Depressive Disorders and Management

Sheldon P. Wagman, D.O., F.A.C.N.

Course Objectives

- Review of the Depressive Disorders
- Suicide Issues
- The Treatment Options for Depression
- Being Psychologically Tuned
- Referral / Crisis Sources
- References

Symptoms of Depression

- Depressed Mood
- Suicidal Thought
- Changes in Sleep
- Feelings of Guilt / Worthlessness
- Psychomotor Agitation or Retardation
- Impaired Concentration
- Changes in Weight
- Loss of Interest in Usual Activities
- Fatigue

DEPRESSIVE DISORDERS

I. Epidemiology
A. Lifetime prevalence
   1. Men 7-12%
   2. Women 20-25%
B. Prevalence in Primary Care Setting
   1. 5-10%
   2. 20-40% with coexisting medical problems
C. *A recurring illness
   50%-1st, 70%-2nd, 90%-3rd

DEPRESSIVE DISORDERS

II. Clinical Features
A. High mortality; 15% suicide rate
B. Depression can complicate the presentation and treatment of patients with medical conditions.
DEPRESSIVE DISORDERS

II. Clinical Features

D. Suicide risk may paradoxically increase as the patient begins to respond to treatment. Initiative and energy can improve allowing patients to follow through with suicidal ideas.

E. Suicide risk is most related to the degree of hopelessness a patient is experiencing and NOT the degree of depression.
**CASE HISTORY**

A 37 year-old woman comes to see her internist with a chief complaint of depressed mood, inability to sleep, difficulty concentrating and focusing, a weight loss of 8 lbs, feelings of hopelessness to the degree that she is considering suicide. She reports these symptoms have intensified over the past 10 months following the death of her husband from cancer.

**III. Classification of Depressive Disorders**

A. Adjustment Disorder with Depressed Mood:
B. Chronic/Recurrent
C. Psychotic Features
D. Catatonic Features
E. Melancholic features
F. Atypical Features
G. Postpartum onset
H. Seasonal Pattern

---

**DYSTHYMIC DISORDER**

**DSM-IV-TR Diagnostic Criteria**

A. Depressed mood most days, more days than not which has been present for at least two(2) years.

B. Presence of at least two(2) of the following:
   1. Lack of appetite or overeating
   2. Insomnia or hypersomnia
   3. Low energy or fatigue
   4. Low self-esteem
   5. Difficulty concentrating or making decisions
   6. Hopelessness

**DYSTHYMIC DISORDER**

**Clinical Features**

1. Loss of pleasure - anhedonia
2. Feeling inadequate
3. Social withdrawal
4. Guilt
5. Irritability
6. Multiple physical complaints, i.e., headache, stomach ache, back ache
7. Impaired occupational and / or interpersonal functioning
8. Psychotic symptoms **ABSENT**

---

**CASE HISTORY**

A 42 year-old man is brought for evaluation because of irritability, despondency, insomnia, difficulty concentrating and a 6 lb. weight loss since the death of his best friend who had battled hepatitis C for the past two years. He states that he has been depressed on and off since childhood. He has been able to work and be a husband to his wife and a father to his children. He denies suicidal ideation or hallucinations.

**Dysthymia + Major Depression = Double Depression**
CASE HISTORY
A 34 year-old man has felt unhappy, sad, low self esteem, guilty, difficulty concentrating and focusing, episodes of insomnia and dissatisfaction with interpersonal relationships most of his life. In the past 4 weeks he has become severely depressed, irritable, helpless, worthless and unable to find anything that is pleasurable. He was laid off from his job of 8 years 5 weeks ago with no severance package or health insurance coverage.

The suffering of the suicidal person is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description. Kay Redfield Jamison

SUICIDE
Derived from Latin word for “self murder”

INCIDENCE
• 8th leading cause of death in USA – 30,000 deaths / year
• 600,000 attempts made yearly
• In USA every 20 minutes a person commits suicides — about 85/day
• 1983-1998 suicide rate relatively stable except in 15-24 year olds - 2-3 fold increase
• Golden Gate Bridge – San Francisco more than 800 suicides since the bridge opened in 1937

ELEVEN MYTHS ABOUT SUICIDE
Numerous misconceptions exist about suicide. Physicians must be alert to these inaccurate assumptions so that they can assess and treat patients effectively.

