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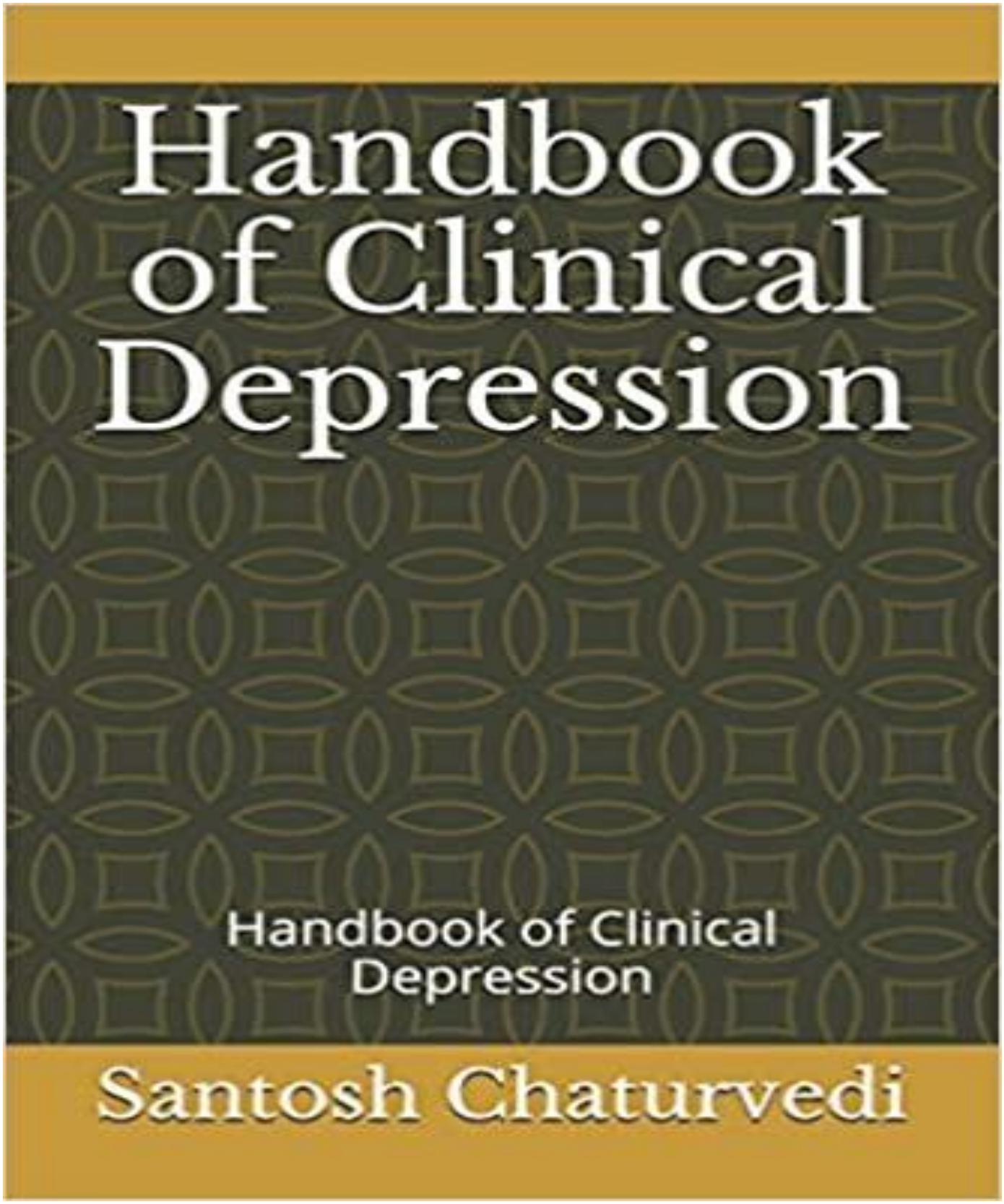
Handbook of Clinical Depression
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Santosh Chaturvedi

HANDBOOK OF CLINICAL DEPRESSION

for

Family Physicians, General Practitioners, Nurses &

Mental Health Professionals

Santosh K Chaturvedi MD [Psychiatry]. FRCPsych [UK]

Consultant Psychiatrist
Former Dean Behavioural Sciences &
Senior Professor of Psychiatry [Retired]
National Institute of Mental Health & Neurosciences
Bangalore India

The book has been written in Indian English.

First Edition: January 2021

Last updated in February 2021

Disclaimers: Medical sciences are not precise, and medical knowledge is constantly changing with addition of new findings and discoveries from research opinion differ. The views expressed in the book are those of the editor. Readers are advised to consult the latest information about treatments including pharmacological, psychosocial and alternative therapies and to be guided by their local guidelines. It is the responsibility of the practitioner to exercise judgement regarding treatments they provide to their patients. Neither the publishers, nor the editors are responsible or liable for any damage caused to an individual, organization or property from the publication

ISBN-13: 979-8594786264

The author of this book, Dr Santosh Kumar Chaturvedi, MD (Psychiatry) FRCPsych (UK), was previously associated with the National Institute of Mental Health & Neurosciences, NIMHANS, Bangalore as Dean, Behavioral Sciences, and Senior Professor and Head of Department of Psychiatry. He was also the Head of Department of Mental Health Education, and Head of Psychiatric Rehabilitation Services at NIMHANS, Bangalore.

Publisher: Self published by Santosh K Chaturvedi

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Preface

Depression is one of the commonest problems in clinical practice. It causes social, occupational, financial, and interpersonal difficulties. Moreover, depression also causes increased medical morbidity and mortality through suicide, accidents, and worsening of medical problems such as cardiac diseases, respiratory diseases and stroke. Most people suffering from depression first go to their general physicians or family physicians. However, most physicians are very busy and preoccupied with general medical problems. Moreover, the general physician is not well acquainted with psychiatric problems. This difficulty is further compounded by the fact that many medical illnesses may cause depression, either directly or indirectly.

Further, the medical treatment of number of physical illnesses can be complicated by depression. These many facets of depression are likely to pose a clinical problem or challenge to physicians and medical specialists.

This book attempts to help medical specialists and general physicians by introducing them to current developments and fundamental skills in appropriately diagnosing and treating depression.

Acknowledgements: The author thanks Dr. Ravi Phillip Rajkumar, MD, Senior Resident in Psychiatry for updating certain chapters of this book.

Chapter 1 Introduction

What is depression?

Sadness, often referred to as "depression", is a normal emotion. All people at some time or the other experience low mood, low spirits, disinterest or disgust. Like all emotions, it serves an important function. Sadness can be understood as the mental equivalent of physical pain. It acts as a signal or warning to inform us of a loss, or of the failure to attain a particular goal. This, in turn, leads to certain behaviours that help us cope with such situations.

In certain situations, and circumstances, this normal response crosses a limit: it becomes either unbearable or problematic, lasts longer than expected, or interferes with sleep, appetite or day to day functioning. Depression is ubiquitous. The word "depression" is often confusing to doctors and laypersons alike, because it is interchangeably used to describe an emotion, a symptom, a syndrome, and a disease in the classic meanings of those words. A person who feels sad over a life event or stressor may describe himself as feeling "depressed", but this is quite different from the disorder known as depression or depressive disorder. The term "clinical depression" has been used by some doctors to make a distinction between the two. Because of the very diversity of depression in all its aspects, the problems at both theoretical and clinical levels are at once stimulating, challenging, and often frustrating.

Epidemiology or magnitude of depression

How common is depression?

Depression, as mentioned above, can be a symptom of a variety of conditions. The group of conditions in which sadness of mood is the predominant symptom, or one of them, are referred to as depressive disorders. They are one of the commonest types of psychiatric disorders. They are also the commonest psychiatric problems that a general practitioner or

family physician is likely to encounter, in some form or the other. Unfortunately, depressive disorders are also the most likely conditions to be missed, go undetected or inappropriately treated in such a setting. A major psychotic episode, let us say, of schizophrenia, can be diagnosed and treated with much more ease than an episode of mild or moderate depression.

Epidemiological data on depression in India has been gathered from two sources – the general population and various clinics. In the general population, depression has been found, on an average, in about 34 people per 1,000 population, or 3.4%. Clinic-based studies have noted rates of 6% to 35%. Recent work has found that about 10% of patients seeking treatment in primary health centers may have depression. Thus, depression is a common disorder. These studies have also found that milder, chronic forms of depression are much more common than severe, "psychotic" forms of depression that are generally treated as in-patients in psychiatric settings.

Gender differences

Depression is consistently found to be more common in women than in men, with a ratio of approximately 2 to 1. While morbidity is higher in women, mortality in the form of suicide is greater in men. Suicidal attempts – sometimes referred to as parasuicide - on the other hand, are more common among women. However, this may not be true in India, where the use of methods such as poisoning and self-immolation among women may result in almost equal mortality compared to men: male-to-female ratios of 1:1.2 to 1:1.7 have been found. A study from Chennai found that depression was associated with a 19-fold increase in the risk of suicide.

Age variations

Although there are indications that the prevalence of depression is highest in middle age – in the third and fourth decades of life - it occurs at all ages. There are certain unique characteristics of depression at the extremes of the age spectrum, childhood and the elderly, which will be dealt separately in later chapters.

Other demographic variations

There are indications that the rates of depression in North India may be higher than those in South India. The exact reasons for this are unknown, and this difference may be due to differences in the ways in which studies were carried out. Common reasons for this variability may include diagnostic practices or methodological issues, bias/tolerance to depressive symptoms, genuine differences in susceptibility to illness or its frequency of occurrence, and demographic and cultural differences. A study from West Bengal suggested that, while the rates of mental disorders as a whole remained fairly stable over a period of 20 years, rates of depression had increased during this period.

What are the risk factors?

A number of risk factors associated with depressive disorders have been noted: female gender, personality type, unemployment, poverty, illiteracy, problems in personal relationships, lack of social support, certain occupations (for example, business), certain castes, and living arrangements, such as men living in joint families. Depressive disorders sometimes run in families, with many members being affected. Having a chronic physical illness, or another mental disorder, also raises the risk of depression. Certain factors, such as a supportive family, social or religious environment, may protect against depression.

To Recapitulate …

- Depressive disorders are one of the commonest types of psychiatric disorder.
- The general practitioner or family physician is likely to encounter depression, in one form or another, as the commonest psychiatric problem.
- Clinic-based studies on depression in India have noted rates of 6% to 35%.
- Depression is more common in women than in men, at a ratio of approximately 2 to 1.
- Although there are indications that the incidence of depression is highest at middle age, it occurs at all ages.

- ❖ There are indications of higher rates of depression in North India compared to South India.
- ❖ Risk factors for depression are
- Female gender,
- Social or economic deprivation – poverty, illiteracy, unemployment, caste status,
- Personality type,
- Problems in personal relationships – such as marital disharmony,
- Lack of social support,
- Genetics – though this does not apply in all cases
- Having another chronic physical or mental illness.

Chapter 2 What causes depression?

