DEPRESSIVE DISORDERS

FOR PATIENTS AND FAMILIES

Depression may simply be transient feelings of dejection and sadness from disappointments, rejections, and losses that are a part of our lives. On the other hand, it may be from grieving the loss of a loved one. These feelings of sadness are usually less severe and are shorter in duration than untreated **major depression** (a more severe form of depression). In milder forms of depression, although psychotherapy and medications may help the individual deal with feelings of sadness and loss, the body's natural recuperative ability eventually "heals the mind."

On the other hand, major depression is a clinical diagnosis of a more severe form of depression. A depressive episode may come on suddenly or insidiously, developing gradually without a precipitating cause. Besides altering mood, major depression also affects bodily functions and thinking. Patients with clinical symptoms of major depression frequently present with changes in sleep, appetite, and daily activity. The depressed patient may have difficulty sleeping or may sleep too much. He or she may have diminished appetite or may eat excessively. There may be significant weight loss without dieting, or weight gain. The patient feels lack of energy and is apathetic, fatigued, or sluggish and leaden. Depression is often associated with somatic (bodily) complaints, with unusual aches and pains, and it is not uncommon for the patient to seek medical attention for what he or she believes are physical ailments, when, in fact, the primary problem may be depression.

Psychologically patients may experience impaired concentration, feelings of guilt, worthlessness, hopelessness, indifference, and loss of interest and ability to feel pleasure (**anhedonia**). Thinking may be slowed, muddled, and confused. Patients often complain of memory problems. They may feel overwhelmed with sadness and express concerns of having a "nervous breakdown." Thoughts of death and suicide are common, and the risk of committing suicide is especially high in depressed patients.

> **Delusions** are false beliefs or perceptions about something or someone. **Hallucinations** are false sensations. These sensations can be heard (auditory), seen (visual), smelled (olfactory), tasted, (gustatory), or felt (tactile).

Delusions and hallucinations may occur in severely depressed patients. The content of the patient's delusions or hallucinations may be consistent with the depression and may be manifested by perceptions of inadequacy, guilt, death, or deserved punishment. Or, the content of the delusions and hallucinations may be more bizarre and may be manifested in symptoms of persecutory delusions (the patient may have delusions in which others want to hurt him), thought insertion (the patient thinks his thoughts are implanted in his mind by other people or forces), and thought broadcasting (the patient thinks her thoughts are broadcasted and can be heard by others). Major depression with delusional or hallucinatory symptoms is a severe form of major depression (**psychotic depression**), requiring aggressive treatment, including use of antipsychotic medications.

Patients with manic-depression, or **bipolar disorder**, may be afflicted with both manic and depressive episodes, with mood swings that take the patient from expansive, manic states to depressive states of hopelessness and despair. The symptoms are almost indistinguishable during a depressive episode in bipolar disorder from major depression.

COURSE OF ILLNESS

The risk of depression extends throughout life. It may begin during any age period, from childhood, adolescence, adulthood, and old age. Generally, depressions are treatable with medications with successful results. However, some patients may not respond to medications, while others may not respond fully and have residual symptoms.

Without treatment, a depressive episode may last for months or even years, but usually it clears spontaneously in about 6 months. However, in patients treated with antidepressants, their depressive episodes last about 3 months (underscoring the importance of antidepressant therapy). Unfortunately, major depression is a chronic disorder, and there is a high rate of relapse. A significant number of patients will have recurrence of their depression. Fortunately, if the patient's first depressive episode was successfully treated, and if it recurs, subsequent depressive episodes will usually respond well to treatment. However, patients who have recurring depressive episodes usually do much better if they continue taking antidepressants. By continuing antidepressants, recurrences are often averted, and if they do occur, they are usually much less severe.

RISK OF SUICIDE

The risk of suicide is very high during the early stages of major depression. Approximately 10%–15% of severely or clinically depressed patients will take their own lives. The risk of suicide is increased in depressed patients who live alone, were recently divorced, have a history of alcohol and drug abuse, have a history of previous suicide attempts, and have expressed suicidal ideations. Patients who are considered high risk for suicide should be hospitalized for inpatient treatment and kept under close watch until they are stabilized.

