Depressive Disorders

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Case Presentation

• ID: KM, a 43-year-old African American woman, presents during your Internal Medicine walk-in clinic hours.

• Chief Complaint: “I’m tired all the time, can’t sleep at night, hurt all over, and just don’t feel right.”
Case Presentation (cont’d)

• HPI:
  – KM reports that, for the past four weeks, she increasingly has felt fatigue and lethargy with a decrease in appetite and an associated weight loss of ~10lbs. She has had intermittent brief periods of tachycardia with related shortness of breath and diaphoresis. As a result of her symptoms, she has experienced difficulty concentrating at work and has noticed an overall decline in her performance. She has taken six “sick days” over the past month.

• What else do you want to know?
Case Presentation (cont’d)

• **ROS:**
  - Constitutional: Tired/fatigued with myalgias.
  - EENT: Unremarkable.
  - Skin: Unremarkable.
  - Respiratory: Intermittent shortness of breath.
  - Cardiovascular: Intermittent palpitations/tachycardia.
  - Genitourinary: Unremarkable.
  - Gastrointestinal: Chronic constipation.
  - Neurologic: “Forgetfulness”.
  - Musculoskeletal: Unremarkable.
  - Endocrine: Intermittent diaphoresis.
  - Immunologic: Unremarkable.
  - Hematologic: Unremarkable.
  - Psychiatric: Endorsed sometimes thinking, “I can’t go on feeling like this”. Denied any past or present auditory/visual hallucinations.
Case Presentation (cont’d)

• Past Medical History:
  – Anemia

• Past Surgical History:
  – None

• Home Medications:
  – Daily iron supplements
  – OCPs
Case Presentation (cont’d)

• Social History
  – Married, but recently learned that husband has been having an affair
  – Two children, youngest of which left for college several months ago
  – Successful patent lawyer
  – No nicotine history; drinks two glasses of wine a night; remote history of marijuana use
  – Sexually active with husband

• Family History
  – Mother with “Bipolar Disorder”
  – Sister with SLE & Anemia
Case Presentation (cont’d)

• Physical Exam
  – VS: HR 90, RR 12, BP 120/80, T 98.6
  – General: Thin middle-aged woman in NAD
  – Otherwise, exam is unremarkable
Case Presentation (cont’d)

• Labs
  – CBC with Diff, BMP, LFTs, TSH, ESR unremarkable
  – STI screen (including HIV) unremarkable
  – UA unremarkable
  – U-Tox & BAL negative

• Other Studies
  – EKG: sinus tachycardia; otherwise normal
Case Presentation (cont’d)

• Differential Diagnoses:
  – Medical diagnosis
  – Psychiatric diagnosis
    • Major Depressive Disorder
    • Dysthymic Disorder
    • Adjustment Disorder with Depressed Mood
    • Bipolar Disorder
    • Mood Disorder due to General Medical Condition
    • Substance-Induced Mood Disorder
      – Alcohol/Drugs & Medications (prescribed & unprescribed)
    • Anxiety Disorder, Not Otherwise Specified (NOS)
    • Panic Disorder
What’s Depression Got to Do With You?

- **Depression is a medical illness**
- **Facts:**
  - Affects one in eight Americans
    - Lifetime prevalence:
      - Men: 7-12%
      - Women: 20-25%
  - Costs US economy >$43 billion annually
    - Approximately 25% of depressed patients abuse alcohol or illegal drugs ("self-medication") vs. 8% of general population
  - Mood symptoms are often seen in general medical patients
    - Although 20% of patients in primary care clinics are clinically depressed, only 50% of these 20% had been diagnosed as such by a physician
    - Stigma
      - Cause increased use of medical services
    - Become medically ill more often with greater physical disability and sometimes greater death rates when ill
      - Death rate 6 months after acute MI is five times greater in depressed patients
  - 15% of patients with severe mood disorders die from suicide
  - About 20% of suicide victims had contact with mental health services within 1 month of their suicide. On average, 45% of suicide victims had contact with primary care providers within 1 month of suicide.
  - Primary care physicians are the main prescribers of SSRI antidepressants
Major Depressive Disorder

• DSM IV Criteria for Major Depressive Episode
  – Depressed mood OR Anhedonia (loss of interest/pleasure)
    AND
  – Change in appetite/weight
  – Change in sleep
  – Psychomotor agitation/retardation
  – Fatigue/loss of energy
  – Feelings of worthlessness / built
  – Diminished ability to think/concentrate or indecisiveness
    • In extreme, “pseudodementia” – typically in elderly
  – Recurrent thoughts of death or thoughts/actions of suicide

  – 5+ criteria present during same 2-week period with at least one symptom being depressed mood or anhedonia
Major Depressive Disorder (cont’d)

• SIG-E-CAPS:
  – Sleep disorder (either increased or decreased sleep)
  – Interest deficit (anhedonia)
  – Guilt (worthlessness, hopelessness, regret)
  – Energy deficit
  – Concentration deficit
  – Appetite disorder (either decreased or increased)
  – Psychomotor retardation or agitation
  – Suicidality
Major Depressive Disorder (cont’d)