GENDER
• Men 3:1 – succeed using more lethal methods i.e., firearms
• Women 4:1 - more likely to attempt
• Firearms most common method used

E.S.Shneidman
AGE

- Highest risk people - 75 or older - more than three(3) times the rate than with young people
- Elderly white males at greatest risk because:
  - Failing health with physical impairments
  - Death of loved ones
  - Cognitive loss from dementing processes
  - Depression - Anxiety
  - Polypharmacy
  - Unemployed
- Third leading cause is in 15-24 age group

SOCI ECONOMIC AND PROFESSIONAL STATUS

- Physicians at great risk 36/100,000 - 2 to 3 times the general population
  - Woman physicians 41/100,000
  - Women nonphysicians 12/100,000

Causes
- High level of stress
- Access to prescription medications
- Alcohol and drug abuse
- Reluctance to seek help
- Previous diagnosed mental disorder

CLINICAL ASSESSMENT

- Recent thoughts about suicide
- *Previous suicide attempts or fantasies about suicide
- Views about death including religious beliefs and ideas about afterlife
- Presence of symptoms of:
  - Depression
  - Panic anxiety - panic attacks
  - *Hopelessness - exhaustion
  - *Plan - intent - availability of means
- Concerns for effect on family members “they will be better off if I am gone”

CLINICAL ASSESSMENT

- Verbalized suicidal ideation to coworkers - friends - family
- *Preparation of a will - fired from a job - giving away valued possessions
- Current or prior life stressors
- *Substance use and abuse
- Impulsiveness
- *Family history of mental illness including suicide attempts
- Lack of support system
- History of recent psychiatric treatment

SUICIDE AND SUBSTANCE ABUSE

- Alcohol
  - Implicated in 25-50% of all suicide attempts
  - Up to 15% of alcoholics commit suicide
    270/100,000 annually in U.S. – 7,000 to 13,000/year
  - Up to 40% of suicidal alcoholics have history of previous suicide attempts
  - Up to 40% of alcohol suicides occur within a year of the last hospitalization

SUICIDE VS HOMICIDE
Why do patients not receive effective treatment for their depression?

"TIME"

1) Internist, PCP’s, PA’s and NP’s give preferential attention to physical illness
2) Patients may have insufficient access to a mental health specialist
3) Physicians do not adequately monitor the psychiatric medications prescribed
4) Patients are reluctant to accept the stigma of mental illness

Biopsychosocial Model Versus Evidence Based Model

Compliance

In General:

One third comply completely
One third comply with certain aspects of the treatment
One third do not comply

TREATMENT for DEPRESSION

Interpersonal Therapy
Uses the relationship between therapist and patient as the curative agent.

Cognitive - Behavior Therapy (CBT)
Focuses on controlling pessimistic thinking so the patient can break the cycle of negative thoughts, expectations, and actions.

TREATMENT for DEPRESSION

Individual Psychotherapy
Focuses on past events and internal conflicts that may interfere with the patient’s ability to achieve his/her full potential currently.

Group Psychotherapy
Enables patients to receive support from other patient’s in the group. Helps patient’s achieve more effective relationships with friends, significant others and people at work.
Medications

- Medications are not a goal of treatment, but rather they can help patients reach their own goals.
- Medications are a tool for recovery and can make non-pharmacological treatments more effective.

Ronald Diamond, M.D. Professor of Psychiatry in the School of Medicine and Public Health at the University of Wisconsin

### Secondary Amines
- Desipramine (Norpramin)
- Protriptyline (Vivactil)
- Nortriptyline (Pamelor)

### Tertiary Amines
- Imipramine (Tofranil)
- Amitriptyline (Elavil)
- Doxepin (Sinequan – Silenor)
- Clomipramine (Anafranil)

### Tetracyclic Amines
- Maprotiline (Ludiomil)
- Amoxapine (Asendin)
- Mirtazapine (Remeron)

*Problems with TCA’s
- Side effects – anticholinergic
- Lethality – cardiac arrhythmia’s

### Selective serotonin Reuptake Inhibitors (SSRIs)
- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Fluvoxamine (Luvox)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Vilazodone (Viibryd)

### SSRI - SNRI Side Effects
- Weight issues
- Sexual issues
- Headaches
- Insomnia
- GI upset
- Suicide ideation

Discontinuation Syndrome
- Dizziness, nausea, irritability, headaches, diarrhea, electric shocks down arms and legs nervous, anxious, sweating, fearfulness
Antidepressant Medications

6. Monoamine Oxidase Inhibitors (MAOI’s)
   a. Phenelzine (Nardil)
   b. Tranylcypromine (Parnate)
   c. Selegiline (Emsam)

7. Miscellaneous Antidepressants
   a. Trazodone (Desyrel – Oleptro)
   b. Bupropion (Wellbutrin)

Other Treatments for Depression

Electroconvulsive Therapy (ECT)
Vagus Nerve Stimulation
rTranscranial Magnetic Stimulation
Deep Brain Stimulation

Crisis Numbers

1-800-SUICIDE
480-784-1500 (Maricopa County)
602-222-9444 (Maricopa County Crisis Line)
1-800-631-1314 (Maricopa County Crisis Line)
1-866-205-5229 (Arizona – toll free)
480-736-4949 (Sexual Assault Hotline – Maricopa County)

EMPACT – Suicide Prevention Center
618 S. Madison Dr. Tempe, AZ 85281
480-784-1514

References

• R.K.Hahn, L.J.Albers, C.Reist : Current Clinical Strategies – Psychiatry
• L.J.Albers, R.K.Hahn, C.Reist : Handbook of Psychiatric Drugs – Current Clinical Strategies

Medicine is a Jealous Mistress