Mood Disorders

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S.U.

Mood Disorders

- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorders
- Cyclothymic Disorders

Major Depressive Disorder

- **Definition of Depression**
- **Epidemiology**
- **Phenomenology**
- **Biological symptoms**
- **The Diagnosis of Major Depressive Episode**
- **Etiology**
- **Treatment** (Psychological Intervention and Pharmacotherapy)

DEPRESSION

- A CAR WITHOUT GAS AND NO WHERE TO GO
- A Metaphor to Describe Depression
- What does it mean in your understanding?

every day in your practice ,you will see at least one patient who is suffering from depression.

Is it right?

Is the condition really so serious?

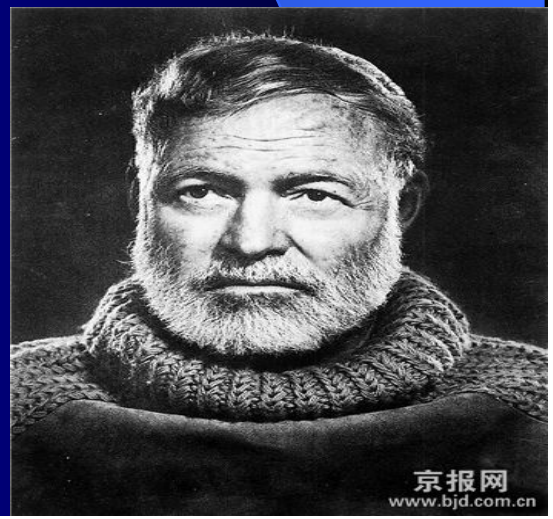
Which features does a depressed patient have?

And what can we base on to tell my patient

“you have got a depression, not other illness”?

What have happened in his/her emotional world?

What can we do for those people?



Definition

The very term "depression" is in many ways ambiguous.

It is used to refer to:

- a mood、
- a symptom、
- a syndrome 、
- an illness.

As a mood

depression is an altered state of mood as a reaction to life event.

Just as happiness is to be desired , unhappiness, particularly as appropriate response, does not represent a disorder, and does not constitute a diagnostic category.

Unhappiness and normal sadness should not be confused.

Sometimes we use other words, such as "grief" or mourning ", to describe this sate of mood.

Such a reaction calls for sympathy and reassurance, but not for medical therapy.

If a sudden, overwhelming loss leads to excessive tension, sleep disorder, or agitation, tranquilizers or hypnotic drugs may sometimes be indicated but **only for brief, symptomatic treatment.**

Physicians who prescribe specific anti- depressants for a grief reaction may, at best, be **wasting their efforts** or, at worst, harm-fully interfering with the necessary and natural process of working through the mourning period.

Depression as syndrome or disorder is the only clinically sound usage of the term, and its use should be so **restricted.**

From this point, depression, is discussed as a psychopathological term.

It lasts for 2 weeks that is marked by dysphoric mood and is accompanied by some of other symptoms, such as a disorder of sleep and appetite, loss of energy, psychomotor retardation or agitation, loss of interest, self-reproach, thought of death and suicide.

--- **DSM-Ⅳ(Diagnostic and Statistical Manual of Mental Disorder, ed 4)**

As a syndrome, depression can be seen in many medical situations as follows:

1. Physical conditions (such as physical diseases and medications) can cause depression, which is called "**depression secondary to**……".
2. affective disorder, which includes **major depression episode** and depression episode of bipolar affective disorder. This is what we will discuss here.
3. other mental disorders, as an acompanying state.

Epidemiology

In U.S.A

The current over all prevalence for major depressive episode is between 3 to 5 %t.

The lifetime risk for a major depressive episode seems to be 8 to 12 % in males and 20 to 26 % in females.

The age of onset for the first major depression episode is usually by the mid-twenties.

The is no increase in **postmenopausal period**.

There has not been demonstrated relationship between **social class and the rate** of major depressive episodes.

There has also been no relationship shown between race and either the prevalence or the incidence of the disorder.

The **first-degree relative** of major depression shown a lifetime risk.

Phenomenology

- the clinical features of depression

[CASE REPORT]

a 43-year-old professional had been feeling frustrated with his life over the past six months. After his father's death he found himself questioning his own life. Then he was passed over for a promotion and he was dissatisfied; his job no longer interested him, he found it boring and repetitive.

