Depressive Disorders

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Depressive Disorders

Introduction

- Common features
  - Sad, empty or irritable mood
  - Somatic + cognitive changes
  - Affect capacity to function

- Differences
  - Duration
  - Timing
  - Presumed etiology

Disruptive Mood Dysregulation Disorder

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DMDD – Diagnostic Criteria

A. **Severe, recurrent temper outbursts** (verbal or behavioral)
   - Grossly out of proportion (intensity/duration) to situation
B. **Inconsistent with developmental level**
C. **3+ times per week** (on average)

D. **Persistently irritable/angry mood** (between outbursts)
E. **Duration 12+ months**, but no 3 month period without all sx
F. Present in **2 of 3 settings** (home, school, peers), **severe in 1**

G. Diagnosis **NOT before age 6** or **after age 18**
H. **Onset before age 10**

I. **Never mania/hypomania criteria** for more than 1 day
J. Not exclusively during MDD or better explained by AMD
K. Not due to substance, AMC or neurological condition

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DMDD – Coexisting Mental Disorders

- If meets criteria for **DMDD & ODD → only dx DMDD**

- If ever had **manic/hypomanic episode → NOT DMDD**

CAN coexist with	CANNOT coexist with
• MDD • ADHD • SUD • Conduct Disorder	• Bipolar disorder • Intermittent explosive disorder • Oppositional defiant disorder

DMDD – Prevalence

- 6 - 12 month prevalence in C&A = **2 – 5%**
  - **Common** among children presenting to mental health
  - Unclear prevalence in community
  - Higher in → **MALES, school-age** (vs females, adolescents)

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DMDD – Development & Course

- Development
  - Onset must be **before age 10**
  - Do not diagnose if developmental **age <6 or >18**
  - Symptoms likely change as children mature
  - 50% children with severe, chronic irritability still meet DMDD 1 year later

- Conversion to bipolar disorder → **very low**
  - At risk to develop **unipolar depression or anxiety disorders** as adult

- Age-related differences from bipolar disorder
  - DMDD → **more common BEFORE adolescence**, less common into adulthood
  - Bipolar → very low before adol, steady incr into early adulthood

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DMDD – Risk & Prognostic Factors, Gender-Related Issues

- Temperamental
  - Extensive hx of irritability typically manifests before full DMDD criteria met
  - May have complicated psychiatric history
  - May have qualified for **ODD, ADHD, MDD, anxiety disorders**

- Genetic & Physiological
  - Similar familial rates of anxiety, depressive, SUD (as childhood bipolar disorder)

- DMDD → predominantly **MALE**
  - Versus bipolar disorder → equal gender prevalence

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DMDD – Functional Consequences

- Due to low frustration tolerance
  - Difficulty succeeding in **school**
  - Unable to participate in **typical activities**
  - **Family life** severely disrupted
  - Trouble initiating/sustaining **friendships**

- Dysfunction comparable to pediatric bipolar disorder
  - Dangerous behavior, severe aggression, **suicidal ideation/attempts**
  - **Psychiatric hospitalization common**

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DMDD – Differential Diagnosis

- Bipolar Disorder → CANNNOT have both dx
  - Episodic, distinct period of change, elevated/expansive mood, grandiosity
  - DMDD → persistent, may wax/wane, severe irritability

- Oppositional Defiant Disorder → CANNNOT have both dx
  - ODD sx typically occur in DMDD **(DMDD sx rare in ODD)**
  - 15% of ODD meet DMDD criteria → should **only DX DMDD**
  - DMDD → more prominent **mood component** (risk of dep/anx disorders)

- Intermittent Explosive Disorder → CANNNOT have both dx
  - No persistent mood disruption, only 3 months of active symptoms

- ADHD, MDD, anxiety disorders, ASD → can have BOTH dx
  - If irritability only during MDE, anxiety exacerbation → NOT DMDD
  - If only when routine disturbed in ASD → NOT DMDD (secondary to ASD)

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DMDD – Comorbidity

- Rates of comorbidity → extremely high, DMDD rarely occurs alone
  - Higher than many other pediatric mental illnesses
  - **Strongest overlap with ODD**

- Diverse range of comorbidity
  - Disruptive behavior, mood, anxiety, autism symptoms + diagnoses
  - Cannot be diagnosed with bipolar, ODD, IED

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Major Depressive Disorder

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Major Depressive Disorder – Diagnostic Criteria

A. 5+/9 sx during 2-week period, represent a change from previous functioning must include either depressed mood or anhedonia
   1. **Depressed mood** (may be irritable mood in C&A)
   2. **Anhedonia**
   3. **Appetite or weight change**
   4. **Sleep changes**
   5. **Psychomotor changes**
   6. **Energy loss,** fatigue
   7. **Guilt**, worthlessness
   8. **Concentration difficulties**, indecisiveness
   9. **Suicidal ideation**, thoughts of death

B. Cause significant distress or impairment

C. Not due to substance or AMC

D. Not better explained by psychotic disorder

E. Never experienced manic or hypomanic episode

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Major Depressive Disorder – Grief vs MDE

- If significant loss, grief sx may be appropriate (but still consider MDE)
  - Bereavement, financial ruin, natural disaster, serious illness/disability
  - Base on personal history, cultural norms for expression of distress in loss