No single factor can possibly explain this complex human experience of depression. Thus, depression is considered to be a multifactorial disorder. The relative contribution of each factor may be different in each case. The various factors identified to be involved in the causation of depression are discussed in the following paragraphs.

Genetic factors

It is clear that hereditary factors predispose some individuals to the development of depression, though depression is not, strictly speaking, a "hereditary disease" such as haemophilia. In this connection, it is not only the occurrence of depressive disorders in the family members of the individuals but also a number of other related illnesses that are implicated. Genetic factors are thought to play a role in vulnerability to these disorders, which are called *depressive spectrum disorders.* These disorders include alcoholism, drug abuse and antisocial personality in men, and somatization and dissociative disorders in women. There is also a strong genetic link between anxiety, especially generalized anxiety, and depression. Recent work has shown that the interaction of genetic factors with life stressors probably leads to the development of depression.

Environmental factors

These are very easily acknowledged in most cases. Environmental factors are considered to be etiologically important in some types of depression. These may occur in the form of either change in the internal environment, for example intercurrent or chronic illnesses or medications which can cause depression – or, more frequently, external environmental factors in the form of various stressors. Besides stressors, social factors such as rapid economic or cultural change, migration, urbanization and even globalization have been thought to play a role in the development of depression. Though external environmental factors can be demonstrated in many types of depression – and, indeed, in many other

illnesses, physical and mental - they are not necessarily involved in the causation of every depression.

Life events

Life events are significant and important changes occurring in the individual's life which produce stress and require adaptability from the individual. Positive and negative social experiences and relationships seem to play an important role in the development of some, but not all, forms of depression. Life events can also affect the kinds of symptoms that patients present to their physicians. For example, depression that is triggered by *loss*, such as through death or separation, is associated with high levels of sadness, inability to feel pleasure, loss of appetite, and guilt. On the other hand, depression triggered by *failures* is associated with symptoms of fatigue and increased sleep.

Other factors

The final common pathway of the many etiologic factors in any depression is the biological response of a given individual, which is manifested in the form of biochemical changes as well as psychological and behavioral symptoms.

For clinical purposes, a detailed study of all theoretical factors involved in depression is less important than careful observation and timely intervention for depressed patients. Thus, a through evaluation of the depressed patient should include assessing familial, environmental, social and physiological factors to understand the contribution of each factor to the development of depression in his or her case. Assessment and evaluation will be further discussed in another chapter.

Chapter 3 Clinical features of depression

What are the symptoms of depression?

There are numerous symptoms which have been considered to be characteristic of depression. These clinical features are summarized in the following table.

Clinical symptoms of depression

1. Affective or mood symptoms
2. Cognitive or thought symptoms
3. Behavioural symptoms
4. Physical, bodily or somatic symptoms
5. Biological symptoms
6. Psychotic symptoms
7. Neurocognitive symptoms

Affective symptoms

Sadness of mood is considered to be the key symptom of depression. Sadness, when severe, may be accompanied by a desire to weep or crying spells. The person feels extremely sad and cannot "pull" himself out of it. Normally when a person feels sad, he can "cheer himself up" by certain activities or thoughts, but a depressed person finds this strategy to be ineffective. The depressed person also feels dejected and disappointed.

Another characteristic affective feature is the inability to enjoy or derive pleasure from usual activities which gave him pleasure earlier, also known as anhedonia. Similarly, there is a lack of interest in common day-to-day activities, like reading newspapers, watching television, or meeting or talking to people.

The person describes himself or herself as sad, gloomy, low in spirits, depressed, miserable, "as if a black cloud has come over him". In severe cases, this dejection is all-pervading and may be completely uninfluenced to the environment. Some patients describe a qualitative difference between their mood and normal sadness. The mood is unpleasant and patients experience a degree of "psychic pain" which causes them more anguish than

the worst of physical pains. They take no pleasure in anything, and their interests become narrowed or lost completely.

Depressed mood can be distinguished from normal sadness by its persistence, its tendency to come flooding back even after momentary distraction, its painfulness, its relative invariance or persistence in response to changing circumstances, and the inability of the patient to divert his thoughts to more cheerful events or memories.

Depressed mood can be recognized without the accompaniment of a depressed appearance, but the latter will increase confidence that one is dealing with a pathological state. The face looks sad, with the corners of the mouth downturned, deepened nasolabial folds, the eyes downcast with the eyebrows drawn together and their medial ends raised obliquely. The forehead shows vertical ridges with horizontal furrows in the center. There may be tears or an appearance of dry-eyed sadness. They face may seem frozen or stiff in grief.

Affective symptoms of depression

1. Dejected mood
2. Negative feelings about oneself
3. Reduction in enjoyment
4. Loss of emotional attachments
5. Crying spells

Cognitive symptoms

These usually manifest as “bad” or “negative” thoughts about the self, about the outside world (including the family, and workplace), and about the future. The person feels “low” about himself, and has no confidence, low self-esteem and disturbances of body image; this may progress to outright feelings of worthlessness. He tends to blame himself for minor mistakes, and many times there is an unreasonable feeling of guilt and self-blame. The depressed person feels hopeless, and has a bleak and pessimistic view of the future. He also feels terribly helpless, and may believe that there is nothing that he, or anyone else, can do to improve his current situation. He finds it difficult to make decisions and thus keeps procrastinating. He might get fed up of life and feel life is not worth living. These

thoughts may subsequently lead to suicidal ideas and death wishes, such as thinking that it would be "better if I went to sleep and never woke up" or that he would be "better off dead".

In some cases, patients may feel morally worthless. Associated with this feeling is the tendency to feel guilty. Many mildly depressed patients may feel they are to blame for getting themselves into this state, and think that they are a source of trouble, or a "burden", to their relatives. This is to be distinguished from pathological guilt, the essence of which is inappropriate self-blame (see "Psychotic symptoms", below).

Cognitive symptoms of depression

1. Low self-evaluation.
2. Negative expectations – pessimism, hopelessness.
3. Self-blame and self-criticism, guilt.
4. Indecisiveness.
5. Disturbances of body image.
6. Problems with concentration and memory
7. Motivational manifestations like:
    - Paralysis of the will,
    - Avoidance, escapist and withdrawal wishes,
    - Death wishes and suicidal ideas,
    - Increased dependency.

Behavioural symptoms

A depressed person is slowed down, both in behaviour and in mental processes. This is known as *psychomotor retardation*. He may take a long time to finish his usual tasks, such as eating or doing simple activities. He is slow to take care of his personal hygiene and thus might have appear unkempt, with poor attention to his appearance. On the other hand, sometimes depressed persons are very restless and agitated. Such patients feel very nervous, have high levels of anxiety and distress, and may be unable to remain still; they may constantly be moving about or bemoaning their fate.

Physical, bodily or somatic complaints

By and large, most depressed patients in our country suffer from somatic complaints when depressed. These "somatic complaints" include many common physical complaints, such as headache, low back pain, abdominal pain, multiple aches and pains constipation, tiredness or fatigue. Others may present with more vague complaints, such as lethargy, , feeling weak, or feeling "run-down". This is of special significance for general physicians and medical specialists since the depressed patient is likely to consult them first quite naturally due to their physical distress. It is important to analyze and investigate such symptoms appropriately. While depression must not be missed, it is also important to identify the symptoms of any physical disorder that may be contributing to depression.

Biological symptoms

Disturbed sleep is the commonest biological symptom of depression. In fact, the occurrence of sadness along with disturbed sleep might be a good indication that the sadness is morbid or pathological, and thus one can differentiate it from normal sadness. The commonest sleep disturbance is a reduction in total sleep time. Depressed patients have difficulty in falling asleep (initial insomnia), have numerous interruptions while asleep (middle insomnia) and also wake up much earlier in the morning than usual (terminal insomnia). Moreover, the depressed person might report than he does not feel fresh on awakening and has a poor quality of sleep. In contrast, some depressed persons might have increased sleep.

Appetite is also reduced commonly in depression. When severe and long-standing, it can lead to loss of weight. Sometimes a depressed patient may complain that food has lost its taste, and thus explain his reduced intake of food. Weight loss could also be due to loss of interest in eating food. As in the case of sleep, some depressed patients could have increased appetite, craving for carbohydrate-rich foods, and weight gain.

Loss of libido is also reported. The depressed person has a decreased interest in sexual activity. Men may also report difficulty in attaining an erection, and both genders may complain of difficulties in arousal or orgasm.

Biological symptoms of depression

1. Loss of appetite
2. Sleep disturbance
3. Loss of libido

Psychotic symptoms

There are certain psychotic symptoms which also might occur in depression. These are usually in the form of delusions and hallucinations, and will be discussed under the heading of *psychotic depression* in a later chapter. Delusions in depression can be understood as extremes of the negative thoughts mentioned earlier. For example, a depressed patient worried about his job may develop a delusion that he has lost all his money, and that his family will be forced to "live on the streets".

Similarly, in some patients, ideas of guilt can become fully delusional. The patient may accuse himself of a heinous sin or crime, or believe that he will be punished by God for his past "misdeeds". There may be a grandiose element in these delusions, with the patient believing that some action or omission of his is responsible for great disasters in faraway places. Such a patient may also have "guilty ideas of reference", in which he feels that those around him are blaming him or even accusing him. Similarly, delusions of persecution are often an extension of this line of thought, the patient feeling that others, such as the police, are quite justified in "punishing" him for his acts. However, not all depressed patients with delusions of persecution do feel their persecutions are justified.

Common psychotic symptoms in depression

Delusions

1. Persecution and reference
2. Worthlessness

3. Nihilism
4. Somatic
5. Poverty
6. Crime and punishment

Hallucinations – usually having a depressive tone, in the form of hearing voices denigrating the depressed person.

Severely depressed patients may experience auditory hallucinations. These are usually 'second person' - that is, they address the patient directly - and are always consistent with the patient's mood, being derogatory, critical, jeering, or foretelling disaster. Some patients may describe voices ordering them to kill themselves. However, they are not persistent – if they are, the possibility of schizophrenia should be considered.

Neurocognitive symptoms:

Depression can cause also disturbances in memory and concentration. A depressed person may find it difficult to concentrate on tasks and may be easily distracted by the above thoughts. He may also find it difficult to remember things and perceive himself as being "forgetful" or "slowed down".

Signs of depression

These may be prominent or altogether missing – they include a sad facial expression, stooped posture, tearfulness and motor retardation or agitation. At times, depressed patients may put on a smile for social reasons, the so-called 'smiling depression'.

Speech may be retarded, with a delay in answering and gaps between phrases and words. The voice may die away at the end of the sentence and often has a monotonous tone.

The patient may experience subjective slowing of movements, the feeling that he can only move in slow motion. Energy is reduced, as is work output and efficiency. The patient may look retarded, with a slow laboured walk and a reduction of purposive and expressive movements. In extreme cases, the patient may pass into a *depressive stupor* in which he

remains nearly immobile and mute. Such patients may need feeding but are rarely incontinent, as is seen in stupor due to brain damage.

Some patients are visibly agitated with much purposeless activity, pacing up and down, wringing their hands and showing signs of obvious distress.