Soon he would awake with a low mood and would dread having to leave the house and within a month became increasinglymiserable and sad. The future appeared bleak.

He wanted to leave his job but was unable to make his plans.

He could not concentrate and assignments piled on his desk as he just sat there trying to decide where to start.

At home he would awaken in the early hours of the morning and pace about aimlessly.

He lost his appetite

and his wife became irritated and kept telling him to "snap out of it ".

But it only made him feel worse and useless.

Things came to a head early one morning when his wife found him standing by the window crying uncontrollably and saying he just wanted to end everything.

Depressive state

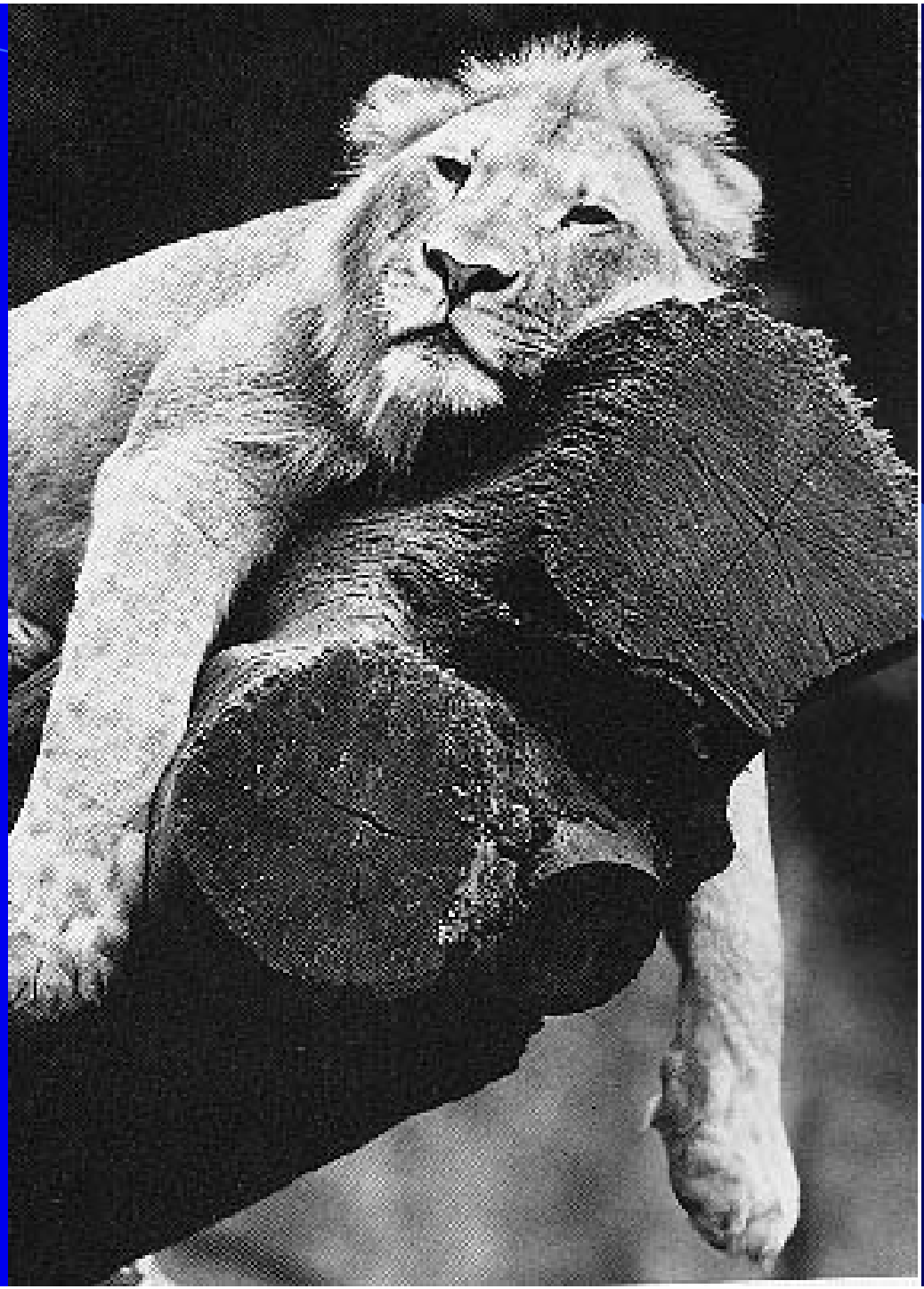
In the simplest term, depressive states typically show a combination of three psychological symptoms:
1. depressed mood 2. drive inhibition 3. anxiety.