CAUSE OF DEPRESSION

The study of clinical depression has focused on the neurobiology of the brain and abnormalities in neurotransmission. When earlier studies indicated that antidepressants such as imipramine and monoamine oxidase inhibitors worked by boosting the level of the neurotransmitter **norepinephrine**, scientists postulated that depression might be caused by a deficit of norepinephrine in certain nerve cells throughout the brain. However, with the discovery of fluoxetine (Prozac), another very effective antidepressant, which does not act on the norepinephrine system but instead acts on serotonin, it became evident that other neurotransmitter systems may be involved in depression as well. Understanding depression from a biochemical basis became pivotal to the development of new and improved antidepressants.

Although a biochemical hypothesis to explain the cause of depression may be an oversimplification, it remains useful. It may help patients understand that depression, like other disease processes, is caused by a dysfunction of the body and not a character flaw or weakness. For example, it is analogous to diabetes, in which the disease is caused by low insulin levels or defective insulin regulation and utilization. Similarly, depression may be associated with low levels of neurotransmitters or the abnormal regulation of neurotransmitters. Like many other diseases, depression may be triggered by the environment or inherent in our genes.

Depression may also be caused by a number of physical disorders, the most common of which is decreased thyroid function (hypothyroidism). Occasionally, patients who have strokes become seriously depressed. Depression may occur in women during pregnancy or shortly after childbirth (postpartum depression). Alcohol and drug abuse and certain medications may also cause depression.

DIAGNOSIS

Major Depression

For a diagnosis of major depression, five or more of the following symptoms must be present for at least 2 weeks, and at least one of the symptoms is either depressed mood or loss of interest or pleasure.

- Depressed mood most of the day, nearly every day
- Markedly diminshed interest or pleasure in all, or almost all, activities
- Decreased or increased appetite and weight
- Decreased (insomnia) or increased (hypersomnia) sleep

- Physical agitation (inability to sit still, hand wringing, pacing) or slowness (retardation) of activity
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate or unusual indecisiveness
- Recurrent thoughts of death or suicide

When a major depressive episode is accompanied by hallucinations or delusions, the major depressive disorder is a psychotic depression (**major depression with psychotic features**).

Another subtype of major depression is the **melancholic** type. This type of depression is very responsive to antidepressant medications and electroconvulsive therapy (ECT). In addition to the symptoms listed above, **major depression with melancholic features** is characterized by

- Depressed mood occurring more severely in the mornings
- Awaking early in the morning before the usual time and having difficulty going back to sleep
- Significant loss of appetite and weight loss
- A relatively fixed depressed mood that does not react to pleasurable events

Other Forms of Depression

Seasonal Affective Disorder (SAD)

For some people living in climates with marked seasonal changes of daylight, their mood may fluctuate with the seasons. Dark, dreary winter months may bring on annual depression that begins around October or November, with January and February generally being the worst months. The depression usually resolves with the coming of spring in March or April. This seasonal pattern of depression is called **seasonal affective disorder** (SAD) and has many of the symptoms of major depression, but the symptoms are usually not quite as severe.

Patients with mild seasonal affective disorder may respond simply to phototherapy, a treatment using ultraviolet lamps to simulate sunlight. In more severe seasonal depression, patients may need both phototherapy and antidepressant medications.

Dysthymia

Dysthymia is a milder form of depression that has an early onset, developing in childhood, adolescence, or early adulthood. The impairment is due to the continuous nature of the disorder rather than its severity in this form of mild, chronic depression. The depressed mood is often accompanied by feelings of inadequacy, poor self-esteem, self-deprecation, indecisiveness, poor concentration, pessimism regarding the future, a sense of hopelessness, overeating or poor appetite, hypersomnia or insomnia, and tiredness or lack of energy. Dysthymic patients often seen to be unhappy but may not be aware that they are depressed, for their symptoms are less intense than those of major depression. However, these patients are more prone to develop major depression.

TREATMENT

The primary medical treatments of depression are medications and ECT. Psychotherapy may be used in addition to medications or ECT to support treatment. With mild depression, some clinicians may elect to try psychotherapy first before prescribing medication.

Antidepressants

Antidepressants can be divided into two general groups: 1) the *earlier antidepressants*, which include the tricyclic and tetracyclic antidepressants (TCAs) and the monoamine oxidase inhibitors (MAOIs); and 2) the *newer antidepressants*, which include the selective serotonin reuptake inhibitors (SSRIs) and other antidepressants

that do not fit into the categories above, such as bupropion (Wellbutrin SR), nefazodone (Serzone), and venlafaxine (Effexor XR).