Grief	Major Depressive Episode
• Mainly **emptiness + loss**	• **Depressed mood + anhedonia**
• **Dysphoria decreases** in days-weeks • Occur in waves **('pangs of grief')** • Associated with **thoughts of deceased**	• Depressed mood **persistent** • **Not tied** to specific thoughts
• Can have **positive emotion/humor**	• Typically NO positive emotion/humour
• **Preoccupation** with thoughts/memories of deceased	• **Self-critical/pessimistic** ruminations
• **Preserved self-esteem** • If self-derogatory, typically about failing deceased	• **Worthlessness, self-loathing** common
• If thoughts of death, typically **focused on deceased or joining deceased**	• If thoughts of death, **focus on ending own life,** due to worthlessness, un-deserving, unable to cope

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Major Depressive Disorder – Specifiers

- *Specify if:*
  - Single or recurrent episode
  - Recurrent → interval of 2+ consecutive months where dx criteria are NOT met

- *Severity specifier:*
  - Mild/Moderate/Severe

- *Course specifier:*
  - In partial or full remission

- *Specify:*
  - **With anxious distress**
  - **With mixed features**
  - **With melancholic features**
  - **With atypical features**
  - **With mood-congruent psychotic features**
  - **With mood-incongruent psychotic features**
  - **With catatonia**
  - **With peripartum onset**
  - **With seasonal pattern**

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Major Depressive Disorder – Diagnostic Features

- Criterion symptoms present nearly every day, for 2+ weeks
  - **Psychomotor disturbances** → less common, greater severity if present
  - **Delusional guilt** → less common, greater severity if present
  - In milder episodes, function may appear normal, but requires more effort

- A1) Mood
  - Depressed, sad, discouraged, down in dumps
  - May be denied at first, then elicited (facial expression, demeanor)
  - May complain of no feelings, anxiety, somatic sx, irritability
  - C&A → **irritability, cranky** (vs just frustration)

- A2) Anhedonia
  - Less interested in hobbies, not caring, no enjoyment
  - Social withdrawal, neglect of fun
  - Decreased sexual interest/desire

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Major Depressive Disorder – Diagnostic Features

- A3) Appetite changes
  - **Decr appetite** → force self to eat
  - **Incr appetite** → may crave specific foods
  - Children → failure to make **expected weight gain**

- A4) Sleep changes
  - **Insomnia** → initial, middle, terminal
  - **Hypersomnia** → night, daytime
  - Can be presenting sx

- A5 Psychomotor changes
  - **Agitation** → can't sit still, pacing, hand-wringing, pulling/rubbing skin
  - **Retardation** → slowed thinking/movement, pauses before answering, speech slower/quieter/monotone
  - **Must be observable** by others (not just subjective)

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Major Depressive Disorder – Diagnostic Features

- A6) Energy
  - Decreased energy, tiredness, **fatigue without exertion**
  - **Substantial effort with small tasks**, decreased efficiency

- A7) Guilt
  - Unrealistic negative evaluation of **self worth, personal deficits**
  - Guilty preoccupation/ruminations of **minor past failings**
  - Exaggerated **sense of responsibility**
  - Misinterpret neutral/trivial **day-to-day events** → may be **delusional level**
  - NOT just blaming self for being sick, not meeting responsibilities

- A8) Concentration
  - Impairment in ability to think, concentrate, make minor decisions
  - Easily distracted, "memory difficulties", difficulties with demanding tasks
  - Children → significant **drop in grades**
  - Elderly → **"pseudodementia"**, improves when MDE resolves

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Major Depressive Disorder – Diagnostic Features

- A9) Suicidal ideation
  - Thoughts of death, suicidal ideation, suicide attempts
  - **Passive SI** → wish to not wake, better off dead
  - **Active SI** → specific plan
  - **Severe SI** → affairs in order, acquired materials, chose location/time
  - **Motivations**
    - Giving up due to insurmountable obstacles
    - End to unending/painful emotional state, no foreseeable enjoyment
    - Not to be burden to others
  - Resolution of such thinking is a more meaningful sign of lower risk (vs no plan)

- If there is a comorbid general medical condition (cancer, stroke, MI, DM, pregnancy)
  - May have overlapping sx → should count to MDE unless clearly GMC
  - **Non-vegetative sx helpful for dx** (dysphoria, anhedonia, guilt, conc, SI)

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Major Depressive Disorder – Associated Features

- Higher mortality in MDD
  - Mainly due to **suicide** (not only cause)
  - In nursing homes → **incr likelihood of death within 1st year**

- Presentation
  - Tearfulness, irritability, brooding, obsessive ruminations, anxiety, phobias
  - Excessive worry about **physical health**
  - **Pain** → headaches, joints, abdominal
  - Children → **separation anxiety** may occur

- No diagnostic laboratory tests
  - HPA-axis hyperactivity associated w/ melancholia/psychotic fts, suicide risk
  - Genetic variations in **neurotrophic factors, pro-inflammatory cytokines**
  - **fMRI** → abnormal emotion processing, reward seeking, emotional regulation