These psychological symptoms are associated With:

Some functional symptoms usually including disturbance of appetite, sleep, and sexual libido.

Behavior symptoms such as social withdrawal, crying spells, and suicidal behavior,

Occur along with the typical depressive posture and faces with furrowed brow, turned-down corners of the mouth, and lack of animation.



It has been reported that lack of energy, fatigue, and insomnia have usually been the first symptoms of a clinical depression, followed within a few days weeks of the core symptoms of the depressed mood.

This sustained , fixed mood of feeling sad ,blue, bored, despairing, gloomy, dejected is by far the most frequently symptom of all clinical depressions.

It may not , however , be prominent in every case or may be overshadowed by other symptoms(esp. physical symptoms).

Dysthymia

It is a prolonged and pervasive emotional state,

for which patients use a number of descriptive words:

depressed, sad ,blue, bored, gloomy, dejected.

The essential clinical feature is a dysphoric mood usually experienced as a depression.

The disturbance of mood is prominent, persistent, and usually associated with other symptoms as well.

Anhedonia

an another depressive symptom, which the patient describe" I have no ability to experience pleasure, or even the sadness that they used to be capable of feeling " the bloom they feel is off the rose.

If a depressed person won the lottery, he would probably complain because now he has to pay more taxes.

Patients may identify a loss of interest or pleasure in their usual activities as the features.

Lack or diminished sense of self-esteem

is usually present, and varies from mild to severe.

The patients may show marked guilt feeling over real and imagined past events. They are often in a state of giving up, feeling that nothing they do seems to make any difference.

3" less":

To the past, they feel worthless;

To the now, they feel helpless;

To the future, they feel hopeless.

Cognition impairment

Impairment of memory is frequently reported, but seems to be associated with a reduced ability to stimuli rather than to record them.

Difficulty in concentrating, reasoning, and performing complex mental task is common.

Indecisiveness is quite frequent reported.

Both psychomotor agitation or psychomotor retardation may be present, but usually **only one is found in a given case.**

Signs of **psychomotor agitation** include restlessness,pacing, or hand wringing;

Psychomotor retardation is best illustrated

by a paucity of movement and a slow, almost absent, monotonous speech.

Suicidal ideation and attempt

People with depressive illness kill themselves at approximately ten times the frequency of patients with other psychiatric diagnoses(neurosis、schizophrenia) .

It is estimated that at least 40 to 50 % of all suicide are committed by depressive patients.

Suicidal thought are present in most , if not all, moderately to severely depressed patients, probably in at least 70 % of them.

The danger of suicide must always be considered to be present in virtually in depressed patient—if not today, then perhaps tomorrow or next week. Suicide risk is the greatest among those patients who express more or less complete hopelessness.

Risk factors for suicide:

Time :

In the early stages of depression, before help has become available and while the patient is in a state of great anxiety over what happening.

When a patient is close to remission, the illness has improved,and actually seems to be free of symptoms much of the time, especially during the period that the psychomotor retardation has solved being frightened by the illness.

Unlike in the depths of depression, strength and initiative are renewed to plan and execute a “successful” suicide. This is a point at which clinicians, family, and friends may have let their guard down. The time of release from active treatment and the following 3 months are particularly important time for all who are concerned to keep their guard up.

Clinician also know that depressed patients who suddenly appear to be unusually calm may have reached the stage of resolution to commit suicide and should be observed with special care.

Gender

Women make far more suicidal attempts (parasuicides) than men, whereas men complete suicide more frequently than women.

Others

Patients, who are in the greatest danger of self-killing, are constantly and compulsively preoccupied with suicide and have made specific plans on how to carry it out.

Single, men over midlife, living alone having substance abuse(misusing of alcohol, heroin, amphetamine et al).

