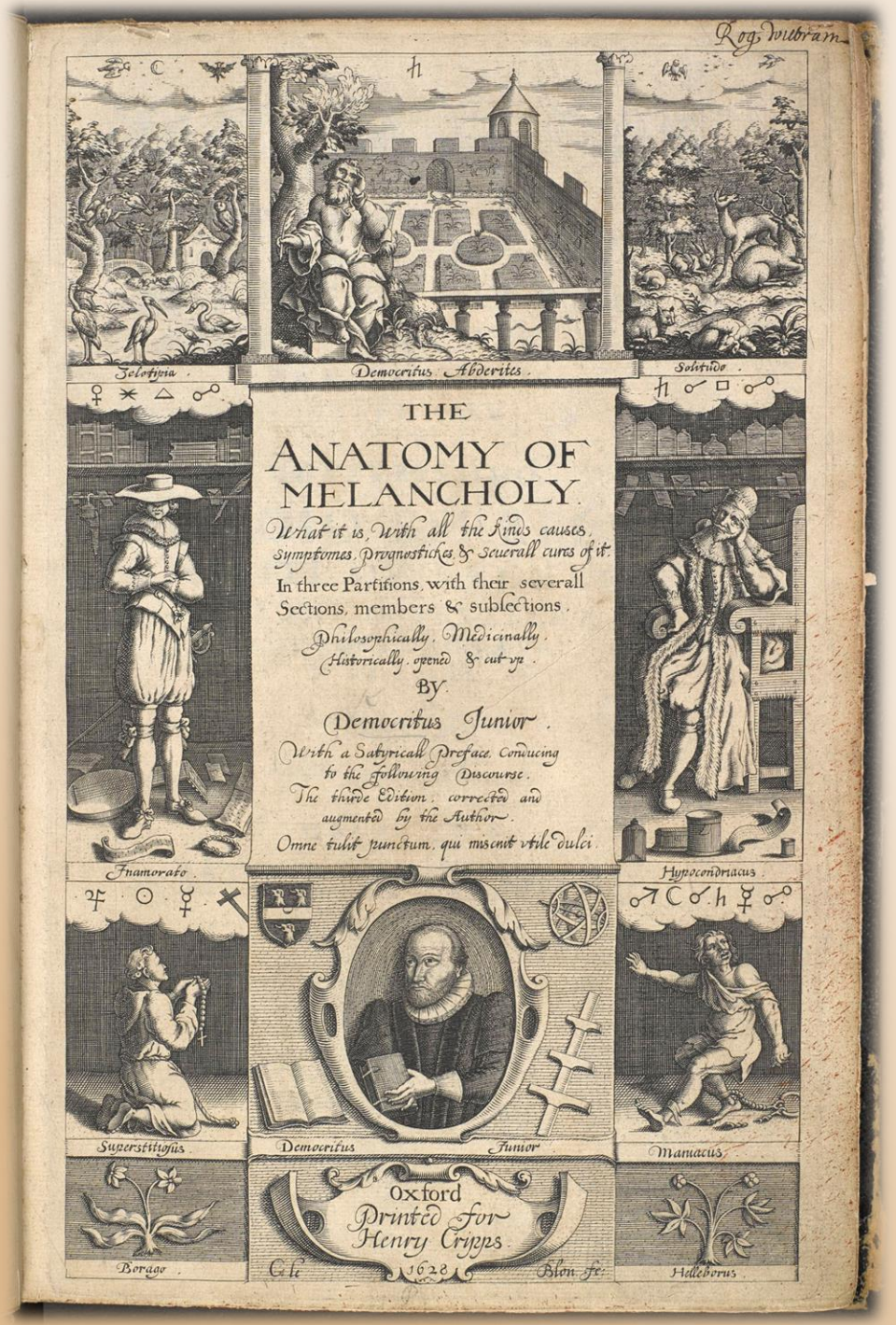

Robert Burton (1621): The Anatomy of Melancholy, What it is: With all the Kinds, Causes, Symptomes, Prognostickes, and Several Cures of it. In Three Maine Partitions with their several Sections, Members, and Subsections. Philosophically, Medicinally, Historically, Opened and Cut Up

Depressive disorders

Department of Psychiatry and Psychotherapy

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What is depression?

Sadness and sorrow
≠
Depression

Mood disorder
≠
Depression

A. Dürer (1514): Melancholia (engraving)

Symptom domains of depression

1. Affective symptoms: depressed mood, and loss of interest and pleasure.

depressed mood: a distinct quality of emotions

2. Cognitive symptoms: disturbances of attention, concentration and memory. Negative views of the world and of themselves. Ruminations about loss, worthlessness, guilt, suicide and death.