Major Depressive Disorder – Prevalence

- US 12-month prevalence = **7%**
  - **3x higher in age 18-29** (vs age >60)
  - In early adolescence → **1.5-3x higher in FEMALES** (vs males)

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Major Depressive Disorder – Development & Course

- Onset & Course
  - Increases markedly **with puberty** → **peak incidence in 20s**
  - Some never have remission vs some just have discrete episodes
  - Distinguish exacerbation of chronic illness vs new symptoms

- Chronicity of depressive symptoms
  - More likely underlying **personality disorder, anxiety disorder, SUD**
  - **Less likely full symptom resolution**
  - Ask about last period of >2 months without any depressive sx

- Recovery
  - Begins within 3 months of onset → **40%**
  - Begins within 1 year of onset → **80%**
  - MORE likely to recover → **more recent onset**
  - LESS likely to recover → **episode duration, symptom severity, psychotic features, prominent anxiety, personality disorder**

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Major Depressive Disorder – Development & Course

- Recurrence
  - Lower risk → **longer duration of REMISSION**
  - Higher risk → **preceding severe episode, younger, multiple episodes**

- Bipolar
  - Often begin with MDEs → more likely underlying bipolar if:
    - **Onset in adolescence**
    - **Psychotic or mixed features**
    - **Family hx of bipolar**

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Major Depressive Disorder – Development & Course

- Gender & age differences
  - **Course, treatment response** → NO gender/age differences
  - Phenomenology → NO gender differences, but age differences
    - Younger → **hypersomnia, hyperphagia**
    - Older → **melancholic, psychomotor changes**
    - Middle/late life → **decr likelihood of SA**, no difference in completed suicides
  - Earlier onset → more likely **familial, personality disturbances**
  - Course within individual → **doesn't change with aging**
    - Mean time to recovery, likelihood of being in an episode → stable over time

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Major Depressive Disorder – Risk & Prognostic Factors

- Temperamental
  - **Neuroticism (negative affectivity)** → well-established risk factor
    - Higher levels → more likely to develop MDE if stressful life events

- Environmental
  - **Adverse childhood experiences** → esp if multiple diverse types
  - **Stressful life events** → can be precipitant

- Genetic & Physiological
  - First-degree family members → **2-4x higher risk**
    - Higher if early-onset, recurrent forms
  - **Heritability = 40%** (esp neuroticism)

Major Depressive Disorder – Risk & Prognostic Factors

- Course Modifiers
  - **All major non-mood disorders** → incr risk of MDE, more refractory
    - **SUD, anxiety, borderline PD** → may obscure/delay dx of MDE
    - Treating underlying disorder can improve depressive symptoms
  - **Chronic/disabling GMC** → incr risk of MDE
    - DM, morbid obesity, CVD
    - Often complicated by MDE, more likely to be chronic MDE

Major Depressive Disorder – Culture-Related Issues

- Variation among cultures
  - Up to 7x differences in 12-month prevalence rates
  - **More consistency in gender ratio, mean age of onset, comorbid SUD**
  - Majority of cases go unrecognized, may present with somatic sx
  - Insomnia + fatigue → most uniformly reported

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Major Depressive Disorder – Gender-Related Issues

Females	Males	Same
• Higher **prevalence** • Higher risk of **suicide attempt**	• Higher risk of **completed suicide**	• Symptoms • Course • Tx response • Function

Major Depressive Disorder – Suicide Risk

- **Past hx of suicide attempts** → most consistently described
  - But most completed suicide NOT preceded by unsuccessful attempts

- Other risk factors for complete suicide
  - **Male sex**
  - **Single, living alone**
  - **Prominent feelings of hopelessness**

- Risk factor of future suicide attempts
  - **Borderline PD**

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Major Depressive Disorder – Functional Consequences

- Varying degrees of impairment
  - Can be **very mild**, others unaware
  - Can cause **complete incapacity** → no basic self-care, mute, catatonia

- MDD in general medical settings
  - **More pain, physical illness**
  - **Physical, social, role dysfunction**

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Major Depressive Disorder – Differential Diagnosis

- Manic episodes with irritable mood/mixed episodes
  - Presence of manic symptoms (vs just MDE with irritability)
- Mood disorder due to AMC
- Substance/medication-induced depressive/bipolar disorder
- ADHD
  - Both may have distractibility, low frustration tolerance → may dx both
- Adjustment disorder with depressed mood
  - Psychosocial stressor, but MDE criteria NOT met
- Sadness
  - Periods of sadness inherent aspect of human experience
  - Consider severity, duration, distress, impairment → may dx MDE

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Major Depressive Disorder – Comorbidity

- Frequently co-occur
  - Substance-related disorders
  - Panic disorder
  - OCD
  - Anorexia nervosa
  - Bulimia nervosa
  - Borderline PD

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Persistent Depressive Disorder

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Persistent Depressive Disorder – Diagnostic Criteria

A. Depressed mood, for **≥2 years**
1. In C&A → **depressed or irritable** mood, ≥**1 year**

B. 2+/6 depressive symptoms (no anhedonia, psychomotor)
1. **Appetite** change
2. **Sleep** change
3. Low **energy/fatigue**
4. Low **self-esteem**
5. Poor **concentration**
6. **Hopelessness**

