Diagnosis and Clinical Features of Depressive Disorders

Introduction

- Mood disorders are characterized by pervasive dysregulation of mood and psychomotor activity and by related biorhythmic and cognitive disturbances.
- Depression conceptualizes a variety of psychic and somatic syndromes.
- The diagnosis is derived from diligent clinical observation.
- Depression as a term in popular use is mostly considered to be synonymous with low mood or grief.

DSM-5

The broad category of depressive disorders includes:

- Major depressive disorder (MDD)
- Dysthymic disorder
- Premenstrual Dysphoric Disorder (PMDD)
- Depressive disorder due to another medical condition
- Substance/medication induced depressive disorders
- Disruptive Mood Dysregulation Disorder (DMDD)
- Depressive disorder not otherwise specified.

ICD-10

- **F06.3Organic mood [affective] disorders**

  F06.32- Organic depressive disorder
- **Substance related depressive disorder**

  F1x.54 Psychotic disorder, predominantly depressive symptoms
- Post-schizophrenic depression

- **F32 Depressive episode**
- **F33 Recurrent depressive disorder**
- **F34.1 Dysthymia**

ICD-10 v.s DSM-5

- The diagnostic criteria are essentially the same with regard to nature of symptoms, duration and exclusion criteria
- The difference is in the number of required symptoms.
- ICD-10: depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. (Core Sx) along with other Sx.

grades of severity are specified to cover a wide range of clinical states

'Somatic syndrome': 4 out of 9 sx

ICD-10 v.s DSM-5

- DSM-5: Five or more of the Sx along with either depressed mood or loss interest/pleasure. One of the 9 sx cluster is- Psychomotor agitation/retardation

Points to consider when making diagnosis of depression

- By definition, a major depressive disorder should be incapacitating.
- Is usually perceived as a break from a person's usual or premorbid self.
- Often experienced by the patient as qualitatively distinct from grief or other understandable reactions to loss or adversity
- H/o past episodes
- Family history

Single-Episode & Recurrent Subtypes

- One third of all major depressive episodes do not recur (single episode)

Such pts are usually older, lack +ve family history, protracted course of disorder (1-2 yrs).

- First episodes of recurrent major depressive disorder

Such pts tends to be younger, h/o a depressive temperament or dysthymic disorder.

- Those who switch to bipolar disorder are more likely to have experienced recurrent depressions (5 or more episodes).

Prototypical course of recurrent depression

- MDD, recurrent, with no antecedent dysthymic disorder and a period of full remission between the episodes.
- MDD, recurrent, with no antecedent dysthymic disorder but with prominent symptoms persisting between the two most recent episodes (i.e., partial remission is attained).
- MDD, recurrent, with antecedent dysthymic disorder and no period of full remission between the two most recent episodes. (20-25% of pts)
- MDD, recurrent with antecedent dysthymic disorder but with full interepisode recovery between the two most recent episodes (<3% of pts)

Dysthymia

Core concept of dysthymic disorder refers to a sub affective disorder with

(1) low-grade chronicity for at least 2 years,

(2) insidious onset with origin often in childhood or adolescence, and

(3) persistent or intermittent course.

compatible with relatively stable social functioning.

Dysthymia- Clinical feartures

- Sx tend to outnumber signs (more subjective than objective depression).
- Marked disturbances in appetite and libido are uncharacteristic, and psychomotor agitation or retardation is not observed.
- A depression with attenuated symptomatology.
- The essential features of such primary dysthymic disorder include habitual gloom, brooding, lack of joy in life, and preoccupation with inadequacy.
- Dysthymia then can be viewed as a more symptomatic form of that temperament, a depressive personality disorder

Post-psychotic Depressive Disorder of Schizophrenia

a)the patient has had a schizophrenic illness meeting the general criteria for schizophrenia within the past 12 months
(b)some schizophrenic symptoms are still present; and
(c)the depressive symptoms are prominent and distressing, fulfilling at least the criteria for a depressive episode.

Premenstrual Dysphoric Disorder

- Mood lability, irritability, dysphoria, anxiety symptoms
- Occur repeatedly during premenstrual phase
- Remit with onset and progress of menses.

Positive family h/o mood disorders

Important to exclude bipolar features in such pts.

Depression with atypical features

- Reverse vegetative signs with rejection sensitivity, often contrasted to melancholia
- Atypical features are so common in bipolar disorder, especially bipolar II disorder.
- It is clinically wise to exclude bipolar II disorder, especially where hostile-labile features predominate.