Extended suicide

although violence is rare among depressed patients, extended suicide has to be considered as a definite risk. Typically, a depressive mother may kill her baby who are young enough to be felt by her as a symbiotic part of herself.

Biological symptoms

physical symptom

Some patients who suffer from depression experience it as primarily an emotional and psychological problem, and they talk about it in those terms.

However, the family doctor will often see patients with depression who present with a physical compliant.

Often these patients will either present amplified medical problems or will have symptoms of undermined cause.

Your first impulse will be to treat these "medical complaints."

But unless you recognize their origin and treat their cause, you will be frustrated and depressed as your patient!

The vast majority of depressed patients spoke of their suffering not in psychological symptoms (i.e. "I feel hopless, helpless, or worthless") but in terms of physical symptoms (i.e. "I can't sleep, food tastes awful, I don't have any appetite, my lower back is hurting more, my gut still aches, etc ".)

Physical symptom is one of the most common symptoms seen in depressed patients.

They may be as outstanding as the emotional ones, and they may overshadow the depressive states. Some doctor call this state as

"masked depression".

sleep disorder

Disturbances of sleep are universal

depressed patients—

insomnia occurring in about 90 %,

and are usually among the first

symptoms to be reported.

The anxiety pattern of insomnia is frequent, in which the patient cannot fall asleep for hours (increased sleep latency).

In the depressive pattern of insomnia, early awakening (e.g. at 2 or 3 A.M.) is the rule. The remaining hours of the night are usually filled with painful ruminations, and it is believed to be specific for depression.

Some patients may have a pattern of restless, intermittent sleep. The patients can fall asleep quickly, but wake up frequently during the night and do not feel rested in the morning.

Hypersomnia, or unduly, but mercifully, prolonged sleep (14 or 15 hours a day), afflicts a significant minority of depressed patients, particularly those suffering from atypical depressions.

Eating disorder

Appetite is frequently disturbed in depressed patients, **with loss of appetite(anorexia)** being the most common manifestation. They are not capable of enjoying formerly favorite food. They may have to force them to eat even the greatest delicacies, which is now seem **tastless.**

But there are **exceptions,** which patients show **increased appetie**.

Weight disorder

When the loss of appetite is significant,

there will be **weight loss.**

But, a minority of patients overeat and

oversleep and exercise less daily, and

then, may **gain weight.** And that

symptom may further depress those

already depressed women.

About the sexual

Loss of sexual drive is an almost universal symptom in depressed patients.

For men, there is usually a history of little or on libido and activity and have erectile dysfunction;

for women, such activity may continue, although without interest.

other physical symptoms

Complain of pain, frequently of the chronic type, are common in depression.

The pain are located in head, but may be in the chest or abdomen.

Chronic pain in the shoulder or back also may appear as a stubborn somatization symptom

The Diagnosis of Depressive Episode

criteria for "depressive episode" in ICD-10

A. Depressed mood

Loss of interest and enjoyment

Reduced energy and decreased activity

B. Reduced concentration

Reduced self-esteem and confidence

Ideas of guilt and unworthiness

Pessimistic thoughts

Disturbed sleep

Diminished appetite

Mild: **at least 2 of A and at least 2 of B**

Moderate: **at least 2 of A and at least 3 of B**

Severe: **at least 2 of A and at least 4 of B**

Criteria for major depressive episode of DSM-Ⅳ

A. five (or more) of the following symptoms

- have been present during the same 2 weeks
- period and represent a change from previous
- functioning;

at least one of the symptom is either (1) depressed mood or (2) loss of interest or pleasure.

1.Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful)

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 made by others).

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.