The above signs are commonly described in psychiatric practice. However, virtually any symptom of which patients commonly complain can be associated with depression. Dry mouth, constipation, difficulty concentrating, poor memory, dryness of the skin and many other symptoms have been associated by patients with their depression.

To Recapitulate…

CLINICAL EFATURES OF DEPRESSION

- Sadness of mood is a key symptom of depression, and when severe may be accompanied by a desire to weep or crying spells
- Inability to enjoy or derive pleasure from usual activities which gave pleasure earlier.
- Lack of interest in day-to-day activities.
- Bad thoughts – about oneself, the outside world (family, friends, work), and the future.
- Self-blame, self-criticism and guilt.

Chapter 4 Clinical assessment of depression

The clinical assessment includes an evaluation of the signs and symptoms of depression, described in the previous chapter. It would involve establishing whether the person has a depressive disorder or not, and if present, the severity of the depressive features.

Symptomatic assessment

Assessment should proceed systematically, and should assess:

- Type of onset
- Level of depressed mood or severity of depression
- Significant evidence of change in behaviour
  - slowing of though, speech or movement
  - marked sleep disturbance, especially early morning wakening
  - diurnal variation of mood, e.g. feeling worse during the morning
  - loss of appetite
  - weight loss
  - loss of general interest, and interest in sex
  - pathological guilt: overvalued and delusional
    - presence and severity of anxiety
    - presence and severity of agitation
    - presence of delusions and hallucinations
    - dangerousness (suicide, homicide, infanticide, self-neglect).

This must be assessed at the first interview.

Medical assessment

- Effect of other medical conditions on mood state and on any proposed antidepressant medication
- Complete general physical examination
- Full blood counts, ESR, blood urea and electrolytes, sugar, cholesterol, vitamin D and vitamin B12.
- Thyroid function tests - T3, T4, TSH.

- Electrocardiogram, especially if the patient is above 40 years of age
- Medication history
    - Current medication, licit or illicit (including barbiturates)
    - Depressant medication (including steroids, oral contraceptives)
    - Alcohol consumption.

Social assessment

Is the patient's response normal in the context of his situation? (e.g. bereavement) Look for difficulties and stressors in the areas of:

- Health
- Sexual function
- Family
- Other relationships
- Other activities.

Depressed patients are not, as a rule, socially isolated. Therefore, the psychiatrist should concentrate on the following factors in assessing the social network of the patient:

- Relationships as a source of strain and of support
- Any counter-productive effect of the patient on those who are close to him
- Interaction between the patient and his relatives
- The family's perception of the illness and expectations regarding the patient's treatment.

Assessment of the patient's social performance ideally requires an informant. What is the patient's usual level of performance in the following roles?

- Relationships
- Practical management
- Work.

Has there been a definite change in these related to the onset of illness?

Screening for depression

As is evident from the previous descriptions of depressive disorders, it might be difficult to interview every patient in detail to detect depressive disorders. For such situations, there are certain screening scales available for the detection of depression.

Some of these are in the form of scales, such as:

1. Hamilton's Depression Rating Scale (HDRS or HAM-D)
2. Beck's Depression Inventory (BDI)
3. Hospital Anxiety and Depression Scale (HADS)
4. General Health Questionnaire (GHQ)

Of these, the Hamilton and Beck's Depression scales are quite lengthy and time consuming. The GHQ is usually helpful in identifying individuals with psychiatric morbidity. The Hospital Anxiety and Depression Scale picks up symptoms of anxiety and depression in population from medical clinics and general practices. It is a 14-item scale with seven items measuring depression and seven items measuring anxiety.

How to proceed with diagnosis:

Patients with depression often present a confusing picture and pose management problems for the physician. In the absence of a straightforward complaint about depressed mood, and in the presence of many somatic complaints it seems quite natural to pursue general medical, or "organic", causes for the patient's complaints. The distinction between "organic" and "psychological" causes is spurious. In the end, depression - which people complain of in 'psychological' terms - is the result of brain dysfunction which is as yet poorly understood. Physicians are increasingly aware of the many different presentations of depression, and consideration of depression as an explanation for the patient's complaints has risen higher on most physicians' lists of common medical problems.

Once the possibility of depressive illness has been recognized, physicians can often move fairly quickly to confirm their suspicions and institute appropriate antidepressant treatment. Masked depression can sometimes by uncovered by the use of depression questionnaires. A carefully conducted interview which explores the status of mood, thinking, vegetative

functioning and general behaviour will usually provide the data necessary for a differential diagnosis among the depressive disorders. History-taking of this kind is best done in an unhurried and uninterrupted fashion. This pattern of history taking may be difficult to arrange on short notice in a busy practice, but detailed history of this kind is just as useful as a detailed general history and complete physical examination. A careful psychiatric history can often be scheduled in a block of time usually reserved for a complete medical history and physical examination.

After obtaining the patient's permission, contact with relatives is often helpful in confirming the patient's reports of either symptoms or behavioural changes, and in providing additional observations which the patient has failed to notice or report. Once relevant information has been obtained, processing it in a suitably systematic and efficient fashion is clearly the next step. This is critically important, as there are various kinds of depression, and treatment can differ substantially depending on the diagnostic subtype.

Chapter 5 Types of Depression

Depressive disorders have been classified in a number of ways over the years. The common subtypes of depressive disorders and their characteristic features have been described here.

Major depression

When most of the aforementioned symptoms have been present nearly continuously for a period of at least two weeks, the condition is referred to as *major depression*, or a *depressive episode*. Depressive episodes are clear-cut episodes, lasting weeks to months or even years – their average duration is about 6 to 9 months. Patients are completely well before and after an episode, but major depression has a tendency to recur in over two-thirds patients. If more than one episode occurs in a patient, the term *recurrent depression* can be used.

Criteria for the diagnosis of major depression

(Adapted from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition)*

Primary criteria – these must be present in all cases to make the diagnosis

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all activities

Secondary criteria – in addition to (1) and (2), any three of these should be present for a period of at least two weeks, for a total of at least 5 symptoms.

3. Significant weight loss *or* weight gain (total change of 5% body weight)
4. Decreased sleep (insomnia) *or* increased sleep (hypersomnia)
5. Slowness (psychomotor retardation) *or* agitation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Difficulty in concentrating, thinking or making decisions
9. Recurrent thoughts of dying or committing suicide

A depressive episode can be further graded as *mild*, *moderate* or *severe* based on how much these symptoms impair the patient's functioning in social and occupational situations.

Other terms used to describe a depressive episode

First of all, it seems appropriate to separate primary from secondary depression. Primary depressions are those which arise in and of themselves, while secondary depressions follow in the train of some other illness or event. Other terms that have been commonly used include:

- *Endogenous* and *reactive* depression
- *Psychotic* and *neurotic* depression

The first set of terms refers to the probable *cause* of a depressive episode, while the second refer to symptom profile. These terms, however, have not stood the test of time. In some ways, endogenous depression may appear synonymous with primary depression and reactive with secondary. The endogenous-reactive dichotomy is sometimes taken to be synonymous with severity, with many people equating endogenous with psychotic and reactive with neurotic depression respectively. That this is an oversimplification becomes clear when one must treat a patient with what appears to be a lifelong neurotic illness, for which no external precipitants in the life of the individual can be identified - an "endogenous neurotic" depression. Conversely, one sometimes sees acutely depressed patients with psychotic symptoms with a good premorbid personality who "come apart" as a result of severe trauma – a "reactive depressive psychosis".

It is probably most consistent and useful at this point in time to recognize the limitations of the endogenous-reactive and psychotic-neurotic dualisms since they add more confusion than clarity to the process of classification. They do remain clinically useful in treatment selection, and we will retain them for that reason.

Over the years, the term endogenous depression has been used for a multitude of purposes. Among them are:

1. The opposite of neurotic or reactive depression,
2. Depression occurring in people with normal premorbid personalities,
3. Depression with no precipitating event,

4. Depression that responds to somatic treatment (medication or ECT),
5. Depression with a characteristic complex of symptoms, principally vegetative symptoms, diurnal variation, and early morning awakening.

The term neurotic depression also carries a multitude of meanings, often with etiologic connotations. Neurotic depression, has been variously defined as being mild depression, non-psychotic depression, depression that is less socially incapacitating, depression following a life event, depression without endogenous symptoms, or depression arising in individuals with long-standing characterological problems. These definitions are not comparable, and thus lead to confusion.

The common characteristics of neurotic depression can be summarized as:

- It is mild,
- It is nonpsychotic, i.e. lacks psychotic symptoms,
- It is less socially incapacitating,
- It is situational or reactive, as a reaction to an event or situation,
- No endogenous symptoms, like marked loss of weight, appetite, guilt, diurnal variation is prominent,
- The depressive symptoms are worse in the evening,
- They tend to blame others
- Sleep is disturbed, intermittent awakening, or difficulty in falling sleep,
- Characterological, in terms of being long term,
- It results from an unconscious conflict which usually cannot be easily identified,
- It is associated with other neuroses like anxiety, obsessions, conversion, somatization or hypochondriasis.

Dysthymia (chronic depressive disorder)

The word *dysthymia* means “ill-humoured”. Dysthymia is characterised by a chronic nonpsychotic depression, of more than 2 years' duration, involving either depressed mood or loss of interest or pleasure in all or almost all usual activities and pastimes, and associated symptoms as mentioned above, but not of sufficient severity to qualify for a

depressive episode. Patients may describe themselves as chronically feeling sad, blue, "down in the dumps" or low.

The depressed mood or loss of interest or pleasure may be either relatively persistent or intermittent and separated by periods of normal mood, interest and pleasure. These normal periods last a few days to a few weeks. Patients do not experience delusions or hallucinations, and are usually less impaired in their functioning than those with depression.

The exact prevalence of dysthymia is not known. However, the condition is probably common among outpatients. The disorder is more common in women. This disorder usually begins early in adult life, and for this reason was earlier referred to as depressive personality. In other cases, it may begin at a later period.

Such patients can develop superimposed major depressive episodes, which may cause marked impairment in their ability to function or require hospitalization. Such depressions are called 'double depression'. Dysthymia is also associated with a risk of developing substance abuse, particularly in men.

A predisposing factor is the presence of a chronic physical disorder, chronic life stresses, or another psychiatric disorder, such as a personality disorder or major depression which does not completely remit and merges imperceptibly into this condition.

Adjustment disorder (reactive depression)

The essential feature of an adjustment disorder is a maladaptive reaction to an identifiable life event or circumstance, and which is not merely an exacerbation of an already existing the mental disorder. Adjustment disorders usually remit if and when the stressor ceases. The maladaptive nature of the reaction is indicated by the presence of either impairment in social or occupational function or symptoms, or other behaviours that are in excess of an expected and culturally appropriate reaction to the stressor. There may or may not be a concurrent personality disorder or organic mental disorder, which may render the individual more vulnerable to the adjustment disorder.