C. During 2 yrs, **never without** Criteria A+B sx for **>2 mo straight**

D. May have MDD continuously for 2 years

E. Never manic/hypomanic episode, **not cyclothymic** disorder

F. Not psychotic disorder

G. Not due to substance or AMC

H. Sx cause significant distress or impairment

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Persistent Depressive Disorder – Specifiers

- *Specific if:*
  - **With anxious distress**
  - **With mixed features**
  - **With melancholic features**
  - **With atypical features**
  - **With mood-congruent psychotic features**
  - **With mood-incongruent psychotic features**
  - **With peripartum onset**

- *Specify if* (for most recent 2 years of PDD):
  - **With pure dysthymic syndrome**: no MDE
  - **With persistent MDE:** MDE throughout
  - **With intermittent MDE, with current episode**
    - Full MDE criteria currently; there have been periods of 8+ wks with**out** full sx of MDE
  - **With intermittent MDE, without current episode**
  - Very few who have depressive sx for >2 years will NOT meet PDD

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Persistent Depressive Disorder – Specifiers

- *Specify if:*
  - **In partial remission**
  - **In full remission**

- *Specify if:*
  - **Early onset** (age <21)
  - **Late onset** (age ≥21)

- *Specify if:*
  - **Mild**
  - **Moderate**
  - **Severe**

Persistent Depressive Disorder – Diagnostic Features

- MDD may precede PDD
  - MDE may occur during PDD
  - If MDD for 2 years, **give BOTH dx**

- Describe mood as sad, "down in the dumps"
  - Becomes part of the individual's day-to-day experience
  - In C&A → required duration is only 1 year

- No symptom free intervals ≥2 months

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Persistent Depressive Disorder – Prevalence, Development and Course

- PDD = dysthymic disorder + chronic MDD

- 12-month prevalence
  - **PDD = 0.5%**
  - **Chronic MDD = 1.5%**

- Often early + insidious onset → chronic course
  - May have common mechanism to borderline PD

- Early onset
  - Higher likelihood of **comorbid personality disorders, SUD**

- If sx severity develops to MDE, likely to subsequently revert to lower level
  - Depressive sx LESS likely to resolve in PDD (vs MDE)

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Persistent Depressive Disorder – Risk & Prognostic Factors

- Temperamental
  - **Neuroticism, sx severity, global function, anxiety/conduct disorders**
  - Predicts poorer long-term outcome

- Environmental
  - **Parental loss or separation** (in childhood)

- Genetic & Physiological
  - No clear difference between dysthymic disorder or chronic MDD in illness development, course or family history → findings likely apply to PDD
  - PDD pts → higher proportion of **first-degree relatives with PDD**
    - Likely more depressive disorders in general
  - Implicated brain regions → **prefrontal cortex, anterior cingulate, amygdala, hippocampus**
- **Functional Impairment** can be **as great or greater than MDD**
  - Varies widely

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Persistent Depressive Disorder – Differential Diagnosis

- Major depressive disorder
  - PDD → 2 year duration, may have no/intermittent/persistent MDE
- Psychotic disorders
  - Not PDD if depressive sx occur only during course of psychotic disorder
  - Including during residual phases
- Depressive/bipolar disorders due to AMC
- Substance/medication induced depressive/bipolar disorder
- Personality disorders
  - If coexisting PD → give both dx

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Persistent Depressive Disorder – Comorbidity

- PDD higher risk (vs MDD)
  - **Psychiatric comorbidity**
  - **Anxiety disorders**
  - **SUD**

- Early-onset PDD
  - Strongly assoc with **Cluster B + C personality disorders**

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Premenstrual Dysphoric Disorder

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PMDD – Diagnostic Criteria (1)

A. 5+/11 sx in the **FINAL WEEK BEFORE menses**
- **Improve within days** of menses, become **minimal in week POST-menses**
- Affect the **majority** of menstrual cycles, in **preceding year**

B. 1+/4 mood symptoms	C. 1+/7 associated behavioral/physical symptoms
• **Affect lability** (mood swings, sudden sadness, rejection sensitivity) • **Irritability/anger**, interpersonal conflicts • **Depressed mood**, hopelessness, self-deprecating thoughts • **Anxiety, tension,** keyed up, on edge	• **Anhedonia** • **Concentration** difficulties • Low **energy/fatigue** • **Appetite** changes • **Sleep** changes • Feeling **overwhelmed** • **Physical symptoms** (breast tenderness/swelling, joint/muscle pain, bloating)

D. Causes significant distress or impairment

E. Not merely exacerbation of other disorder
- MDD, PDD, panic disorder, personality disorder (but may co-exist)

F. Confirmed by **prospective daily ratings, for 2 cycles**

G. Not due to substance or AMC

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PMDD – Diagnostic Features

- **Essential features**
  - Mood lability, irritability, dysphoria, anxiety symptoms
  - Accompanying behavioral + physical symptoms

- Occur repeatedly during premenstrual phase
  - **Peak around onset** of menses, **can linger** for first few days of menses
  - Remit with onset of menses or shortly after
  - Must have **symptom-free period in follicular phase,** after menses onset
  - Affect the majority of menstrual cycles

