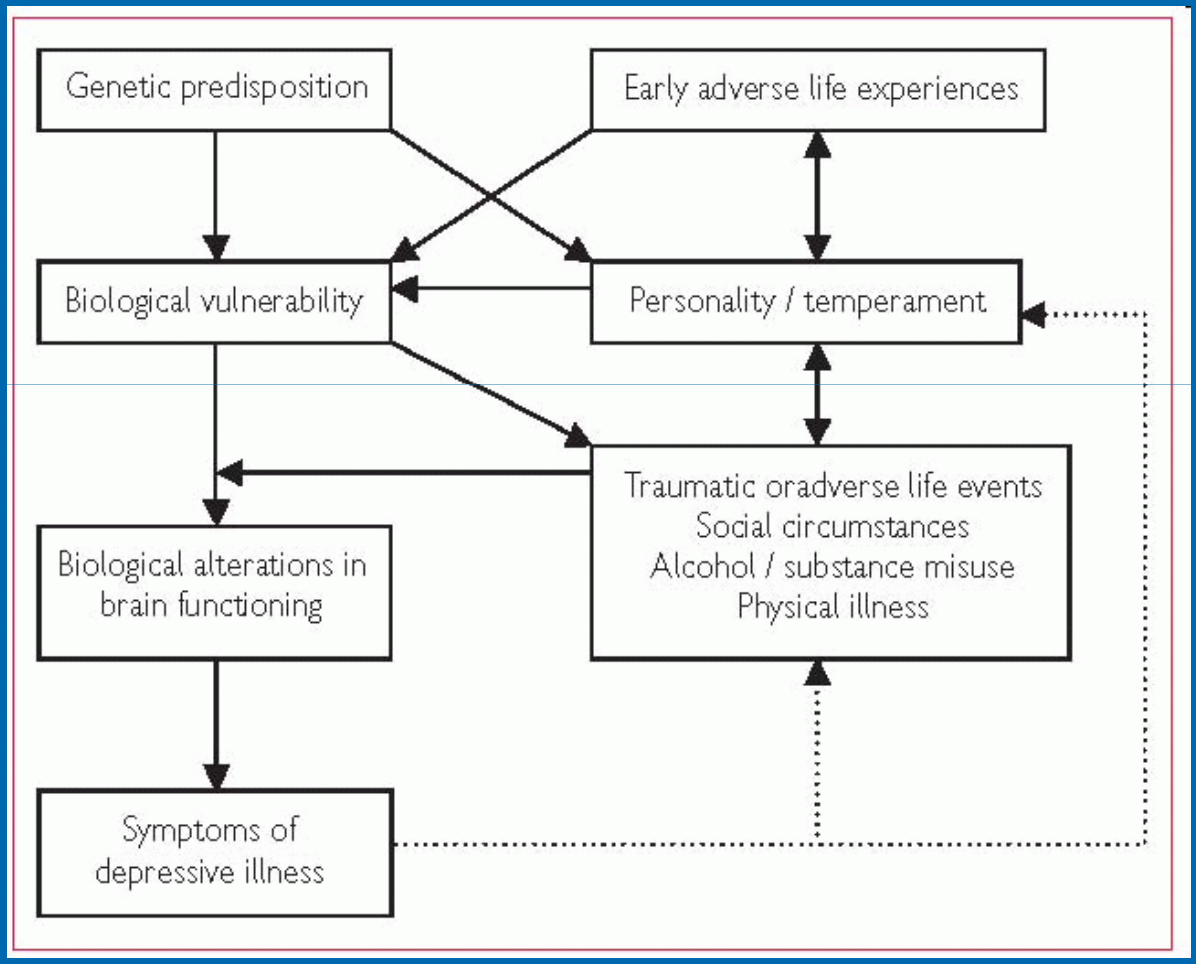
  - social selection

    predisposed individuals drift down to lower social positions, or fail to rise from them

    (i.e. a genetic argument)

  stronger evidence for the social causation argument, as social isolation has been shown to be a key risk factor

The biopsychosocial model of depression



Diagnosis: symptoms

- Terminology is slightly different between ICD-10 and DSM-IV
- Core symptoms are almost identical

ICD-10

International Classification of Diseases

- Endorsed in May 1990
- Came into use in WHO Member States as from 1994

DSM-IV

- **Diagnostic and Statistical Manual of Mental Disorders, 4th Edition**

- A manual published by the American Psychiatric Association (APA) that includes all currently recognized mental health disorders