Stressors may be single, such as an uncomplicated divorce, or multiple, such as the death of a loved one occurring at a time of marked job difficulties and physical illness. They

may be recurrent, as with chronic illness, unemployment, or financial difficulties. They may occur in a family setting, as with discordant familial relationships. They may be likely to be limited in effect to the patient, such as being the victim of a crime or having a psychological reaction to physical illness. Finally, they may occur in a group or community setting where the stressor involves many others, such as a natural disaster, or persecution based on racial, social, religious, caste or other group characteristics. Some stressors are associated with specific developmental stages, such as going to school, failing to attain occupational goals, the last child leaving home ("the empty nest syndrome") and retirement. They may also be associated with transitions in the life cycle: puberty and adolescence, marriage, parenting, menopause, and old age.

The severity and impact of the stressor is a complex function of the nature and number of stressors, their duration, reversibility, and the environmental and personal context. For example, the stress of losing one's parents is, not unexpectedly, different for a child of ten and a married man in middle age.

The manifestations of the disorder are varied. Depressive or anxious features, or a combination of mixed emotional features, are particularly common, especially among adults. Physical symptoms may occur at any age, but are more likely to be seen in children or among the elderly. Disturbances of conduct are more common in children or adolescents, but can also be seen at other ages. They may include aggression, reckless driving, use of alcohol and other substances, or failing to meet responsibilities. In other instances withdrawal may be the primary presenting symptom. Various admixtures of these symptoms, sometimes referred to as "mixed disorder or emotions and conduct", can also be seen.

Adjustment disorder is common, though its exact prevalence is not known. The age of onset and course are variable. The symptoms do not necessarily begin immediately after the stressor. The onset may be either immediate or delayed and either sudden or gradual. Though many adjustment disorders resolve with time, some may be chronic or even lifelong due to the persistence of the stressor.

Reactive depression needs to be differentiated from normal grief or uncomplicated bereavement which, although associated temporarily with impaired social and occupational

functioning, is an expected reaction to the loss of a loved one and thus is not considered an adjustment disorder.

Other mental disorders from which an adjustment disorder must be distinguished include major depressive disorder, dysthymia, disorder, brief reactive psychosis, generalized anxiety disorder, somatization disorder, the various substance use disorders, conduct disorders and posttraumatic stress disorders.

Secondary depression

Depressive symptoms in relation to physical illnesses may persist longer and be more severe than those seen in adjustment disorders. However, it must be stressed that there is no clear separation between the two diagnostic categories of reactive and secondary depression. A diagnosis of Reactive depression is considered as the psychological reaction to a stress factor, more severe than the adjustment disorder, secondary depression is due to the biological changes due to medical disease or side effects of medications for the medical disease. Usually, the symptoms are depressive in nature, but features of anxiety are also common.

The category of secondary depression allows a useful conceptual framework for understanding symptoms following physical illness. In secondary depression, depression follows and parallels a significant, life-threatening or severe medical illness. Secondary depression must be distinguished from *symptomatic* depression, as discussed below. It would be more logical to restrict the term to describe depression that follows the diagnosis of a medical illness whose nature is appreciated by the patient. These syndromes of depression with or without anxiety result from the patient's awareness of the illness and its implications.

Some important differences need to be considered when diagnosing secondary depression in the medically ill. The characteristic somatic symptoms of depression - insomnia, anorexia, weight loss and bodily pains - do not have the same significance in this population and cannot be relied upon from a diagnostic viewpoint. They may all be attributable to the underlying physical disorder. Reliance must therefore be placed on the psychological symptoms – low mood, loss of pleasure and interest in activities, and negative thoughts or views of the self, the world and the future – in diagnosing depression in these patients. .

Depressed patients in medical wards are less deeply depressed as a whole, though some may have severe depression. They more often have feelings of pessimism, helplessness, anxiety and self-pity but less often have suicidal feelings. The core symptoms of depression in medical patients were identified as: feeling like a failure, loss of interest in people, feeling punished, suicidal ideas, dissatisfaction, difficulty with making decisions and crying.

Depression in chronic (non-neurological) medical conditions

In some patients, depression may develop over the course of chronic medical conditions, such as renal failure, liver failure, or infections such as tuberculosis. While some of these depressions may be "secondary" to the stress of having a serious illness, as discussed above, others are due to chemical and metabolic changes that accompany these disorders, which indirectly alter the functioning of the brain. Such conditions are commonly seen in general hospital settings. Treating the underlying condition (for example, with dialysis or antituberculous treatment) may reverse depression.

Symptomatic depressive disorders

This term is best used for disorders presenting with symptoms characteristic of a depressive episode, but in which cerebral dysfunction can be assumed with reasonable certainty from the patient's clinical condition. This implies that the functional symptoms develop as a result of organic brain disease, or a general medical condition affecting brain function. Such disorders are also referred to as "depression due to a general medical condition" or "organic mood disorders". Symptomatic depression can also be due to the effects of using or experiencing withdrawal from a drug of abuse, such as alcohol or cocaine. This type of depression is also called "substance-induced mood disorder".

Symptomatic disorders often occur in people who are unaware that they are physically ill and the disorders consequently assume special significance as the initial manifestation of an illness that has not yet declared itself. They can take the form of any functional disorder, but depressive and anxiety disorders are the commonest. They emphasize the importance

of a thorough physical examination in all psychiatrically ill patients. Mood disorders should be suspected of being symptomatic of an underlying physical illness especially in the following circumstances:

- The mood disorder presents for the first time in middle or late life,
- There is a stable premorbid personality,
- There is no family history of psychiatric illness
- There is no apparent psychosocial precipitant
- Depression is associated with signs and symptoms suggestive of a general medical or neurological condition

Several groups of physical illness are known to be associated with depressive syndromes.

Neurological diseases

Depression is a common complication of neurological diseases, particularly cerebrovascular disease. Depression is common after a stroke and approximately a quarter of patients experience severe depression, while another quarter experience minor degrees of depression. At first sight, these are not unexpected observations, given the major disabilities which stroke patients experience. But several studies have shown little correlation between post-stroke depression and the degree of physical disability in the weeks immediately after the stroke. However, the association becomes more pronounced with time, so that a complex interaction between mood and physical impairment is established.

Major depression is more frequent in patients with strokes involving the left frontal cortex and left basal ganglia. Non-fluent aphasia also occurs after left frontal lesions, but this does not seem sufficient to explain the development of depression because a similar degree of depression occurs with left frontal lesions not complicated by aphasia. Subcortical atrophy, as shown by ventricular enlargement on a CT or MRI scan, may be a predisposing factor for post-stroke depression. Some studies have found no difference in the frequency of depression between patients with left and right hemisphere lesions, so this issue needs further investigation.

Patients with cerebrovascular disease can experience mood disturbances which are too brief to justify the diagnosis of organic mood syndrome. These disturbances are referred

to as pathological emotionalism, or emotional lability, and their defining features are an increase in tearfulness with sudden episodes of crying which are not under normal social control.

Endocrine disorders

There is a close relationship between the endocrine system and mood. Endocrine diseases as a cause of psychological symptoms, including depression and anxiety, are well known. Anxiety symptoms are prominent in hyperthyroidism, pheochromocytoma and hypoglycaemia due to an insulinoma. The anxiety may be persistent or episodic, and in the case of pheochromocytoma the onset is so abrupt that it resembles an acute panic attack. Depression is a common accompaniment of hypothyroidism, Cushing's syndrome, Addison's disease and hyperparathyroidism. It is occasionally seen in hyperthyroidism in the elderly ('apathetic thyrotoxicosis') and in hypoparathyroidism.

Depression in cancer

There have been intriguing reports of depression as a prodromal manifestation of cancer, although not all studies have found an association between the two conditions. Several explanations have been proposed to account for the hypothetical link, the most likely being that the generalized debilitating effects of cancer mimic the symptoms of depression to such an extent that a diagnosis of depression is made before the tumour becomes manifest. This would account for the alleged association between depression and pancreatic carcinoma, a tumour which is notoriously difficult to diagnose in its early stages. Depression may be an early presenting feature of a primary or secondary cerebral tumour. Several non-metastatic neuropsychiatric syndromes have also been described, and they are believed to result from the effects on the nervous system of peptide substances secreted by the tumor. Non-metastatic metabolic changes can be responsible for depressive symptoms: carcinoma of the lung is known to secrete ectopic ACTH or parathormone, giving rise to the clinical features of Cushing's syndrome or hyperparathyroidism. Autoimmune

mechanisms in cancer can also cause limbic encephalitis, which is associated with behavioural and mood changes.

It is also possible that an antecedent depressive illness can reduce the patient's immunological competence. Chronic depression or stress impairs cell-mediated immunity, thus allowing the development and proliferation of malignant cells. Some studies have claimed that treating depression may prolong survival and reduce recurrences in patients with cancer.

Collagen disease

Neuropsychiatric features are being increasingly recognised in this groups of conditions which include systemic lupus erythematosus (SLE), rheumatoid arthritis, polyarteritis nodosa and temporal arteritis. Particular attention has been given to SLE, in which neuropsychiatric manifestations are one of the diagnostic criteria. Organic mental disturbances are the commonest psychological changes but depression and psychotic syndromes can also occur. Changes in cerebral blood flow in these patients and episodes of cerebral vasculitis alter blood flow and allow leakage of autoantibodies into brain tissue.

Medication-induced depression

Depressive symptoms comprise one group of adverse drug reactions which account for a considerable degree of psychiatric morbidity.

Drug-induced psychiatric disorders may be divided as follows:

- Behavioral toxicity: irritability, edginess, restlessness, aggressive outbursts, hostility and hypersexuality. These are psychological or behavioural symptoms which arise as side effects of psychotropic medications. If these features are considered to be arising out of depression, the dosage of medication may be enhanced, giving rise to more side effects and toxicity.
- Delirium: Elderly subjects with delirium can be hypoactive, have disturbed sleep, and may be misdiagnosed as having depression. However, fluctuating consciousness, altered sleep cycles and cognitive impairments differentiate delirium from depression.

- Depressive reactions: varying from mild mood changes to severe psychotic depression. Some drugs can produce transient negative mood states (dysphoric reactions).
- Paranoid and schizophrenia-like psychoses: delusions of persecution with or without auditory hallucinations; also thought disorders of the schizophrenic type,
- Hallucinatory states: usually visual without other features of delirium,
- Dementia and cognitive impairment: cognitive changes usually are reversible on stopping the drug, though some drugs can produce irreversible brain damage,
- Neuropsychiatric states: a combination of psychological symptoms with involuntary movements, ataxia, dysarthria or convulsions

This list of drugs causing affective symptoms is lengthy.

For convenience they can be grouped into the following categories:

- Antihypertensives - e.g. reserpine
- Cancer chemotherapeutic agents
- Hormonal preparations – e.g corticosteroids, progesterone
- Minor tranquilizers – e.g alprazolam
- Opioid analgesics – e.g pentazocine
- Anti-parkinsonian drugs – e.g levodopa, bromocriptine
- Anti-epileptic drugs – e.g topiramate
- Weight reducing agents – e.g sibutramine, rimonabant
- Stimulants – during rapid or sudden cessation

In most cases, the mood changes take the form of mild depression. Some drugs are particularly likely to cause euphoria, occasionally amounting to mania. These include steroids, isoniazid, levodopa and fenfluramine.