- Intensity and expressivity depends on social + cultural background
  - Affected by family perspectives, religious beliefs, social tolerance, gender role issues

- Need **daily prospective symptom ratings for ≥ 2 cycles**

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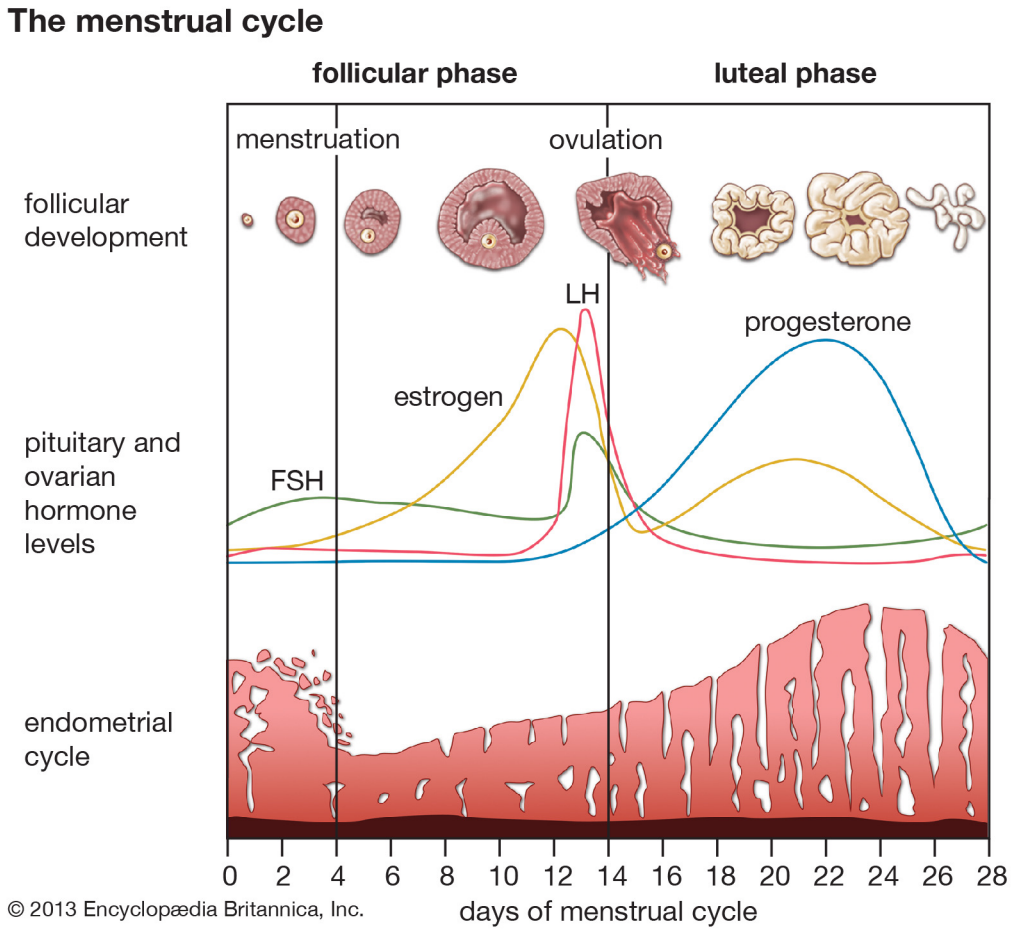
PMDD – Associated Features

- Delusions, hallucinations → **late luteal phase** (rare)

- Risk of suicide → **premenstrual phase**



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PMDD – Prevalence, Development & Course

- 12-month prevalence = **1.8 – 5.8%** (of menstruating women)
  - May be overestimate if retrospective reports (vs prospective daily ratings)
    - But daily ratings may underestimate if symptoms impair ability to rate
  - PMDD without fxnal impairment = **1.8%**
  - PMDD with fxnal impairment, no other mental disorder sx = **1.3%**

- Incidence = 2.5%
  - Can occur any point **after menarche**
  - Anecdotal reports that symptom worsen approaching menopause

- After menopause → symptoms cease
  - **Cyclical hormone replacement** → can trigger re-expression of symptoms

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PMDD – Risk & Prognostic Factors, Cultural Issues

- Environmental
  - Stress, hx interpersonal trauma, seasonal changes
  - Sociocultural aspects of female sexual behavior, female gender role

- Genetic & Physiological
  - Heritability of **PMDD → unknown**
  - Heritability of premenstrual symptoms = **30-80%** (most stable component of premenstrual sx have 50% heritability)

- NOT a culture-bound syndrome
  - Observed in US, Europe, India, Asia
  - Unclear whether rates vary by race

- Frequency, expressivity, and intensity of symptoms likely significantly influenced by **cultural factors**

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PMDD – Diagnostic Markers, Functional Consequences

- 2 months of prospective symptom ratings (all validated)
  - **Daily Rating of Severity of Problems (DRSP)**
  - **Visual Analogue Scales for Premenstrual Mood Symptoms (VASPMS)**
  - **Premenstrual Tension Syndrome Rating Scale** (self-report)

- Impairment in week prior to menses
  - Marital disorder, problems with children/family/friends
  - Distinguish from chronic marital/job problems