Diagnosis: Symptoms

Core symptoms should fulfil the following :

- Present for at least 2 weeks and represent a change from normal
- Are not secondary to the effects of drug/alcohol misuse, medication, a medical disorder, or bereavement
- May cause significant distress and/or impairment of social, occupational, or general functioning

Core symptoms

- *Depressed mood*

  Present most of the day, nearly every day, with little variation, and often lack of responsiveness to changes in circumstances. There may be diurnal variation in mood with mood being worse in the morning and improving as the day goes on

- *Anhedonia*

  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 made by others)

- *Weight change*

  Loss of weight when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), associated with decreased or increased appetite

Core symptoms contd.

- ***Disturbed sleep*** insomnia (with early morning wakening 2-3hrs sooner than usual) or hypersomnia
- **Psychomotor agitation or retardation** observable by others, not just subjective feelings of restlessness or being slowed down
- **Fatigue or loss of energy**
- **Reduced libido**
- **Feelings of worthlessness** or excessive or inappropriate guilt (which may be delusional); not just self-reproach or guilt about being ill
- **Diminished ability to think or concentrate or indecisiveness**
- **Recurrent thoughts of death or suicide** (not ‘fear of dying’) which may or may not have been acted upon

Somatic symptoms

Biological, melancholic (DSM-IV), or vital

- Loss of emotional reactivity
- Diurnal mood variation
- Anhedonia
- Early morning wakening
- Psychomotor agitation or retardation
- Loss of appetite and weight
- Loss of libido

Psychotic symptoms/features

Delusions

- Poverty
- Personal inadequacy
- Guilt over presumed misdeeds
- Responsibility for world events: accidents, natural disasters, war
- Deserving of punishment
- Other nihilistic delusions

Psychotic symptoms/features

Hallucinations

- *Auditory*: defamatory or accusatory voices, cries for help or screaming
- *Olfactory*: bad smells such as rotting food, faeces, decomposing flesh
- *Visual*: tormentors, demons, the Devil, dead bodies, scenes of death or torture

Clinically significant depressive episode (minimum criteria)

- ICD-10 at least 2 typical symptoms (depressed mood, anhedonia, or fatigue), plus at least 2 others from the core symptoms list
- DSM-IV requires the presence of 5 or more symptoms from the core symptoms list (at least one of which must be depressed mood or anhedonia)

KEY SYMPTOMS

persistent sadness or low mood

and/or

Loss of interests or pleasure in most activities

Most days, most of the time for at least 2 weeks

Case Example

L, a 36-year-old single woman, is a lab technician in a big biotech company. She has a Masters in science and is a highly competent professional. She loves the outdoors and likes to spend her weekends hiking and biking with friends. She describes herself as somewhat shy and cautious in her relationships with other people. Has had a couple of "serious relationships" with men but none lasted very long.

Usually, she says, the relationship would be "wonderful" in the beginning but after a few months she would get bored and feel that the relationship did not fulfil her needs. When the relationship broke up, she would feel disappointed, empty and angry.

Case Example

L would usually confide in her best friend, F. Recently, however, F got engaged and even though she initially felt happy for F, she has also been having feelings of jealousy and a deep sense of loss.

"Our relationship" she says " will never be the same once F gets married. In fact, it has already changed…she's just not available as before and she doesn't seem as interested in spending time with me."

Case Example

L had felt a change for the worse in her mood during the few weeks before Fs' engagement but says that since the engagement her mood has markedly spiralled downward. She has felt sad and generally upset and she has not been able to get enough sleep. In fact, she has found herself waking up at 4 or 5 a.m., not being able to fall back to sleep. "I basically lie in bed" she says "and obsess about how my life sucks and how worthless I am. I think to myself: 'Nobody loves me, nobody cares, I'm all alone in this cruel world'. And then I start sobbing and sobbing…I can't stop myself…and then it's time to get ready for work and I don't want to get out of bed ."

Case Example

L missed 3 days of work last week, something that has not happened in a long time. On the days she did go, she found it difficult to concentrate on her work and was unable to complete an important and rather urgent experiment. "I feel worthless" she says, "why bother going to work if you're not going to be productive?" L expressed feelings of guilt about her reaction to Fs' engagement. "F is the happiest woman on this planet right now" she says "and I can't be happy for her. I'm just a horrible, selfish person…and there are moments when I think I do not deserve to live." Indeed, L admits she has had thoughts of killing herself, telling herself that nobody would care if she died anyhow. In the past 3 weeks she has felt so down that she did not go out with friends and stopped going to yoga classes. In therapy she said "I can't go on living like this-this is hell!"