Aetiological considerations

If affective symptoms can be produced by produced by a wide range of physical disorders, which have not yet manifested themselves in other ways, it must be asked whether the physical process has a causal or precipitating effect. Structural brain damage could have a direct causal effect, but in other cases the relationship is not so clear.

In contrast, where depression or mania occurs as a result of drug, toxic or metabolic effects, the patients are likely to have a genetic or constitutional disposition to depression. In these cause the physical disorder appears to precipitate episodes of mood disturbance which may have arisen spontaneously or in response to other adverse factors.

Management of symptomatic depressive disorders

Treatment is aimed at reversing the underlying condition and when this can be achieved the results are very satisfactory. In drug-induced conditions, stopping the offending agent may be all that is required. Similarly, treating an infectious illness with antibiotics may be sufficient to relieve all accompanying depressive symptoms. If the underlying cause cannot be reversed, depression may still respond to antidepressant medication.

To Recapitulate…

- Primary depressions are those which arise in and of themselves.
- Secondary depressions follow in the train of some other illness or event.
- Other classifications are endogenous or reactive and psychotic or neurotic.
- Symptomatic depressive disorders often occur in people who are unaware that they are physically ill.
- Mood disorders should be suspected of being symptomatic of an underlying physical illness in certain circumstances,
- Depression due to illness, viz, endocrine disorders, cancer, collagen disease is also fairly common.
- Drug induced depression is seen with antihpertensives, corticosteroids, major tranquilizers, leveodopa, stimulants (withdeawal),

Chapter 6 Depression in women

The life-time prevalence of depression is twice as high in women as in men. The reproductive years in women are one of the greatest risk periods for the development of depression. Mood changes have been found to be associated with reproductive life events such as menarche, the premenstrual period, menopause, pregnancy, childbirth, oral contraceptive usage, tubal ligation, abortion, and infertility. Let us discuss depression in relation to some of these reproductive life events, or situations.

Menarche

Traditionally, adolescent girls in Indian homes are given little or no information about menstruation before their first menstrual period. This event, referred to as "coming of age", is considered a special event in many communities. As a result, most young girls are unprepared for the menarche and may perceive this event as being stressful. Depression, worry and transient thoughts of danger to one's health are common emotional responses. Much depends on how the adolescent is able to accept her experience - as a negative one or a positive one. Invariably, depression related to menarche is short-lasting and is overcome by information provided by womenfolk in the household and peer group. It rarely requires antidepressant therapy. Physicians may be called upon to counsel adolescents at times, when there is a need to provide them with accurate information about reproductive functioning.

Premenstrual tension or syndrome related depression

Most women are aware of premenstrual physiological and emotional changes. Typically these premenstrual changes are mild, do not interfere with day to day functioning, do not require medical intervention, and are considered "normal". However, about 5-10% women suffer from moderate to severe depression, often associated with irritability, during the premenstrual period, which tends to recur over consecutive cycles. Low mood, weepiness, increased sensitivity, irritability, and depressive thoughts appear 5 or 6 days before the onset of the periods, and are often accompanied by features of water retention, such as a sense of bloating, weight gain or ankle swelling. Typically, these

subside with the onset of menstruation. No features of depression or irritability are reported during other days of the cycle.

Confirmation of premenstrual depression requires examining women at different times of the month, to observe fluctuations in behavior, mood and physical symptoms. Sometimes, it is helpful to ask women to maintain a diary in order to make the relationship between menstrual cycle phases and symptom exacerbations.

A number if treatment strategies have been attempted, and no single treatment regimen has proved to be the best. SSRIs are probably the safest and best studied options, though not all women respond to them. Other alternatives include suppression of ovulation using oral contraceptives or other hormonal agents, and symptomatic treatment with diuretics, anxiolytics, or prostaglandin-related agents. Supportive counselling, exercise and diet also play an important part in treatment.

Menopause

Psychological and emotional symptoms which occur during menopause are thought to be due to decreased ovarian activity, sociocultural factors, and psychological factors. Menopause is a natural process, a positive experience, and a normal reproductive life cycle event which normally presents few difficulties, but the effect of psychosocial factors is complex. Most women do not seek medical help for menopause, though for working and professional women it is timed at the peak of their careers. Sociocultural factors affect the experience of menopause. Menopausal symptoms are increased in women of lower, socioeconomic status, especially those with low self-satisfaction and low self-esteem.

A natural menopause does not have adverse psychological consequences for the majority of middle-aged healthy women. Though the commonest reason why women seek treatment for menopause is physical complaints, such as hot flashes, some women do develop significant depression. Depressive symptoms during the menopause commonly include sadness, slowness, excessive concerns about the future and multiple physical or somatic complaints. Many times women may complain of only physical complaints – like weakness, aches and pains in different parts, tiredness etc, rather than sadness or disinterest in surroundings. Physicians and gynaecologists must be alert to the possibility of

depression, and screen for it appropriately rather than dismissing a woman's complaints as "normal" or unimportant.

Counselling and advice about age-related physical problems, concerns about the future and depression are required. Severe menopausal symptoms like hot flushes, restlessness, irritability may require hormonal treatment. If a diagnosis of depression is made, antidepressants in low doses are helpful in alleviating depression and anxiety, as well as vague somatic symptoms, in menopausal women.

Pregnancy related depression

Depression is more often related to an unwanted or unplanned pregnancy than to a desired and planned pregnancy. Depression during pregnancy may thus be reactive in nature, and mild. In primiparous women, it could be related to the anxiety about childbirth, as well as survival and welfare of the foetus. The use of modern technology in the prenatal period, though it reduces risks, can stimulate anxiety about abnormalities. Sometimes, depression could be due to first trimester complications, such as hyperemesis. Obviously, medications should be avoided as much as possible during the first trimester, due to risk of congenital malformations. During the second and third trimester, depression can be safely treated by a judicious use of antidepressants and counseling or psychotherapy. Antidepressants should also be withheld prior to delivery, if possible, as they cross the placenta during labour and can cause neonatal complications.

Post partum depressive disorders

Post partum depression, also called postnatal or puerperal depression, covers a spectrum from mild emotional setbacks to profound disruptions requiring psychiatric hospitalization. Those disorders are fairly common, largely go undetected and are generally treatable. Though the causes of postpartum depression are not well understood, it is thought that multiple factors – physical, psychological, hormonal and social - contribute to the genesis and maintenance of postpartum depression. Depressive symptoms following delivery may take on various forms:

Postpartum blues

Postpartum blues are common, experienced by 50-80% of women following delivery. Symptoms are mild and short lived, but 20-25% progress to postpartum depression. They usually begin on the 3rd day following delivery, may last from may last from a few minutes to several days, and are self limited and benign. Full resolution usually occurs within 2 weeks.

Postpartum blues are characterized by crying, depressed mood, mood lability (including euphoria, tearfulness, anxiety and irritability), sleeplessness, restlessness, loss of appetite, fatigue, apathy, physical complaints, headache, excessive dreaming, nightmares and hostile thoughts or feelings towards the baby or other children. Women may feel overwhelmed by their responsibilities, may lack confidence and sometimes feel that they cannot cope with their baby.

Postpartum blues are widely considered a "normal" phenomenon, though in individual cases, physical, emotional or social stressors may worsen or prolong their duration. Sleep deprivation can aggravate the blues. No specific management is needed, except for education regarding the benign and harmless nature of the symptoms, and support and validation of the patient's experiences.

Women who seem overly anxious or who are preoccupied with thoughts of harming their babies, who have a past or family history of mental illness, or whose symptoms persist beyond 2 weeks should be referred to a psychiatrist, since these mild disturbances may escalate into more serious disorders.

Postpartum depression

Depressive disorders during the postpartum period are similar to depression which occurs at other times. Childbirth functions as a precipitating factor or nonspecific stress. Up to 10-25% of women experience one or more episodes of postpartum depression.

Risk factors include a past history of depression, depression during pregnancy, an unplanned or unwanted pregnancy, early or late motherhood, marital discord or dissatisfaction, poor coping skills, and poor social adjustment. Stress factors like economic hardship and isolation may contribute to depression.

Early or prodromal symptoms include excessive anxiety, irritability, crying and severe sleep disturbances. Sleep may be reduced and irregular because of the baby's sleep-wake pattern, but if the sleeplessness persists even when the baby is sleeping, this is indicative of significant insomnia.

The risk of postpartum depression begins in the first week after childbirth but symptoms may appear after weeks or months. Typically, symptoms appear by the 4^{th} - 6^{th} week. Unfortunately, most women with postpartum depression never come to medical attention, and may go undetected and untreated. Many consult their general practitioners of family physicians even routinely during the postpartum period. Therefore, general practitioners have a crucial role in identifying women with postpartum depression.

Other reasons for lack of detection of postpartum depression include:

- Young mothers are shy or ashamed of their feelings and fear criticism for being depressed when then they are expected to be happy.
- Practitioners confuse transient blues with clinical depression.
- Many believe that postpartum depression is a social problem reflecting the changing role of women or that it is self-limiting.
- Practitioners are primarily occupied with the health and well being of the baby, rather than of the mother.

Signs and symptoms of postpartum depression

These are varied, but often include sad mood, fatigue, confusion, poor concentration, irritability, crying, insomnia, feeling of inadequacy and difficulty in coping, guilt over not loving the baby enough, and severe anxiety. There is excessive concern about the baby's health, feeling, or safety and intense preoccupation with the details of infant's care. Recurring thoughts occur that the baby is abnormal or will die and fears that one may accidentally or willfully harm the baby are common.

Untreated postpartum depression has serious consequences. There is a small but significant risk of both suicide and infanticide, especially in severe or psychotic depression. In addition, poor mother-infant bonding during the first months of a child's life can cause lifelong developmental, cognitive, emotional and behavioural problems. Thus, it is

essential that postpartum depression should be recognized and treated as early as possible, to minimize the risk of such complications

Treatment includes counseling and antidepressant medications. If psychotropic drugs are used, breast-feeling should be avoided for at least 4-5 hours after a dose of medication. However, most available antidepressants do not pose a major threat to the nursing infant, and since breastfeeding has health benefits for both mother and baby, it should not be interrupted unless absolutely necessary.

Regarding the prevention of postpartum depression, women as well as physicians and gynaecologists can be educated about symptoms and risk factors for the development of postpartum depression and this can facilitate early referral, less postpartum depression, and better outcome.

Postpartum psychotic depression is an emergency that requires hospitalization and intensive treatment by a psychiatrist at an inpatient psychiatric facility, to prevent harm to both mother and baby.

To Recapitulate …

- The reproductive years in women are one of the greatest risk periods for development of depression
- Mood changes are associated with events like menarche, the premenstrual period, menopause, pregnancy, oral contraceptive usage, tubal ligation, the postpartum period, abortion and infertility.
- Antidepressants are helpful in alleviating depression and anxiety symptoms.
- It is safer to use a drug with fewer side effects.