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PMDD – Differential Diagnosis

- Premenstrual syndrome
  - No minimum symptoms, no requirement of affective symptoms
  - May be more common than PMDD, **less severe**
  - Shares symptom expression during premenstrual phase

- Dysmenorrhea
  - Painful menses (no affective changes) → begins with **onset of menses**

- Bipolar disorder, MDD, PDD
  - Do not follow premenstrual pattern (with daily prospective ratings)
  - Rate of personality disorders → no difference if PMDD (vs no PMDD)

- Hormonal treatments (medication-induced depressive disorder)
  - Associated with hormone use, remit with d/c of use

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PMDD – Comorbidity

- **MDD** = MOST frequently reported previous disorder

- Medical disorders may worsen in premenstrual phase
  - Migraine, asthma, allergies, seizure disorders
  - Other mental disorders
  - Better considered as **"premenstrual exacerbation"**

- PMDD → symptom-free period during post-menstrual interval
  - PMDD can be additional dx if individual experiences characteristic sx and impairment in level of functioning

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Substance/Medication-Induced Depressive Disorder

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Substance/Med-Induced Depressive Disorder – Diagnostic Criteria

A. Depressed mood or anhedonia

- Predominate clinical picture + severe enough to warrant clinical attention

B. History, physical exam, lab findings of **both**:

1. Symptom onset **during/soon after** intoxication, withdrawal, exposure
2. Substance/medication **capable** of producing symptoms

C. NOT better explained by independent depressive disorder

- Symptom onset preceding substance/med use
- Symptom persistence after cessation of sub/med use/intox/withdrawal
- Other evidence (previous non-sub/med-induced episodes)

D. Not exclusively during **delirium**

E. Causes significant distress or impairment

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Substance/Med-Induced Depressive Disorder – Specifiers

- *Specify substance:*
  - Alcohol
  - PCP
  - Other hallucinogen
  - Inhalant
  - Opioid
  - Sedative, hypnotic or anxiolytic
  - Amphetamine (or other stimulant)
  - Cocaine
  - Other (or unknown) substance
  - ***NOT CAFFEINE OR CANNABIS***

- *Specify onset:*
  - **With onset during intoxication**
  - **With onset during withdrawal**

	Psychotic disorders	Bipolar disorders	Depressive disorders
Alcohol	I/W	I/W	I/W
Caffeine			
Cannabis	I		
Hallucinogens			
Phencyclidine	I	I	I
Other hallucinogens	I*	I	I
Inhalants	I		I
Opioids			I/W
Sedatives, hypnotics, or anxiolytics	I/W	I/W	I/W
Stimulants**	I	I/W	I/W
Tobacco			
Other (or unknown)	I/W	I/W	I/W

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Substance/Med-Induced Depressive Disorder – Diagnostic Features

- Persisting depressive symptoms assoc with use of substance
  - Beyond expected length of physiological effects, intoxication, withdrawal
  - Should develop within 1 month of substance use
  - Substance must be capable of producing symptoms
  - May have protracted withdrawal state → long-lasting depressive sx

- Not better explained by independent depressive disorder
  - Onset, course, other factors (history, physical labs)

- Associated medications
  - Stimulants, steroids, L-dopa, antibiotics, dermatological agents
  - CNS drug, chemotherapy drugs, immunological agents
  - Distinguish from recurrence of previously established condition

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Substance/Med-Induced Depressive Disorder – Prevalence, Development & Course

- Lifetime prevalence = 0.26%

- Onset during substance use or withdrawal
  - Often **onset within 1 month** of use
  - Once discontinued → symptom **remission within days to weeks**
    - May depend on half-life, withdrawal syndrome
    - If persisting beyond 4 weeks → consider other causes

- Implicated medications
  - Antivirals (efavirenz)
  - Cardiovascular agents (clonidine, guanethidine, methyldopa, reserpine)
  - Retinoic acids (isotretinoin)
  - Antidepressants, anticonvulsants, antipsychotics
  - Anti-migraine agents (triptans)
  - Hormonal agents (corticosteroids, OCP, GnRH agonists, tamoxifen)
  - Smoking cessation agents (varenicline)
  - Immunological agents (interferon)

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Substance/Med-Induced Depressive Disorder – Risk & Prognostic Factors

- Temperamental
  - Related to risk pertaining to specific drugs
  - Common risk factors: **hx MDD, hx drug-induced dep, psychosocial stress**

- Environmental
  - Risk factors associated with specific medications
  - High doses (i.e. > 80mg prednisone equivalents) or high plasma concentrations
  - **HIGH estrogen/progesterone content** in OCP

- Course modifiers
  - Compared to MDD without SUD, substance-induced depressive disorder more likely:
    - **Male, black, max high school diploma**
    - **Lack insurance, lower family income**
    - Higher family hx of SUD, **antisocial behavior**
    - Higher 12-month hx of stressful life events
    - Greater # of DSM-IV MDD criteria (worthlessness, sleep Δ, SI)
  - Less likely to report depressed mood, parental death before age 18

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Substance/Med-Induced Depressive Disorder – Suicide Risk