4. insominia or hypersomonia in nearly every day.
5. psychomotor agitation or retardation nearly every day (observable by others, nor 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 of

dying), recurrent suicidal ideation

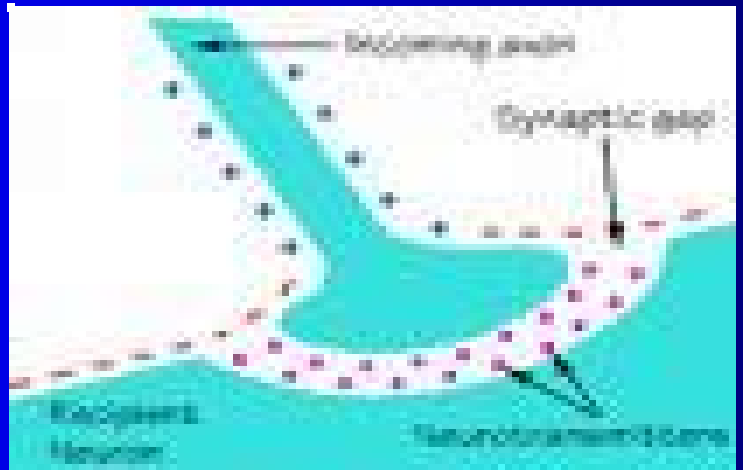
without a specific plan ,or a suicide

attempt or a specific plan for committing suicide.

Etiology--Why?

Biological causes:

1. the dysfunction of monoamine,
   the reducing of norepinephrine(NE)
   and serotonin (5-hydroxytryptamine, 5-HT).
2. the dysfunction of Neuroendocrinology,
   such as:
   hypothalamic-pituitary-adrenal(HPT) axis—
   Hyperactivity of the axis has been extensively reported,
   The dexamethasone suppression test (DST) is abnormal in depressive patient;
   Hypothalamic-pituitary-thyroid axis (HPT) is impaired in depression.



Genetic factors:

The role of genetic factors in susceptibility to

major depression has been supported by family, twin, adoption and molecular genetic study.

Possible genetic component to major depression and suicide is illustrated by family of Ernest Hemingway

- He died by suicide, as did his father, two siblings and his grand daughter.

Genetic factors:

However, the precise nature of the genetic defects remains unknown.

Socio-psychological Factors

1. **early experiences**

there is evidence that a disruptive, hostile, and generally negative environment in a child's home constitutes a risk factors for depression.

2. **social class**

Whereas depressive symptoms and dysphoria independent of diagnosis is less common in the lower social class, but there is no particular pattern to the distribution of major depression across

3.**personality attributes**

many clinical studies have suggested that certain personality characteristics, such as: likelihood to break down under stress, lack of energy,insecurity, introversion and sensitivity, tendency to worry, lack of social adroitness, unassertivity, dependency, and obsessionality.

4.**recent life events**

In general, studies have shown that many, but not all; depressed patients, as compared with the normal, tend to have an excess of negative life events, particularly losses or exits of significant others prior to the onset of a depressive episode.

5.absence of an intimate confiding relationship

In a study of women, the absence of a satisfying intimate heterosexual relationship was shown to be a risk factor for depression.

Treatment of Depression

Psychological Intervention

A. **shot-term and brief psychological counseling or psychotherapy.**

for the major of the patients in a general office practice, that is enough for remedying the patients' depression.

The passage of time, the resolution of immediate life stresses, and spontaneous remission of depression are **three active factors** accounting for most people recovering from depression.

B. In brief psychotherapy for the treatment of depression, the focus is typically on the patient's stresses or problems.

The failure to resolve life problems is a frequent cause of depression. In the vast majority of circumstances, you will be able to determine what problem in your patient's life are triggering or contributing to the depression.

Once you have identified these problems you will be able to embark, with the patient, on strategies designed to reduce or resolve these stresses.

Do not make the mistake, however, of simply being a problem solver of the patient's woes. Your task is to assist the patient on solving his own problems.

It's imperative that you first establish an empathic relationship in which the patient feels understood, accepted and, and respected. Once the patient feels that you have "walked in his shoes," then you may offer solicited advice and training in problem-solving skills.

C. Depressed patient can be like a car with an empty gas tank. The gas tank has been depleted primarily by repeated failures, frustration, negative perception, low self-esteem, worry…..all contributing to a lack of sleep and overextending the amount of energy reserve.

With this perspective, your focus can be three fold:

a. Getting the patient energized

b. Helping your patient decide where he wants to go

c. Clarifying how he wants to get there.

Sounds like a **psychological AAA:**

fueling up, targeting a destination, and selecting a road map to get him there!