3. Somatic/ autonomic symptoms: disturbances of sleep and appetite, weight change, sexual dysfunctions

4. Social and interpersonal problems: impaired social skills, social withdrawal, isolation.

Epidemiology

- The prevalence of major depressive disorder (MDD): 15.1% (l.t), 7.7% (ann.inc.)
  - Male: female = 1: 2 (hormonal differences, effects of childbirth, differing psychosocial stressors, behavioral models of learned helplessness, etc.)
  - Mean age of onset: 40 years (50% of patients have an onset between 20-50 y)
  - Among people younger than 20 MDD ↑ (related to the increased use of alcohol and drugs)

- The prevalence of mood and anxiety disorders in the primary care: 15%

Rihmer & Angst, 2009

Etiology

Multifactorial etiology

- Genetics: the heritability of MDD is 37% (→ weakly linked to multiple genetic risk factors)

  Gene x Environment!! (severe or early stress exposure + genetic vulnerability)

- Neurochemical models: monoamine dysregulation → SER, NE, DA
  - Recent progressive shift from neurotransmitter systems to neuro-behavioral systems (neural circuits, neuro-regulatory mechanisms).
- Alterations of stress regulation → HPA axis dysregulation
- Chrono-biological alterations → disruption of the circadian rhythm
- Structural and functional brain imaging data (alterations of brain regions responsible of mood and affect regulation: prefrontal cortex, anterior cingulate, amygdala, hippocampus
- Personality development, affective temperaments
- Psychological theories:
  - Cognitive theories
  - Psychodynamic theories (e.g. Freud → inwardly directed anger, introjection of love object loss)

Multifactorial etiology 2

➢ Cognitive theories of depression:

- Depression results from specific cognitive distortions → ***depressiogenic schemata***

  (= Cognitive templates that filter both internal and external data in ways that are altered by early negative experiences → cognitive vulnerability/ depressive character)

- Aaron Beck - **cognitive triad** of depression:

  1, views about the ***self*** → negative self-percept

  2, - about the ***environment*** → the world is hostile and demanding

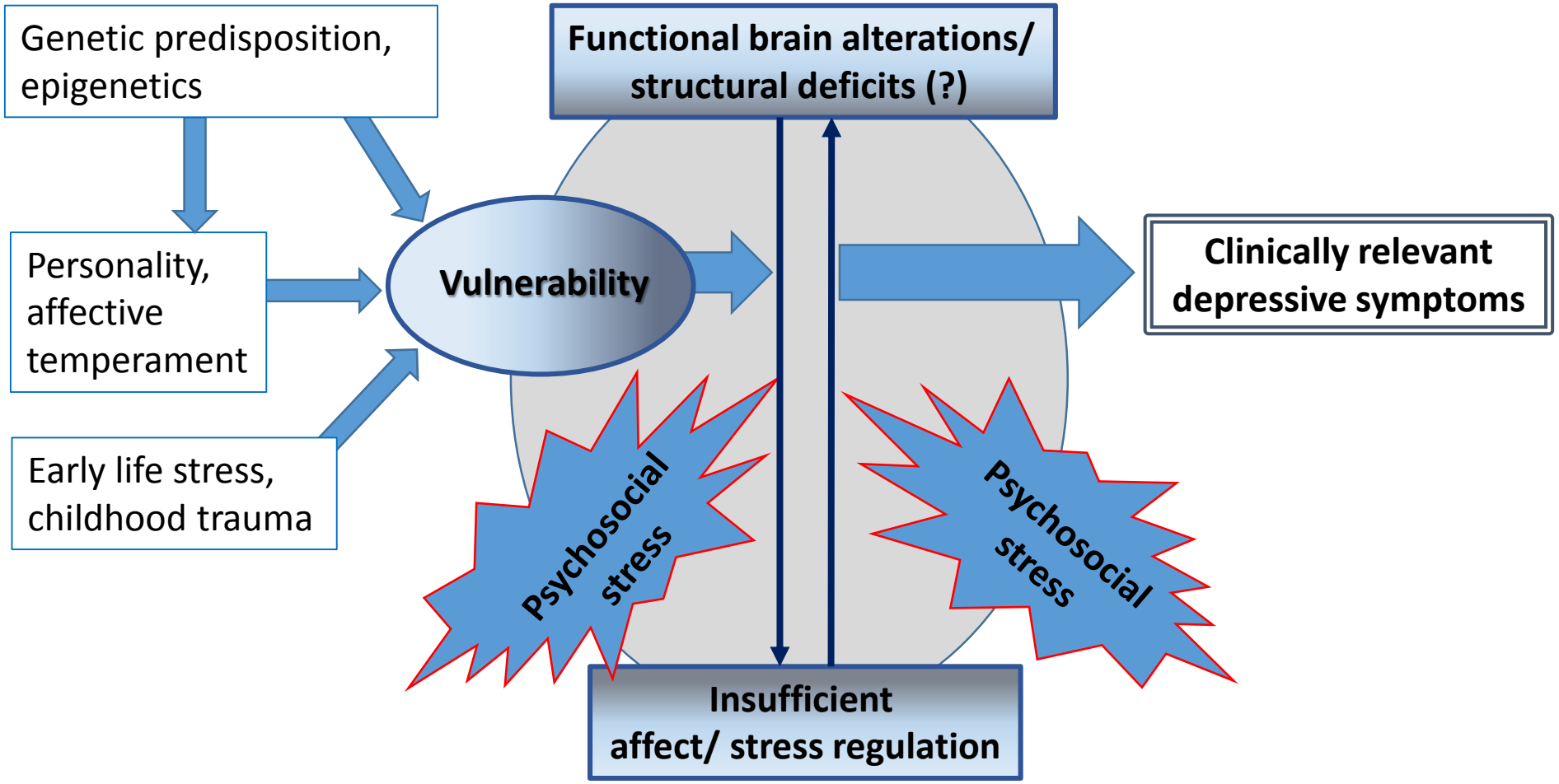
  3, - about the ***future*** → the expectation of suffering and failure