- Drug-induced suicidality → usually temporally associated
  - Distinguish from underlying primary mental disorders

- Treatment-emergent suicidality with antidepressants
  - US FDA meta-analysis → **no increased risk across all adults**
    - Elevated in **ages 18-24 (not significant)**
    - Absolute risk = **0.01% (extremely rare)**
  - Still black-box warning in 2007

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Substance/Med-Induced Depressive Disorder – Differential Diagnosis

- Substance intoxication/withdrawal
  - Only dx substance/med-induced depressive disorder IF depressive sx severe enough to warrant independent clinical attention

- Primary depressive disorder

- Depressive disorder due to AMC
  - Distinguish whether consequence of AMC or mediation tx
  - May need treatment change to determine
  - Both diagnosis can be given
  - If insufficient evidence → other/unspecified

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Substance/Med-Induced Depressive Disorder – Comorbidity

- Substance-induced depressive disorder (vs MDD with**out** SUD) associated with:
  - Higher psychiatric comorbidity
  - Pathological gambling
  - **Paranoid, histrionic, antisocial PDs**
  - LESS likely to have persistent depressive disorder (PDD)

- Substance-induced depressive disorder (vs MDD with SUD)
  - More likely AUD, multiple SUDs
  - Histrionic PD
  - LESS likely to have PDD

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Depressive Disorder due to AMC

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Depressive Disorder due to AMC – Diagnostic Criteria

A. **Depressed mood or anhedonia** predominates clinical picture

B. Evidence of **direct pathophysiological consequence** of AMC

C. Not better explained by another mental disorder
   - i.e. Adjustment disorder with depressed mood

D. Not exclusively during delirium

E. Significant distress or impairment

Specify if:

1. **With depressive features:** full MDE criteria NOT met
2. **With major depressive-like episode:** full MDE criteria met
3. **With mixed features**: mania/hypomania sx present, not predominant

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Depressive Disorder due to AMC – Diagnostic Features

- First establish presence of general medical condition
  - Must be **etiologically related**, through physiological mechanism
  - Temporal association
  - May have atypical features of depression (age of onset, no family hx)

- Clear associations + neuroanatomical correlates
  - Stroke, TBI
  - Huntington's disease, Parkinson's disease
  - Multiple sclerosis

- Neuroendocrine conditions
  - Cushing's disease, hypothyroidism

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Depressive Disorder due to AMC – Development & Course

- Following stroke
  - Can be **very acute onset** of depression → within 1 day
  - Can also be **weeks-months** after CVA
  - Duration of MDE → **9-11 months** (average)

- Huntington's disease
  - **Early onset of depression in course** → first neuropsychiatric symptom
  - Depression often **precedes major motor/cognitive impairments**
  - May be less common as dementia of Huntington's disease progresses

- Parkinson's disease
  - Depression also often **precedes major motor/cognitive impairments**

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Depressive Disorder due to AMC – Risk & Prognostic Factors

- Following stroke
  - Strongly correlated with **lesion location** for depression within days of CVA
    - Greatest risk from **LEFT frontal strokes**
    - Least risk from **right frontal lesions**
  - No location correlation for depression 2-6 months after CVA

- **Gender Issues:** Pertain to gender difference related to AMC
  - SLE more common in FEMALES
  - Stroke more common in middle-age males

- **Diagnostic markers:** Pertain to diagnostic markers related to AMC
  - Cushing's disease → steroid levels (may be assoc with mood syndromes)

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Depressive Disorder due to AMC – Suicide Risk and Fn Consequences

- No epidemiological studies comparing primary vs AMC MDE

- Suicide risk increased in MDE assoc with serious medical illness
  - Esp shortly **after onset or diagnosis**

- Pertain to functional consequences of AMC
  - ? Curing underlying disease may prevent recurrence of MDE

- Static TBI, CNS diseases
  - May have episodic mood episodes

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Depressive Disorder due to AMC – Differential Diagnosis

- Depressive disorder NOT due to AMC
  - Depressive episodes prior to AMC
  - Whether AMC can cause depressive disorder
  - Temporal relationship with worsening of AMC

- Medication-induced depressive disorder

- Adjustment disorders
  - Pervasiveness of depressive picture, severity of symptoms
  - Medical condition itself is stressor

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Depressive Disorder due to AMC – Comorbidity

- Pertain to AMC

- Delirium
- Anxiety (usually generalized symptoms)

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Other Specified Depressive Disorders

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Other Specified Depressive Disorders

- Does not meet full criteria for any depressive disorder
- Clinician chooses to communicate specific reason

- Recurrent brief depression: 2-13 days, once/month, 12 months

- Short-duration depressive episode: 4-13 days

- Depressive episode with insufficient symptoms

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Unspecified Depressive Disorder

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Unspecified Depressive Disorder

- Does not meet full criteria for any depressive disorder
- Clinician chooses NOT to communicate specific reason

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Specifiers for Depressive Disorder

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Specifiers – With Anxious Distress

A. With anxious distress

1. 2+/5 symptoms, majority of MDE/PDD
   - **Tense, keyed up**
   - Unusually **restless**
   - **Concentration** difficulty due to worry
   - Fear **something awful** may happen
   - Feeling of **losing control** of self