Severity

- Number of symptoms
- Severity of symptoms
- The degree of functional impairment

Severity criteria

	ICD-10	DSM-4
Mild	2 typical symptoms + 2 other core symptoms	5 core symptoms + Minor social/occupational impairment
Moderate	2 typical symptoms + 3+ other core symptoms	5+ core symptoms + variable degree of social/occupational impairment
Severe	3 typical symptoms + 4+ other core symptoms	5+ core symptoms + significant social/occupational impairment

Principles for Assessment

- Conduct a comprehensive assessment
- Do not rely simply on a symptom count
- Take into account
  - *The degree of functional impairment*
  - *The associated disability*
  - *The duration of the episode*
- Past and family history of mood disorders
- Availability of social support

Initial Assessment/History

- Any clear psychosocial precipitants
- Current social situation
- Use of drugs/alcohol
- Past history of previous mood symptoms (including ‘subclinical’ periods of low or elevated mood
- Previous DSH/suicide attempts
- Previous effective treatments
- Family history of mood disorder
- Physical illnesses
- Current medication

NICE Guidelines

Asking questions to identify depression

Be alert to possible depression (particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment)

Questions to consider asking

- During the last month, have you often been bothered by:
  - feeling down, depressed or hopeless?
  - having little interest or pleasure in doing things?

Treatment Options

- Psychological
  - CBT
  - Interpersonal therapy
- Pharmacological

- Combination therapy

Discuss possible treatments with them

Stepped Care Model

Provide them first with :

- Least intrusive
- Most effective intervention

The stepped-care model

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[2], and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions

NICE Guidelines, 2009

Mild to Moderate Depression

- Individual guided self-help based on (CBT)

- Computerised cognitive behavioral therapy (CCBT)
- Structured group physical activity programme

If not benefiting , consider an antidepressant

Drug Treatment

Do Not Use Antidepressants Routinely

- Persistent sub-threshold depressive symptoms
- Mild depression

Watchful waiting

Consider Drug Treatment

- Past Hx of moderate or severe depression

OR

- Initial presentation of sub-threshold depressive symptoms that have been present for a long period (at least 2 yrs)

OR

- Sub-threshold depressive symptoms or mild depression that persist(s) after other interventions

Moderate or severe depression

Provide a combination of:

Antidepressant medication

and

A high-intensity psychological intervention

(CBT or IPT)

Subtypes of depressive disorder

- Atypical depression
- Postnatal depression
- Seasonal affective disorder
- Premenstrual dysphoric disorder

Dysthymia (ICD-10)
Dysthymic disorder (DSM-IV)

- Depressed mood (>2yrs)

  + At least 2 of the following:

- Reduced/increased appetite
- Insomnia/hypersomnia
- Reduced energy/fatigue
- Low self-esteem
- Poor concentration /Difficulties making decisions
- Thoughts of hopelessness

Persistent Sub-threshold Depressive Symptoms

- Fewer than 5 symptoms according to DSM-IV
- Present for 2 years
- Dysthymia?

Seasonal affective disorder (SAD)

- Symptoms are generally mild to moderate
- Low self-esteem
- Hypersomnia
- Fatigue
- Increased appetite (inc. carbohydrate craving) and weight gain
- Decreased social and occupational functioning

Postnatal Depression (PND)

- A significant depressive episode
- 10-15% of women within 6 months post-partum
- Peak: 3-4 weeks
- Worries about the baby's health or her ability to cope
- Similar clinical features to other depressive episodes
- A significant anxiety component
- 90% last less than 1 month

Atypical depressive episode

- Mood is depressed but remains reactive (able to enjoy certain experiences but not to ‘normal’ levels)
- Hypersomnia (sleeping more than 10hrs/day, at least 3 days/wk, for at least 3mths)
- Hyperphagia (excessive eating with weight gain of over 3kg in 3 mths).
- ‘Leaden paralysis’ (feeling of heaviness in the limbs, present for at least 1hr/day, 3days/wk, for at least 3mths)
- Over-sensitivity to perceived rejection
- Other infrequent symptoms may include: initial insomnia rather than early morning wakening (EMW); reversed diurnal mood variation (better in the morning); severe motor retardation; absence of feelings of guilt.