Obviously, before a person can worry about where to drive a car, he has **to have some gas in the tank**, i.e. energy. Providing such energy by means of medication, stress reduction, and supportive counseling are the primary "gas station" or intervention **strategies available to you**

Cognitive Behavior Therapy (CBT)

is one of effective psychotherapy. Within this psychotherapeutic model the following characteristics are associated with clinical improvement in depression:

1. Realistic **reassurance**
2. A **supportive, caring attitude**
3. The enlistment of **friends and family to support** the patient.
4. The **challenging** of negative and self defeating beliefs
5. Medication management when **necessary.**

Discussing and Clarifying misconceptions

With most depressed patients, misconception or distorted cognitions about themselves and their condition run rampant.

Patient may feel that they are in a hopeless situation and helpless to do anything about their condition,

may fear that they will be cursed forever by depression,

may worry that they will never improve

and may panic at the thought of "losing their minds"

Predicting Clinical Course

One important strategy in dealing with depression is to predict for patients what type of clinical course they can expect.

For example,

they may expect fear or apprehensiveness to fill their lives,

they may experience some immediate memory problems and problems in concentration.

they may suffer from insomnia and early morning awakening.

Pharmacotherapy

Antidepressants

Many patient can not be recovered only through the psychotherapy, they must be treated with medication(Antidepressants).

But it is helpful to discuss the benefits and potential response to antidepressant medication, esp. including common side effects.

All these drugs have some side effects.

and many patients have to give up taking them halfway. Many patients can expect dry mouths, blurred vision, and some feelings of drowsiness in the first several days on medication.

They should also be aware that it takes several days, sometimes a week to ten days,

before they experience any antidepressant

impact from the medication itself.

With improved sleep in the first day or two , however, they can begin to feel renewed

energy, the vanguard of better things ahead.

Tricyclic Antidepressants (TCA_S):

There are **many** drugs available including imipramine, amitriptyline, desipramine, doxepine.

And **no difference** in clinical effectiveness among the various agents were found.

Monoamine Oxidase Inhibitors ($MAOI_S$):

With the advent of the reversible $MAOI_S$, e,g. RIAMS, the first generation $MAOI_S$ suh ads Isocarboxazid, Phenelzine are not often used because of drug interaction and the "cheese" effects.

And they may cause hypertensive crises,

patients should be given written instructions regarding the avoidance of particular drugs (sympathomimetics) and tyramine-containing foods

SSRI$_S$

(Selective Serotonin Reuptake Inhibitors)

flouxetine, paroxetine and sertraline.

less side effects,

more safe if overdose taking

more convenient to take

more compliant.

Lithium salts

motional stabilizer

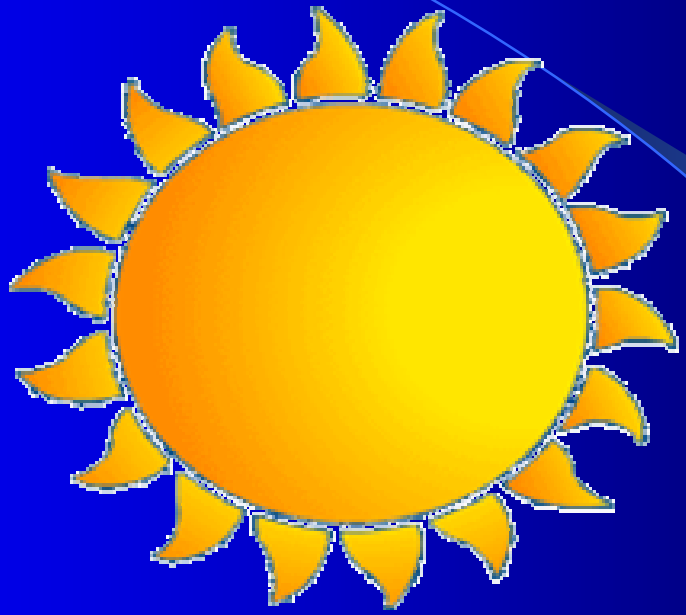
Anxiolytics

For the patients who suffer from anxiety and insomnia during depression episode.

Diaozepam, Lorazepam, Aprazolam.et.al.

others

ECT is an effective way in coping with severe depression if the symptoms are intense, prolonged and distressing to patient, esp to a patient with suicide risk.



Wish you and me have a sunny feeling every day