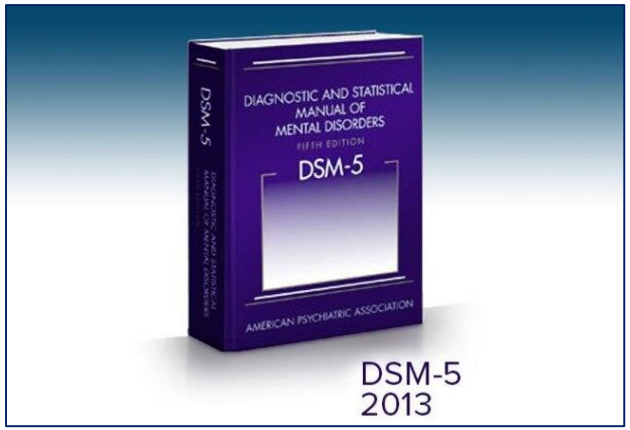
- **Learned helplessness**

  A connection between depressive phenomena and the experience of uncontrollable events. → Learned passivity and loss of self-esteem.

Cognitive and behavioral therapies (CBT)!!!

Integrative pathogenetic model of depression





DSM 5 - Depressive and related disorders

1. Major depressive disorder
2. Pervasive mood dysregulation disorder
3. Persistent depressive disorder (previously dysthymia)
4. Premenstrual dysphoric disorder

Major depressive disorder (MDD) – DSM 5

Five (or more) of the following symptoms:

1. **Depressed mood most of the day, nearly everyday,**
2. **Loss of interest or pleasure (=anhedonia),**
3. Significant weight loss/ gain, or decrease or increase of the appetite,
4. Insomnia or hypersomnia,
5. Psychomotor agitation or retardation,
6. Fatigue or loss of energy,
7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional),
8. Diminished ability to think or concentrate, or indecisiveness,
9. Recurrent thoughts of death, recurrent suicidal ideations, or a suicide attempt or a specific plan for committing suicide.

At least one of the symptoms is either 1 or 2

The symptoms cause significant distress or dysfunctions in occupational or social areas.

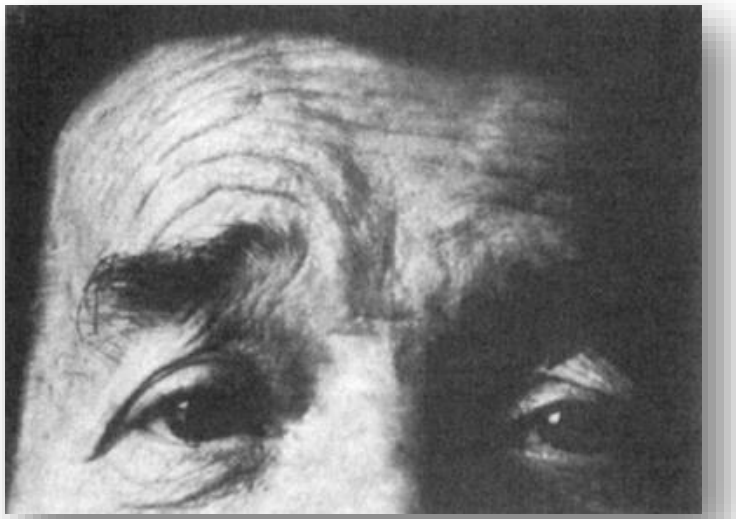
Time criterion: at least 2 weeks

Responses to a significant loss do not necessarily exclude the diagnosis of MDD.