Chapter 7 Depression during childhood

Depressed mood as a reaction to loss or stress is quite common in children, although this is not always evident due to a child's more limited vocabulary and cognitive abilities. Because the child is in a continual process of development, the expression of depressions in children will be conditioned by each particular stage of development and can manifest itself in in various ways, because the repertoire of cognitive and affective behaviour is limited. This raises the problem of "depressive equivalents" or "masked depression" especially among adolescents. Sadness, crying, inhibition, guilt are absent or rare, and other symptoms like conduct problems or somatic symptoms may be the presenting complaint.

The common causes of depression in childhood are bereavement, loss, or significant life stressors such as family disputes or problems in academic and peer group settings. Usually, children may manifest depression in the following ways:

Masked depression

This is most the frequent type of depression. Typical clinical features include hyperactivity, aggressive behaviour, delinquency, school refusal, an unexplained decline in academic performance, reduced socialization or interest in play, psychosomatic illness, and psychogenic pain. In adolescents, a mixture of conduct, depressive and anxiety symptoms is common – the so-called "depressive conduct disorder" or "mixed disorder of conduct and emotions". In some adolescents, depression may present with marked psychotic symptoms, and be misdiagnosed as schizophrenia.

Pure depressive syndrome

This includes symptoms similar to those seen in adults: persistent sad effect, crying spells, social withdrawal, hopelessness, helplessness, helplessness, and lack of interest in school, games or extracurricular activities.

Common non-specific symptoms of depression in children are irritability, weepiness, sadness, tension, moodiness, difficulty in falling asleep and abdominal pain. Enuresis and school refusal are also commonly noted in younger children with depression.

In the background, there may be a family history of affective illness (depression, mania) or alcoholism.

Treatment of depression in children

Because of the atypical presentation, confirming the diagnosis of depression, and evaluation by an experienced child psychiatrist or psychologist is recommended. Pediatricians should have a high index of suspicion for the condition in any child presenting with recent-onset behavioural or academic problems, or medically unexplained symptoms. Over a third of children who present with depression go on to develop bipolar disorder (mania or hypomania) later in life. Children are also sensitive to the serious effects of antidepressants, such as sudden death with tricyclics, and agitation and suicidal ideation with SSRIs. Only the SSRIs fluoxetine and sertraline are approved in juvenile depression, and both carry warnings as to their safety. Therefore, treatment with medications should be initiated cautiously, under the supervision of an experienced professional, and children should be carefully monitored for any evidence of mania or hypomania, such as increased speech, increased energy, overactivity, over cheerfulness, demanding and authoritative behaviour, making unrealistic plans and claims, or a decreased need for sleep and rest. Psychotherapy, especially cognitive-behavioural therapy (CBT) has been shown to improve depression and reduce suicidal tendencies in children and adolescents.

Chapter 8 Depression in old age

Depression is seen often in elderly people. Late-life depression is often complicated by a number of factors, like aging, physical illnesses, multiple medications for medical illnesses, social isolation, retirement and financial difficulties, family stresses, etc. Though elderly individuals are able to cope better, they also face more stresses, and the occurrence of physical illness reduce their coping strength. Some of the common factors which contribute to depression in old age are:

Medical illnesses

A number of medical illnesses are age-related. Hypertension, diabetes and osteoarthritis are the commonest. These illnesses themselves produce a reactive depression in the individual. The person's inability to look after himself, or incapacitation, contributes to depressive feelings and thoughts. Moreover, medications and dietary restrictions can worsen depression.

Vascular depression

"Vascular depression" is the term given to a special form of symptomatic depression that occurs in medically ill, elderly individuals. It is the result of multiple small strokes involving subcortical regions of the brain, which leads to depressed mood, psychomotor retardation, and slowness of thought and speech. Patients may have a history of strokes or transient ischaemic attacks, and often have vascular risk factors such as diabetes, hypertension, obesity, hyperlipidaemia, or cigarette smoking. As it may progress to dementia if untreated, these patients require aggressive control of their cardiovascular disorders with drugs such as antiplatelet agents and antihypertensives.

Social factors

As age advances, more responsibilities have to be shouldered by the individual. There may be marriages and other rituals to be performed for children or grandchildren. Demands on finances increase, whereas the individual would have attained retirement.

Similarly, the need for education of children or grandchildren may also impose a burden on ageing parents. The elderly are often subjected to ill-treatment and isolated due to their physical or mental debility.

Symptoms of depression in the elderly

Depression in old age manifests in a similar manner as is seen in younger age groups. It may seem milder in intensity at many times, but severe agitated depression, often with psychotic symptoms is also noted. Such severe late-life depression has been called "involutional melancholia". Feelings of hopelessness, worthlessness and helplessness are common. A lack of interest in surroundings and a lack of pleasure from usual activities is more commonly noted than sadness or weeping spells. The person finds it difficult to cope with the domestic, financial and social stresses mentioned above.

Sleep reduces as age advances, so sleeplessness due to depression has to be distinguished from the insomnia of old age. Usually, the depressed person would report a change in pattern of sleep, amount of sleep, and not feeling refreshed from sleep.

Appetite may be reduced with weight loss. Loss of appetite and weight in this age group may cause concern to their physicians, who might suspect a malignancy. Libido would also be low and part of it could be age related.

Another important point to note is that some elderly depressed patients may complain chiefly of memory loss or loss of mental function, though their underlying problem is depression. This condition is often misdiagnosed as dementia, and hence is known as *depressive pseudodementia*, or *dementia syndrome of depression*. It is important to recognize this "masked" form of depression, because treating it can cause a complete recovery of cognitive deficits.

<u>Treatment</u>

The main focus of treatment is in identifying medical or physical factors. Underlying medical illnesses could be contributing to the depression, and they should be appropriately diagnosed and treated. Care should be taken to avoid medications which themselves produce depression. Some antihypertensives are notorious for inducing depression.

Antidepressants form the mainstay of treatment of depression in old age. The antidepressants should be initiated at low dose and the dosage should be gradually increased. Maximum doses are usually half the dose used in health young adults. Preferably, antidepressants should be given in divided doses. The patient should be informed of the adverse reactions and side-effects should be explained to the patient and we should be on the common side effects expected. SSRIs and other newer agents are often preferred to tricyclics because of their lesser side-effect profile.

Severe depression, especially with endogenous features, and those with loss of appetite, loss of weight, psychomotor retardation or psychotic symptoms may need electroconvulsive therapy (ECT). Such cases can be referred to a psychiatrist. The response to ECT is usually good in this age group, and it is generally safe and well tolerated.

Chapter 9 Complications of depression

Depressive disorders produce great morbidity and mortality if left untreated. Moderate to severe depression can have adverse effects on a number of spheres of life for the depressed person and his family. Some of the consequences are listed below:

- Suicidal attempts and completed suicides
- Occupational and financial loss due to feeling low, depressed, slowed down or disinterest in work.
- Inability to work due to difficulty in attention and concentration.
- Sedative – hypnotic abuse for sleep disturbance,
- Alcohol abuse and dependence. Dependence on other drugs like cannabis, amphetamines.
- Frequent consultation for physical symptoms. Unnecessary investigations and consultations.
- Increased vulnerability to common medical illnesses like infections and severe diseases like cancer.
- Complications due to antidepressant medications.
- Patients may switch over to hypomania or mania because of the underlying or undetected bipolar nature of their affective disorder.
- Social consequences due to withdrawal and lack of interest in socialising or meeting people. This can disrupt interpersonal relationships and can even lead to marital discord or separation.
- Deliberate self-harm in terms of injuring or hurting oneself as a suicidal gesture, or in order to hurt oneself as a 'deserved punishment'. Irritability and aggression toward family members may also occur, especially in psychotic or agitated depression.

Let us now discuss some of the common and important complications of depression.

Suicide risk

Although there is a higher-than-average mortality from cardiopulmonary disease, accidents and substance use in depressed individuals, suicide accounts for most of the mortality associated with depression and, for the matter, with all psychiatric disorders.

Risk factors

Prediction of suicide risk has been a nagging problem for all physicians. Whatever may be the area of practice, we all see patients who are potentially suicidal and, over time, all us may come across one or more patients who have committed suicide.

Some physicians "forget" to ask relevant questions and may ignore obvious clues that a patient is considering suicide. Even when the physician thinks of suicide risk - and it should always be considered and asked about in any patient with depression - there is the possibility that the physician will not assess the most critical factors or weigh them properly, that the patient will dissemble to hide his true intentions, or that it will be impossible to predict suicide risk for some individuals.

There have been numerous attempts to identify factors that are most predictive of suicide risk. The following factors are useful for evaluation in a clinical setting:

- **Age:** Suicide risk increases with age.
- **Sex:** Males are three to four times more likely to commit suicide than females, who are three to four times more likely than males to attempt suicide.
- **Previous suicide attempt(s)**: Sixty per cent of those who commit suicide have made a previous suicide attempt.
- **Depression:** Eighty per cent of people who commit suicide can be retrospectively diagnosed as depressed: of the remaining 20%, the majority are either schizophrenics (whose suicides are more difficult to predict) or hysterical individuals, whose suicide attempts may be manipulative in intent and who commit suicide by mistake.
- **Physical illness:** The risk is higher in those with chronic, painful or terminal illness, like cancer or AIDS.

- **Alcohol and other drug abuse**: These drugs tend to lower self control and facilitate impulsivity, and are often associated with marginal life styles which can be stressful in their own right.
- Characteristic **personality factors**, like those who are high risk-takers and self-destructive.
- **Knowing someone who has committed suicide.**

This factor seems especially important when the person who committed suicide is a family member or close friend. In the first case, the possibility of an inherited affective disorder may explain the association, whereas identification with a close friend's use of suicide as an ultimate solution to all problems may be as important as any sense of loss. Even when the person who commits suicide is not a friend - as when a famous person dies in this way - their example may be enough to suggest suicide to some susceptible individuals. This has been called the *copycat* or *Werther effect.*

- **Anniversaries and holidays**. These are often lonely and difficult times for depressed people.
- **Social isolation**. The recently bereaved, separated, or divorced person is more vulnerable to self-destructive activities of several kinds.
- Presence of a s**uicide plan**. Perhaps the most important clinical indicator of suicide risk is the individual's suicide plan. First of all, does the patient have a plan at all? If a plan been made, how serious is the risk?

Even when these factors (and others) are carefully assessed, suicide risk prediction remains a very difficult task. Once the risk has been recognized, treatment measures can be instituted which are often effective in reducing suicide risk and subsequent suicide, if it occurs, will not come as a great shock.

Suicide prevention

The first step in preventing suicide is to recognize that it is a serious risk in all depressed individuals. Second, the risk must be assessed as accurately as possible in the face of the admitted uncertainties of risk prediction. Third, active treatment of the underlying cause of the suicide risk (usually depression) will shorten the time the individual is at risk of

acting on suicidal thoughts and feelings. Since antidepressants are potentially lethal drugs, only limited prescriptions should be given to a suicidal individual, and medications should be supervised by family members. The availability of safer antidepressants, such as SSRIs, has significantly reduced the number of deaths from antidepressant overdosage. Hospitalization is an effective temporary measure with actively suicidal patents. This is especially important for individuals who live alone. Unfortunately, hospitalization is no guarantee against suicide; patients have hanged themselves on psychiatric wards or escaped from the hospital and committed suicide.