• Specifiers for MDD, recurrent:
  – Severity/Psychotic/Remission Specifiers
  – Chronic
  – With Catatonic Features
  – With Melancholic Features
    • “Classic form”
    • Severe anhedonia, lack of reactivity, depressed mood, diurnal variation (mornings worse than evenings), early morning insomnia, psychomotor agitation/retardation, decreased appetite with weight loss
  – With Atypical Features
    • Increased sleep and appetite, extreme fatigue, sometimes mood reactivity
    • Preferential treatment with SSRIs & Monoamine oxidase inhibitors (MAOIs)
  – With Postpartum Onset
    • 10% of women have post-partum mood disorders (not just depression)
  – With Seasonal Pattern

• Also of note, anxiety in the form of worry or outright panic often accompanies pessimistic thoughts
Dysthymic Disorder

• DSM IV Criteria
  – Depressed mood for at least 2 years
  – Presence, while depressed, of 2+ of following:
    • Change in appetite
    • Change in sleep
    • Low energy or fatigue
    • Low self-esteem
    • Poor concentration or indecisiveness
    • Feelings of hopelessness
  – During the 2-year period, person has never been without above symptoms for more than 2 months at time
  – “Rule of 2s”
Depressive Disorder, Not Otherwise Specified (NOS)

• DSM IV Criteria
  – Disorders with depressive features that do not meet criteria for...
    Major Depressive Disorder
    Dysthymic Disorder
    Adjustment Disorder with Depressed Mood
    Adjustment Disorder with Mixed Anxiety and Depressed Mood

  – Includes...
    • Premenstrual Dysphoric Disorder
    • Minor Depressive Disorder (2 weeks of fewer than five criteria)
    • Episodes of 5+ criteria for less than 2 weeks’ duration
Grief/Bereavement versus MDD

• If symptoms present beyond two months
  
  AND/OR

• If person has...
  
  – Guilt about things other than actions taken or not taken by survivor at time of death
  
  – Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with deceased person
  
  – Morbid preoccupation with worthlessness
  
  – Marked psychomotor retardation
  
  – Prolonged and marked functional impairment
  
  – Hallucinatory experiences other than thinking that he or she hears the voice of or transiently sees image of the deceased person

• Then it’s MDD and no longer “normal bereavement”
“Normal” versus “Abnormal”

• A mood disorder is distinguished from normal moods and reactions by...
  – Duration & intensity of patient’s suffering
  – Degree of his/her functional impairment

• When certain emotions predominate and persist beyond their usefulness in motivating appropriate behaviour, they become pathological
Suicide

• Risk factors:
  – Melancholia
  – Psychosis
  – Extreme hopelessness
  – Substance abuse
  – Marked impulsivity
  – A poor response to medications
  – Definite plans for committing suicide
  – A history of prior attempts
  – A family history of suicide
  – Race
    • Non-Hispanic whites > people of colour
  – Marital status
    • Divorced persons > widowed persons > single persons > married persons

• Men are three times more successful in their suicide attempts than are women, although women are ten times more likely to attempt suicide

• Asking will NOT make suicide more likely
Emergencies

• Suicidality / Homicidality
• Psychosis
• Significant functional impairment

• NB: All relative to baseline
  – You may encounter chronically sick individuals with baseline symptoms (e.g., ongoing passive suicidal ideation in someone with chronic depression)
  – Heads-up if there is a change from baseline
  – Important to communicate with other providers
“Stereotyped” Mental Status Exam

- **Appearance:** Disheveled; poor ADLs
- **Attitude:** Distant and disengaged
- **Behaviour:** Psychomotor slowing (or agitation)
- **Speech:** Slow; low volume; speech paucity; prosody decrease
- **Mood**: “Depressed”, “sad”, “blue”, “down”, “tired”*
- **Affect**: Dysphoric; constricted range; decreased reactivity
- **Thought Process:** Linear, though slowed; perhaps some concreteness
- **Thought Content:** Focused on worthlessness & guilt; somatic sx’s?
- **Suicidality/Homicidality:** Passive vs. active suicidal ideation
- **Perceptual Disturbances:** None endorsed vs. AVH present
- **Cognition:** Alert & oriented
- **Insight:** Fair
- **Judgment / Impulse Control:** Fair

* Mood is amalgam of emotions that person feels (subjective); Affect is the way the mood is displayed (objective)
+ Some patients do not sense or articulate sadness; they demonstrate *alexithymia* (meaning without words or feelings)
Treatment

• Interviewing
  – Approach
    • Depressed patients tend to discount the past (including positive times) and struggle to imagine a better future
    • Try to establish a baseline
    • Be active & directive
    • Goldilocks’ “just right” principle
      – Encouragement without simplistic reassurance
  – Countertransference
    • Parallel hopelessness
    • Resentment
      – Depression is not a failure of “will powers” or some other form of moral weakness
      – Depression is a medical illness
Treatment (cont’d)

• Therapies
  – Supportive therapy
    • Consciously support already-present strengths
  – Cognitive therapy
    • Target incorrect cognitions that cause depression
  – Interpersonal therapy
    • Address painful social experiences & troubled interpersonal relationships that contribute to depression
  – Psychodynamic psychotherapy
    • Link past experiences (e.g., of loss or guilt) to current life conflicts that recreate earlier feelings
Treatment (cont’d)

• Antidepressants
  – SSRIs
  – TCAs
  – MAOIs

• ECT
Questions

• Email: oliver.stroeh@vanderbilt.edu