Veraguth fold

The main fold in upper eyelid is angulated upwards and backwards.
Described by Otto Veraguth.

Corners of mouth drawn downwards
Typical in depression with melancholic feature,
esp. in patients in Europe or in those with European ancestors.



Persistent depressive disorder

A, Depressed mood for most of the day, for more days than not, for at least 2 years.

B, Presence, while depressed, of 2 (or more) of the following 6 symptoms:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

C, During the 2-year period (1 year for children or adolescents), the individual has never been without the symptoms for more than 2 months.

Criteria for a major depressive disorder may be continuously present for 2 years.

A new diagnostic category which represents a consolidation of chronic major depressive disorder and dysthymia.

Disruptive mood dysregulation disorder (DMDD)

- Severe recurrent temper outbursts, or irritable or angry mood. The outburst occur at least three times a week and for at least a 12-month period.
- The temper outbursts are inconsistent with developmental level.
- DMDD can be diagnosed only between 6 and 18 years.
- The age of onset is before 10 years.

An adequat diagnosis for chronically irritable children who were very often diagnosed as a juvenile bipolar disorder in the past.

Premenstrual dysphoric disorder (PMDD)

- Five (or more) depressive symptoms
- in most menstrual cycles during the past year,
- during the last week of the luteal phase.
- Symptoms remit within a few days after the onset of the follicular phase.

Typical symptoms:

Marked affective lability; persistent anger or irritability, increased interpersonal conflicts; marked depressed mood; anxiety, tension, subjective sense of being overwhelmed, physical symptoms, etc.

(Differential)diagnostics

- Does the patient fulfill the diagnostic criteria?
- Risk for suicide?
- Medical or neurological diseases? (e.g. endocrine diseases, gi tumors, cardiovascular diseases, brain tumors, stroke, etc.)
- Co-inciding substance use? (e.g. alcohol abuse, withdrawal of stimulats)
- Pharmacologic depression? (e.g. ACE inhibitors, glucocortocoids, chemotherapeutics, etc.)
- Longitudinal assessment:
  - Unipolar depression?
  - Bipolar depression?
  - Schizoaffective disorder?
  - Depression related to schizophrenia?
  - Co-morbid psychiatrc disorders? (Personality disorder? Anxiety disorders? Substance use disorder? Other?)

Complete psychiatric history with information from all possible sources

Depression - suicide

- The risk of undiagnosed and untreated depression is suicide.
- Among women, suicide attemts are more common worldwide.
- Female/ male completed suicide ratio: 1:3.
- The prevalence of depression is estimated to be 50-80% in completed suicide and 30-50% in suicide attempts.

Complex therapy of depression

1. Psychoeducation
2. Antidepressant medication → →
3. Other biological therapies
   - ECT (e.g. in severe depressive stupor)
   - Sleep deprivation, light therapy (complex chronobiological intervention)
   - TMS
4. Psychotherapies (PTs)
   - Supportive PT
   - Specific PTs
     interpersonal therapy, CBT, brief dynamic PT
   - Group therapy
   - Family therapy
   - For relapse prevention: mindfulness-based PT

Antidepressants (ADs)

- Reuptake inhibitors
  - SSRIs (fluoxetine, flovoxamine, paroxetine, sertaline, (es)citalopram)
  - SNRIs (venlafaxine, duloxetine)
  - NDRIs (bupropione)
  - NRIs (reboxetine)
- NaSSAs (mirtazapine, mianserine)
- SARIs (e.g. trazodone)
- Multimodal (vortioxetine)
- Others (tianeptine, agomelatine)
- Classical ADs (TCAs, MAO-inhibitors)

In MDD with psychotic feature → combination with atypical antipsychotic

Augmentation with folic acid, omega-3 fatty acids or L-thyroxine, if therapy resistant.

Can ADs increase the risk for suicide?

ADs do not result in immediate relief (2-4 weeks)

1. During the initiation phase ADs can induce anxiety and agitation

   → psychoeducation, + BZD

2. First, psychomotor activity and motivation improve, disturbances of mood and thinking disappear later.

   → early and more frequent follow-up care, or hospital admission

3. If a bipolar disorder is misdiagnosed as a unipolar depression, AD monotherapy can induce mixed affective states → agitated depression

   → Comprehensive history-taking, family history!!, collateral information, questionnaires → If bipolar depression can be diagnosed, ADs can be administered only in a combination with mood stabilizers!

The course and outcome of a major depressive disorder

- After the first episode, the risk of a second depressive episode is 50%.
- After the second episode, the risk of the third depressive epizode is 80-90%.
- Around 15% experience chronic recurrence.
- Major depressive disorder may become chronic.