Patients are particularly likely to make suicide attempts when vigilance is relaxed as they begin to recover. The probable explanations for this experience are a reduction in confusion and ambivalence about living or dying, and an increase in energy to act on a suicide plan as depression begins to lift.

Electroconvulsive therapy has an important role to play in the management of actively suicidal individuals who are seriously depressed. Ordinarily, treatment every other day is sufficient, and most patients will have markedly decreased suicidal ideation and intention after three to four treatments. More frequent treatment is very rarely needed. Usually, an episode of depression will remit with the use of 6-12 sessions of ECT, which can be combined with medications to prevent relapses.

Repetitive transcranial magnetic stimulation rTMS has been used for management of depression.

Grief after suicide

When suicide occurs, the family involved needs and deserves an opportunity to try to understand what has happened. Although some of this can be done during the period of bereavement, it is important and worthwhile to meet with family members on several occasions, in the year or so after the suicide, to re-explore their feelings as time passes. Whether this exploration will reduce family morbidity and the likelihood of subsequent suicidal behavior in the surviving family members is unclear, but it will certainly help the family to cope.

Chapter 10 Management of depression

The first principles in the management of depression are:

- Prevent suicide
- Prevent irritation and reduce sadness
- Provide nutrition, rest, sleep, occupational interest
- Seek to preserve the patient's place in his society

The different modes of treatment are:

Physical treatments: These have been discussed in the section on drug treatment of depression.

Psychological and social management

- Give the opportunity for the patient to express his feelings and difficulties
- Advise, encourage, reassure, inform

One of the greatest fears of depressed patients arises from their feelings that things are running out of control. This fear can be dispelled by:

- Giving information about the patient's illness which may change his view of himself
- Implying that the general physician or the psychiatrist can and will help him to control the situation.

Depressed patients get into all sorts of practical difficulties with finances, family relationships, employment and the general management of their affairs. The family physician can help relieve the depressed patient of the burden of these problems. The resources of social support should be mobilized to reduce pressure on the patient and improve his ability to cope. These resources are sometimes easier to tap if the relatives are given information about the nature of the illness. If they are able to attribute the patient's behaviour to an illness, they may find it easier to deal with him and to be supportive. Depressed patients are not easy to live with and discussing the particular

difficulties which relatives have experienced may enable the doctor to suggest better way of coping with them.

The best use must also be made of the coping strategies open to the patient. Such strategies can be divided into those which change the situation, and those which control the stress of the situation.

Although the initial assessment of the depressed patient and the monitoring of physical treatments is the special expertise of the psychiatrist, it can also be accomplished to a certain extent by the family physician. The social management of depression along the above lines can be carried out by various members of the psychiatric team – psychiatrist, psychologist, nurse, social worker – depending on resources, and the family physician can accordingly refer severely depressed individuals.

Continuing management

One should be careful of the suicidal patient who is recovering – apathy resolves before hopelessness, particularly with ECT, and this may increase the risk of suicide.

Full recovery from a depressive illness implies that the functional shift described above is reversed. Recovery is incomplete if the patient still shows evidence of, for instance, diurnal variation (as reflected by feeling worse in the mornings or early waking.) Medication should not be stopped if such symptoms remain, as relapse is virtually guaranteed.

When the symptoms are in abeyance, medication should be continued for at least 6 months, and ideally for around 12 months. In some patients, maintenance antidepressant therapy may have to be continued. The continuing management of depression should incorporate a graded resumption of the demands of social roles. The aim should be caution: never ask the patient to attempt anything which is likely to be beyond his powers. Small steps provide for a continuity of successes which gradually restore self-esteem and resilience. A start may be made by engaging the patient in small tasks around the ward or home and later by similar structuring of activities in occupational therapy. Household activities should likewise form a graded progression. The big difficulty is the

return to work which cannot often be accomplished in small steps, although even here liaison with a good employer or personnel officer (with the patient's permission) can help. In general, effective resumption of all social roles and the return of relationships to normal tend to occur later than symptomatic recovery.

Adjustment of the patient's coping strategies probably has its major effect in the prevention of future relapses - both spontaneous and provoked - although enthusiasts for cognitive therapy argue that it has a therapeutic as well as a preventive role, even in moderately severe depression. While maintenance antidepressant therapy can protect against spontaneous relapse, it does not seem to mitigate the effects of acute misfortune.

The patient's relatives are often invaluable, although sometimes discounted, as sources of information about relapses. Practical changes in environment (e.g. rehousing) sometimes help but not always.

The physician may consider a decision to admit the patient in a hospital. Admission is a major form of social treatment. It removes the patient from a situation of stress and provides a breathing space in which it may be possible to renew his capacity to cope. On the other hand, especially in milder cases, admission can undermine the ability to cope, disrupt his social circumstances, reduce the opportunity to bolster self-esteem, and create significant stigma, especially in our society.

The following are indications for admission:

- Dangerousness to self and self-harm (suicide, infanticide, violence),
- Malnutrition,
- Severe depression or severe social incompetence,
- Inability to cooperate with outpatient treatment,
- Failure of outpatient treatment or the need for ECT,
- Inadequate support from relatives.

Those with severe depression should not be left alone for the first 2-3 weeks: they can be demoralized and their progress retarded if they fail to cope.

Management and rehabilitation of the chronically depressed patient:

If there are persistent symptoms of the functional shift which are resistant to routine physical treatment, drug compliance should be checked. Outpatients should be asked if they are taking any other medication. Chronic and refractory depressions are best treated by a psychiatrist; physicians should refer such cases to the mental health specialist. Some more information about chronic depression is given in an earlier chapter.

A minority of depressed patients are totally refractory and in consequence are suffering from chronic affective disorder. Such patients who fail to respond to treatment tend to be middle-aged and relatively socially isolated. They suffer from persistent residual disabilities affecting work capacity and relationships, marital and general. Impairment of role performance is often relatively selective. Such disabilities provide a source of continuing stress. The general principle in managing such patients is to focus on restoring or improving social adaptation and the ability to function in daily life situations, even if symptoms persist to a greater or lesser degree. The treating team should work to enhance the emotional capacity of the patient for dealing with social relationships, and for rehabilitation in terms of work performance. Therapy should aim at reestablishing confidence and feelings of mastery and self-esteem. Most patients with chronic resistant depression require a combination of psychotherapy and various pharmacological agents, and such care is best provided by a specialist.

To Recapitulate…

Modes of treatment of depression

Physical treatment

Psychological and social management.

Principles of management of depression are:

Prevent suicide,

Prevent irritation and reduce sadness,

Provide nutrition, rest, sleep, occupational interest,

Seek to preserve the patient's place in society.

Continuing management especially of suicidal patients is necessary.

Those with severe depression should not be left alone for the first 2-3 weeks of therapy.

Chapter 11 Drug treatment of depression

Drug treatment of depression involves mainly the use of various antidepressants. Antidepressants are a heterogeneous group of drugs that alleviate depression by increasing the levels of key neurotransmitters in the brain. The term "antidepressant" is a misnomer, as these drugs are useful in a variety of conditions besides depression. They are classified based on their chemical structure or mode of action.

Commonly available antidepressants

1. **Tricyclic antidepressants:** these are the oldest and most time-tested drugs. They still play a significant role in managing severe depression, but are less frequently used owing to their side-effects. Common members of this group include *amitryptiline, imipramine* and *dothiepin*.
2. **Selective serotonin reuptake inhibitors (SSRIs):** these are a newer group of drugs designed to have more selective actions than the tricyclics, and therefore cause less side-effects. They are safe and effective in a variety of patient groups, including children and the elderly, but not all patients respond to them. Commonly used SSRIs include *fluoxetine, sertraline, paroxetine, citalopram* and *escitalopram.*
3. **Serotonin and norepinephrine reuptake inhibitors (SNRIs):** These drugs were designed to combine the superior efficacy of tricyclics with the lower side-effect risks of SSRIs. SNRIs include *venlafaxine, duloxetine* and *milnacipran.*
4. **"Novel" antidepressants:** these are newer drugs which do not fit into any of the above categories. Each of them has unique properties. Commonly used drugs in this group are *bupropion, trazodone, mirtazapine* and *tianeptine*.

When should antidepressants be prescribed?

The decision to start antidepressants depends on the diagnosis and the nature and severity of depressive symptoms. Antidepressants are prescribed in the following situations:

1. If the depression is endogenous in origin (melancholia), i.e. it is without an appropriate precipitating factor, with diurnal variation in mood, early morning

awakening, low appetite and libido, loss of weight, guilt and psychomotor retardation.

2. If depressive symptoms are severe and intolerable – for example, if a patient feels very weepy, sleepless and is unable to do any work because of depression.
3. If the person has had previous episodes of depression, antidepressants should be started as soon as early changes in mood, behaviour, sleep or appetite are noted, to cut short a full-blown episode.
4. If depression puts the life of the patient (e.g in severe depression with suicidal attempts or food refusal) or others (e.g in a mother with postnatal depression who is unable to care for her child) at risk.

Which antidepressant should I choose?

Most antidepressants are equal in efficacy, but some are more useful in specific conditions. In addition, their side-effect profile and drug interactions also influence drug choice. Choosing an appropriate antidepressant requires a thorough evaluation of the patient, the depressive disorder, and any associated physical or mental conditions.

1. If the person has had previous episodes of depression, enquire about the previous response to antidepressants. Favourable response to previous antidepressants may imply that the current episodes may also respond favorable to the same. A family history of a response to an antidepressant may also be helpful in choosing a drug.
2. Children and adolescents do not respond well to tricyclics, and the elderly may not tolerate them. Thus, SSRIs are the drugs of choice in these patients.
3. If there have been previous episodes of hypomania or mania, antidepressants should not be used alone, but in combination with a *mood stabilizer* such as lithium or divalproate. Otherwise, these drugs can trigger a manic or hypomanic episode in these patients.
4. In a subject with known history of epilepsy, tricyclic antidepressants and bupropion reduce the seizure threshold. The SSRIs are generally safe, but fluoxetine and fluvoxamine also have drug interactions with commonly used

anti-epileptics. Hence SSRIs such as sertraline or escitalopram, or newer antidepressants other than bupropion, can be chosen.