- *Specify current severity*
  - Mild: 2 sx
  - Moderate: 3 sx
  - Mod-severe: 4-5 sx
  - Severe: 4-5 sx + motor agitation

- Prominent feature of bipolar disorder + MDD
  - **Higher suicide risk**, longer illness duration, higher tx non-response

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Specifiers – With Mixed Features (MDE)

A. With mixed features (MDE)

1. 3+/7 manic/hypomanic symptoms, majority of MDE
   - **Elevated/expansive mood**
   - **Grandiosity,** inflated self-esteem
   - **Pressured speech,** more talkative
   - **Flight of ideas,** racing thoughts
   - **Goal-directed activity/energy increased** (social, work, school, sexual)
   - **Risky activities increased**
   - **Sleep needs less,** still rested

B. Mixed sx → observable by others, change from baseline

C. If full criteria for mania/hypomania → dx bipolar I/II

D. Not due to substance

- Mixed features in MDD → sig risk factor for bipolar I/II

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Specifiers – With Melancholic Features

A. With melancholic features

1. 1+/2 sx, during most **severe period** of current MDE
   - **Loss of pleasure,** in activities
   - **Lack of reactivity,** to usually pleasurable stimuli
2. 3+/6 sx
   - **Despair,** despondency, moroseness or empty mood
   - **MORNINGS worse** depression
   - **EARLY-MORNING awakening** (>2 hours earlier)
   - **Psychomotor agitation/retardation**
   - **Anorexia/WEIGHT LOSS,** significant
   - **Guilt,** excessive/inappropriate

- Near-complete absence of capacity for pleasure
  - Mood barely brightens (20-40%, only briefly)
  - Distinct quality, different than non-melancholic MDE
    - Almost **always psychomotor sx**
    - Modest **tendency to repeat**
  - More frequent in → inpatients, severe MDE, if psychotic features present

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Specifiers – With Atypical Features

A. With atypical features

1. **Mood reactivity,** majority of current MDE/PDD
   - Capacity to be cheered up by positive events
   - Euthymic if favorable external circumstances
2. 2+/4 sx
   - **Significant weight GAIN/appetite**
   - **HYPERsomnia** (>10 hrs total, or >2 hours more)
   - **Leaden paralysis** (heavy arms/legs, >1 hour per day)
   - **Interpersonal rejection sensitivity** (not just due to mood, impairing)
3. Not due to "melancholic features" or "catatonia" in same MDE

- Distinguish from classic/endogenous patterns
  - **Interpersonal rejection sensitivity** is pathological
    - Early onset, **persists for adult life**, even if not depressed

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Specifiers – With Psychotic Features

A. With psychotic features

1. **Delusions/hallucinations** present

- Mood-CONGRUENT psychotic features
  - Content consistent with typical depressive themes
  - Inadequacy, **guilt**, disease, death, nihilism, deserved punishment

- Mood-INCONGRUENT psychotic features
  - Content NOT consistent with typical depressive themes
  - May be MIXED congruency

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Specifiers – With catatonia

A. With catatonia

1. **Present for most of MDE**

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Specifiers – With peripartum onset

A. With peripartum onset
   1. If current/recent MDE **during pregnancy or within 4 weeks** of delivery

- Prevalence = 3-6% → **50%** of these cases occur **prior to delivery**
  - Can have severe anxiety, panic attacks
  - Mood/anxiety sx during pregnancy, "baby blues" → increased risk of post-partum MDD

- Specific if with psychotic features
  - **Infanticide** most often associated with psychotic features
    - Command hallucination to kill infant
    - Delusions that infant is possessed, other themes
  - 1 in 500-1000 deliveries
    - May be **more common in FIRST pregnancy**
    - Incr risk if → previous post-partum mood episode, hx depressive/bipolar disorder, family hx bipolar
    - **Risk of recurrence 30-50%** (in each subsequent delivery)
  - **Rule out delirium**

- May impact breastfeeding, subsequent family planning

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Specifiers – With seasonal pattern

A. With seasonal pattern

1. **Temporal relationship,** recurrent MDD at certain time of year
   - Not due to seasonally-related psychosocial stressors
2. **Full remission or change to mania/hypomania** at certain time of year
3. Seasonal pattern for **past 2 years, NO non-seasonal MDE**
4. **More seasonal MDE over lifetime** (than non-seasonal)

- Onset/remission → at characteristic time of year
  - Usually onset fall/winter → remit in spring
  - Less common summer MDE
  - Prominent **decreased energy, hypersomnia, wt gain, carb craving**

- Unclear if more likely in MDD or bipolar (but **bipolar II > I**)
- High prevalence of winter-type if:
  - **Higher latitude, younger; prevalence varies with sex**

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Specifiers – Remission

- In partial remission
  - No longer meets full MDE criteria, OR
  - **< 2 months** with NO symptoms

- In full remission
  - ≥ 2 months with NO symptoms

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Specifiers – Severity

- Mild
  - **Few/no symptoms in excess** for diagnosis
  - **Manageable** intensity
  - Minor impairment

- Moderate
  - Between mild & severe

- Severe
  - **More than required symptoms** for diagnosis
  - **Unmanageable** intensity
  - Marked impairment