Antidepressants

- **TCAs** (Tricyclic Antidepressants)
- **MAOIs** (Monoamine oxidase inhibitors)
- **SSRIs** (Selective Serotonin Reuptake Inhibitors)
- **SNRIs** (Serotonin and Noradrenaline Reuptake Inhibitors)
- **NASSAs** (Noradrenaline and Specific Serotoninergic Antidepressants)

Which Antidepressant?

- **Patient factors**
  - *Age*
  - *Sex*
  - *Physical illness*
  - *Previous response to antidepressants*
- **Issues of tolerability**
  Side-effect profiles
- **Symptomatology**

SSRIs

Selective serotonin reuptake inhibitors

- Increase the extracellular serotonin
- Equally effective as other antidepressants
- A favourable risk–benefit ratio
- Increased risk of bleeding, especially in older people

Citalopram
Fluoxetine (Prozac®)
Fluvoxamine (Faverin®)

Tricyclic antidepressants (TCAs)

- Serotonin/ Noradrenaline , Dopamine reuptake inhibition
- Well-established efficacy
- More effective in severe depression
- Low cost
- Toxicity in overdose
- Less well tolerated than SSRIs

Amitriptyline

Imipramine

Clomipramine

Choice of antidepressant

- Potential side effects
- Discontinuation symptoms
- Potential interactions with concomitant medication or physical health problems

Benefit of medications

- Minimal or nonexistent (mild or moderate)
- Substantial (very severe depression)

Antidepressants & Suicide risk

Increased risk in early stages of treatment

- Previous marked psychomotor retardation
- Unable to act upon thoughts of self-harm
- “Freed” by Partial treatment response

Careful monitoring / Admission to hospital

CBT

- Focuses on thoughts, beliefs and thinking
- Deals with the here and now
- Considers the influence of past events
- Problem-orientated and structured

CBT contd.

- How the thoughts are affecting your life
- Learn to feel differently
- Effective ways of changing

  - What you think (the “cognitive” bit)

  - What you do (the “behavioural” bit)

Patient Choice

- Patients' needs and preferences
- Opportunity to make informed decisions

Some Evidence?

Antidepressant drugs and generic counselling for treatment of major depression in primary care: randomised trial with patient preference arms

Chilvers et al,2001 - BMJ. 2001 August 4; 323(7307): 282

- 12 months after starting treatment, generic counselling is as effective as antidepressants
- Patients treated with antidepressants may recover more quickly
- Given a choice, more patients opt for counselling
- Patients who choose counselling may benefit more than those with no strong preference

Points to mention

- Gradual development of the full effect
- The need to continue treatment after remission
- Potential side effects
- Interactions with other medications
- The risk and nature of discontinuation Sx
- Addiction does not occur with antidepressants
- Offer appropriate written information

Relapse prevention

- Support and encourage

  - To continue medication for at least 6 m after remission

- Discuss

  - This greatly reduces the risk of relapse

  - Antidepressants are not associated with addiction

Follow Up

- Initially fairly frequent (1-4wks)
- Monitor treatment response
- Assess for any unwanted side-effects

Key aims for follow-up

- Therapeutic alliance
- Monitoring
- Enhancing treatment compliance
- Promoting adaptation
- Identifying new episodes early
- Reducing the morbidity

Electroconvulsive Therapy (ECT)

Acute treatment of severe depression

- Life threatening
- Rapid response is required
- Other treatments have failed

RISK of Cognitive Impairment

Reasons for Hospital Admission

- Serious risk of suicide
- Serious risk of harm to others (Postnatal depression)
- Significant self-neglect (esp. weight loss)
- Severe depressive symptoms
- Severe psychotic symptoms
- Lack or breakdown of social supports
- Initiation of ECT
- Treatment-resistant depression (inpatient monitoring)
- To address comorbid conditions (e.g. physical problems, other psychiatric conditions, inpatient detoxification)

Further Reading:

- **New Oxford textbook of psychiatry /** Gelder, Michael G. 2003
- **Oxford handbook of psychiatry** *2nd ed.* Semple, David. 2009
- http://pathways.nice.org.uk/pathways/depression/care-for-adults - with-depression
- www.nice.org.uk/CG90
- www.nice.org.uk/CG91