Some terms not in current nosology

- Minor depressive disorder
- Recurrent brief depressive disorder
- Reactive depression
- Chronic demoralization

Clinical features

- **Mood** described as “sad”, “low”, “hopeless”
- Sadness may be denied initially, but may be elicited in the interview.
- Somatic complaints may be emphasized
- Many pts report irritability, frustration, anger, outbursts
- Mood remains depressed nearly everyday, most of the day, in almost all circumstances

Clinical features

Anhedonia and loss of interest

- Pts report they have lost the sense of pleasure
- The patient give up previously enjoyed pastimes.
- In the extreme, patients lose their feelings for their children or spouses, who once were a source of joy.

Thus, the hedonic deficit in clinical depression might represent a special instance of a more pervasive inability to experience emotions.

Clinical features

Psychomotor Disturbances

Although agitation (pressured speech, restlessness, hand wringing, and hair pulling) is the more readily observed abnormality, it appears to be less specific to the illness than retardation (slowing of psychomotor activity

- The pt experiences inertia, being unable to act physically and mentally.

Clinical features

- paucity of spontaneous movements
- slumped posture with downcast gaze
- overwhelming fatigue (patients complain that everything is an effort)
- reduced flow and amplitude of speech and increased latency of responses, often giving rise to monosyllabic speech
- a subjective feeling that time is passing slowly or has stopped
- poor concentration and forgetfulness
- painful rumination or thinking
- indecisiveness (an inability to make simple decisions).

Clinical features

Cognitive Disturbances

- The cognitive view of depression considers negative evaluations of the self, the world, and the future (the negative triad)
- Faulty thinking patterns are clinically expressed as (1) ideas of deprivation and loss; (2) low self-esteem and self-confidence; (3) self-reproach and pathological guilt; (4) helplessness, hopelessness, and pessimism; and (5) recurrent thoughts of death and suicide.

The essential characteristic of depressive thinking is that the patient views everything in an extremely negative light.

Clinical features

- Psychotic features (mood congruent)

According to Kurt Schneider, delusional thinking in depression derives from humankind's four basic insecurities—those regarding health, financial status, moral worth, and relationship to others.

Delusions of ill health, poverty, guilt, nihilism, worthlessness, reference/persecution

A minority of depressed pts have fleeting auditory or visual hallucinations with extremely unpleasant content along the lines of their delusions (e.g., hearing accusatory voices or seeing themselves in coffins or graveyards).

Clinical features

Hopelessness and Suicide

- The risk of suicide is less pronounced during acute severe depression.
- When psychomotor activity is improving, yet mood and thinking are still dark, that the patient is most likely to muster the requisite energy to commit the suicidal act.
- Hopelessness increases suicide risk.
- Pts are often relieved that the physician asks for & appreciates the magnitude of their suffering.

Clinical features

- Suicidal ideation is commonly expressed indirectly (e.g., in a wish not to wake up or to die from a malignant disease).
- Some depressed persons are constantly resisting unwanted urges or impulses to destroy themselves.
- Others might yield to such urges passively (e.g., by careless driving or by walking into high-speed traffic).
- A third group harbors elaborate plans, carefully preparing a will and taking out insurance.

Clinical features

Vegetative Disturbances

The most reliable somatic indicators of depressive disorder include **anorexia** and **weight loss**.

Weight gain

Insomnia: multiple awakenings, especially in the early hours of the morning, rather than by difficulty falling asleep

Young depressed patients, especially those with bipolar tendencies, often exhibit excessive sleep and have difficulty getting up in the morning.

Clinical features

Seasonality

Some autumn–winter depressions belong to the bipolar spectrum (type II).-- related to reduction of daylight (photoperiods)

There also exist summer depressions---appear to be related to increased temperature.

Clinical features

Sexual Dysfunction

- Decreased sexual desire
- Depressed women are often unresponsive to lovemaking or are disinclined to participate in it, a situation that could lead to marital conflict.
- Erectile dysfunction in males

	bipolar	Unipolar
1.h/o mania or hypomania	yes	No
2.Temprament & personality	cyclothymic	Dysthymic
3. Sex ratio	Equal	W>M
4. Age of onset	Teens , 20,30	30,40,50
5. Post partum episode	More common	Less common
6. Onset of episode	Abrupt	Insidious
7. no. of episodes	3-6	3-12
8. PMA	Retardation >agitation	agitation>retardation
9. Sleep	Hypersomnia>insomnia	Insomnia>hypersomnia
10. Family history in BPAD	yes	+/-
11. f/H in unipolar	Yes	yes
12. Pharmacological response as antidepressant	Induce hypomania - mania	+/-
13. Lithium carbonate	Prophylaxis	+/-

THANK YOU