5. If the subject has history of acute congestive glaucoma or prostatic enlargement, tricyclics and the SSRI paroxetine should be avoided due to their anticholinergic properties.
6. If there is evidence of cardiovascular disease in the past or present, tricyclics are best avoided as they can cause tachycardia, changes in blood pressure, and even cardiac arrhythmias in rare cases. Venlafaxine and tricyclics should be avoided in patients with hypertension. SSRIs and other new antidepressants are safe in this group of patients.
7. Depression following a cerebrovascular accident responds well to either tricyclics such as nortryptiline, or SSRIs such as citalopram and fluoxetine.
8. If there is evidence of duodenal ulcer, tricyclics such as imipramine or doxepin can be chosen as they have acid-suppressing properties.
9. If the depression is characterised by retardation, an "activating" antidepressant, such as fluoxetine or bupropion, may be useful.
10. In depressed patients with concurrent anxiety disorders, or with obsessive-compulsive disorder, SSRIs are the drugs of choice.
11. In agitated depression, sedating antidepressants, such as the tricyclics, are helpful. If tricyclics cannot be used, newer antidepressants with sedating properties include mirtazapine and trazodone.
12. In patients with chronic pain – for example, due to neuropathy or cancer - tricyclic antidepressants can relieve both depression and pain. Duloxetine is a newer alternative for patients who have depression and neuropathic pains.
13. In patients with a high risk of suicide, drugs that can be used in a suicidal attempt, such as tricyclics, should be dispensed with caution. SSRIs are relatively safe in overdose and are preferred in these patients.
14. In depression following acute myocardial infarction, SSRIs such as sertraline are safe and effective, and may reduce mortality rates.
15. Patients who wish to quit smoking and also suffer from depression can be offered bupropion, as it reduces the craving for nicotine.

16. In patients with sexual dysfunction, mirtazapine and bupropion are preferred, as they have less sexual side-effects than other antidepressants. However, in men with premature ejaculation, SSRIs can both treat depression and anxiety and cause a beneficial ejaculatory delay.

What are the correct doses of antidepressants?

Dose ranges for antidepressants vary widely depending on the drug concerned. These medications are usually initiated at low doses and increased every few days to the maximum dose required or tolerated by the patient. The table below lists common dosing regimes for antidepressants in healthy adults. In the elderly, starting and final doses are generally about half of those used in adults: a popular dictum when prescribing in old age is that you should "start low and go slow".

Medication	**Starting dose**	**Dose increase**	**Usual target dose**
Tricyclics			
Imipramine	50-75 mg/day	50-75 mg per week	75-225 mg/day
Amitryptiline	50-75 mg/day	50-75 mg per week	75-225 mg/day
Dothiepin	50-75 mg/day	50-75 mg per week	75-225 mg/day
Nortryptiline	10-25 mg/day	25 mg per 4-5 days	100-150 mg/day
SSRIs*			
Fluoxetine	10-20 mg/day	10-20 mg per week	20-80 mg/day
Sertraline	25-50 mg/day	25-50 mg per 4-5 days	100-250 mg/day
Fluvoxamine	50 mg/day	50 mg per 4-5 days	100-300 mg/day
Paroxetine	20 mg/day	20 mg per week	20-60 mg/day
Citalopram	20 mg/day	20 mg per week	20-60 mg/day
Escitalopram	5-10 mg/day	5-10 mg per week	10-30 mg/day
SNRIs			
Venlafaxine	37.5-75 mg/day	37.5-75 mg per week	75-225 mg/day
Duloxetine	20-40 mg/day	20 mg per 4-5 days	60-120 mg/day

Milnacipran	25-50 mg/day	25-50 mg per week	50-200 mg/day
Novel agents			
Bupropion	75-150 mg/day	75-150 mg per week	150-300 mg/day
Mirtazapine	7.5-15 mg/day	7.5-15 mg per week	15-45 mg/day
Trazodone	50-100 mg/day	50-100 mg per week	200-600 mg/day

** The higher doses mentioned for SSRIs are for the treatment of obsessive-compulsive disorder (OCD). Lower doses are used for patients with depression who do not have OCD.*

Most for adults should be given preferably as a single dose, with the exception of duloxetine, milancipran and nortryptiline which are usually given in two divided doses.
Antidepressants usually take 10-14 days to produce their antidepressant effect, thought effects on sleep, anxiety and restlessness may occur after a few hours. A full response usually takes about 4-6 weeks. Any given antidepressant should be tried for at least six weeks before being considered as ineffective for that person.
The advantages of giving a single bed-time dosage (late evening 7-8 p.m.) are many::

- Compliance is better,
- The beneficial effect lasts the entire day flowing administration, due to adequate half-life.
- Anticholinergic and other side-effects, which usually occur a few hours after ingestion, pass off during sleep, without causing problems to the patient,
- The sedative effect can be taken advantage of since it would help the depressed patient to sleep, and avoid need of an additional sedative.

Some drugs, such as fluoxetine and sertraline, are slightly “activating” and may disturb sleep. These drugs are therefore usually given as single morning doses. The depressed patient and the family members should be educated about the use of antidepressants. The time lag needed for the onset of antidepressant effect should be explained to them. Common side-effects should be explained. They should also be educated about how to cope with the common side-effects like dryness of mouth (use frequent sips of water, chew

gum or mint), orthostatic hypotension (by gradual change of posture) and constipation (by diet, and use of isabgol husk).

Common side-effects of antidepressants

Medication or group	**Common side effects**
Tricyclic antidepressants	1. Anticholinergic effects – dry mouth, constipation, blurring of vision, urinary retention, confusion, sexual side-effects 2. Postural hypotension 3. Sedation. 4. Increased appetite and weight. 5. Cardiac arrhythmias and seizures – rare, at high dosages 6. Fatalities in overdosage.
SSRIs	1. Gastrointestinal – nausea, diarrhoea, loss of appetite 2. Sexual – loss of libido, impaired ejaculation or orgasm 3. Neurological – dizziness, headache, tremor, fatigue 4. Temporary worsening of anxiety and agitation 5. Sleep changes – insomnia or sedation
SNRIs	1. Gastrointestinal, sexual, neurological – same as SSRIs 2. Raised blood pressure – venlafaxine 3. Dysuria 4. Worsening of symptoms if stopped abruptly
Bupropion	1. Decreased sleep and appetite 2. Gastrointestinal disturbances 3. Seizures (at doses of 400 mg/day or more)
Mirtazapine	1. Sedation 2. Weight gain, increased lipid levels 3. Gastrointestinal disturbances
Trazodone	1. Sedation 2. Gastrointestinal disturbances 3. Priapism - rare

For how long should antidepressants be continued?

Antidepressant medications should generally be continued for about 12 months, at the dose that was effective, once a patient has responded. Alternatively, antidepressants can be gradually tapered after 6 months and a maintenance dose (the lowest effective dose) given for another 6 months. If antidepressants are stopped as soon as depression has lifted, the chances of relapse are high. When stopping antidepressants, they must be tapered slowly over a period of about 4 weeks.

Patients with recurrent episodes of depression, or with chronic depression, may require long-term treatment for a period of two to five years, depending on the severity of their illness, the number of episodes and other factors.

To Recapitulate…

- Choosing an antidepressant requires a thorough evaluation of the patient and his depressive disorder.
- Various classes of antidepressants are available; though all are effective, certain drugs are more useful in particular situations.
- Antidepressants for adults are best given as a single dose, usually at bedtime.
- Patients and their families should be educated about the use of medications.
- Antidepressants take 2-3 weeks to work, and a complete response usually takes 4-6 weeks.
- All antidepressants have side-effects, but many of these improve with time.
- Antidepressants should be continued for at least 1 year after recovery from an episode of depression.

Chapter 12 Prognosis of depression

Most depressed patients will either recover completely or nearly so form the first attack (70-92%). Some of this group will have a fairly rapid recurrence of minor affective symptoms. Episodes occurring later in life last longer and are possibly more likely to be chronic. Sex and family history of affective disorder do not influence duration, but slow onset may indicate slow recovery.

A majority of those who recover will relapse. There may be a subpopulation of those who do not relapse, who are much more likely to be depressive than manic. Some have claimed that the chance of recovery becomes less with succeeding episodes.

A substantial minority develop a chronic disability which may follow the first episode. The proportion of chronic cases increases with intensity of follow-up. Between 5 and 10% may be long-term hospital inpatients and an additional 25% may have persistent affective symptoms which are to some degree incapacitating. There is considerable social impairment in this group.

Chronicity may take a non-affective form. A small proportion of patients develop schizophrenia. A few cases develop a chronic defect state having never had schizophrenic symptoms, and a few change to a chronic paranoid state.

Episodes leading to hospital admission are likely to have a total duration of several months. Much of the episode will precede admission. Episodes which do not lead to hospital admission are often shorter and milder.

Episodes of mania may possibly be of more rapid onset and of shorter duration than episodes of depression.

Prospective long-term follow up studies in Indian literature suggest that a change of polarity is higher than that reported in other countries. Bipolar patients have a higher mean number of episodes compared to those with recurrent unipolar depression. Recurrences are associated with an early age of onset, while chronicity is related to a later age of onset. Though completed suicides are low, the percentage of suicidal thoughts and attempts is significant in patients with mood disorders.

Chapter 13 Counseling patients about depression and antidepressants

Generally, physicians can counsel the patients and their family members about depression, the nature of the disorder, need for treatment, and other precautions. Due to prevalent myths and misperceptions about mental illness in general, the patient and his family members need to be educated appropriately about depression, the importance of treatment, and details regarding antidepressant medications, such as:

- The need for antidepressant medication
- The duration of treatment needed
- Common side effects to be expected, and how the patient could cope with them, such as dry mouth, orthostatic hypotension, and constipation – the common anticholinergic side effects of tricyclic antidepressants.
- When to expect an antidepressant response. It usually takes about 2-3 weeks for antidepressant activity to start
- Some early effects, like sedation, can be mentioned
- To improve compliance, we should inform patients about the development of tolerance to most side effects and also that the occurrence of side effects is an indication that the drugs are producing an effect.
- Myths about the development of addiction or dependence to antidepressants should be cleared. Antidepressants should be differentiated from anxiolytics like benzodiazepines, which are more notorious for producing drug dependence.

To Recapitulate….

- Most depressed patients (70-92%) recover completely or nearly from the first attack.
- A majority of those who recover will relapse.
- Generally physicians can counsel the patients and their family members about depression, the nature of the disorder, need for treatment, and other precautions.
- Practical and scientific information on medication should be shared with patients, like:

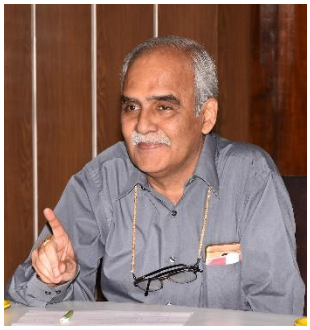
The need to give antidepressants,

How long the therapy should be continued,

Common side effects to be expected and how the patient should cope with them,

When to expect antidepressant response.

Fears about development of addiction or dependence to antidepressants, unlike the real risk associated with benzodiazepines, should be dispelled.



The author of this book, Dr Santosh Kumar Chaturvedi, MD (Psychiatry) FRCPsych (UK), was previously associated with the National Institute of Mental Health & Neurosciences, NIMHANS, Bangalore as Dean, Behavioral Sciences, and Senior Professor and Head of Department of Psychiatry. He was also the Head of Department of Mental Health Education, and Head of Psychiatric Rehabilitation Services at NIMHANS, Bangalore.

ISBN-13: 979-8594786264