Imipramine was one of the first antidepressants developed back in the late 1950s. Imipramine has a three-ring chemical structure, and hence it is known as a tricyclic antidepressant. Imipramine was followed by the development of other tricyclic antidepressants, including amitriptyline (Elavil) and desipramine (Norpramin). Today there are a total of nine tricyclic antidepressant and two tetracyclic (four-ring structure) antidepressants, which differ little from the tricyclic compounds in their mode of action and side effects. The tricyclic and tetracyclic antidepressants are effective antidepressants and were widely prescribed for many decades before they were superseded by a new generation of antidepressants, such as fluoxetine (Prozac). The newer antidepressants are not necessarily more effective than the TCAs, but they are safer and have fewer side effects than the older antidepressants.

Another class of antidepressants, developed around the same time as the TCAs, comprises the *monoamine oxidase inhibitors.* MAOI antidepressants include phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan). Selegiline (Eldepryl), a newer MAOI, was approved by the federal Food and Drug Administration for treatment of Parkinson's disease, but some psychiatrists prescribe it for treating depression as well. With the availability of new antidepressants, the use of MAOIs has been limited, because these agents present potentially dangerous interactions with other medications and certain foods.

With the introduction of fluoxetine, or Prozac, in the early 1990s, the treatment of depression was revolutionized by an antidepressant that was not only effective but highly tolerated by patients. Fluoxetine represented the first in its class that worked by selectively increasing the neurotransmitter of serotonin in the brain. Following fluoxetine, other similar antidepressants were synthesized, and collectively, they are known as *selective serotonin reuptake inhibitors.* These antidepressants *inhibit* the reuptake of released serotonin back into the nerve cells and thus boost neurotransmission of these neurons. Other SSRI antidepressants include citalopram (Celexa), escitalopram (Lexapro), fluvoxamine (Luvox), paroxetine (Paxil), and sertraline (Zoloft).

The other new antidepressants that are not neatly categorized into any one group include bupropion (Wellbutrin), nefazodone (Serzone), trazodone (Desyrel), venlafaxine (Effexor), and mirtazapine (Remeron). These agents are also called dual-action antidepressants because either they affect more than one neurotransmitter or they exert their action at different sites on nerve cells. For a discussion of the antidepressants, refer to *Part 3 (Information About Medications for Patients and Families)*.

Generally, patients are prescribed one of the SSRIs, especially if it is their first episode of major depression. The SSRIs are effective, well tolerated, easy to dose, and generally safe if overdose occurs. The SSRIs may be dosed once daily either in the morning or at bedtime. It usually takes about 2–4 weeks for the antidepressant to achieve full effects, and a therapeutic trial should last 4–8 weeks at the maximum dose. If the patient's depressive symptoms are still present after this period, switching to another SSRI may often produce improved response. If adequate response is not achieved after the second trial of an SSRI, the patient should be switched to an antidepressant in a different class (e.g., bupropion, venlafaxine, or a TCA) with a different mechanism of action.

If the third antidepressant trial fails and a patient's depression is deemed treatment-resistant, it then presents a treatment challenge for the physician. Some patients may benefit from lithium augmentation, in which lithium carbonate is added to boost the effect of the antidepressant. Some physicians may use a different augmentation strategy. Instead of lithium, liothyronine (T_3, Cytomel), a thyroid hormone, is added to the antidepressant, or another antidepressant from a different class is added to the first antidepressant (e.g., an SSRI and a TCA). Some physicians may use a mood stabilizer such as divalproex (Depakote) or carbamazepine (Tegretol) instead of lithium for augmentation. Patients whose depression continues to be refractory to treatment may benefit from treatment with an MAOI. For patients who are nonresponders to medications, ECT may be an option.

ECT

ECT can be a life-saving treatment for severe depression. It is often used for patients who have severe suicidal and/or delusional thoughts and for pregnant women who are severely depressed. When ECT achieves the desired response, it usually takes effect quicker than medications.

Psychotherapy

Supportive psychotherapy may be an invaluable adjunctive treatment for depression in addition to medication or ECT, but some patients with less severe depression (e.g., dysthymia) may respond to psychotherapy alone. The psychotherapist can help patients work through painful, internal conflicts of depression by examining the feelings of guilt, worthlessness, and hopelessness and eventually helping the patient regain confidence and self-esteem. One of the goals of psychotherapy is to identify the external and psychological stresses that may be causing the patient's distress and devise methods for coping with these issues. The clinician may help patients assess their problems with interpersonal relationships and help them recognize that these may be the result of their depressive illness rather than holding themselves responsible for their troubling consequences. This can enable them to deal with the embarrassment, fear, and anxiety of their depression. The clinician may also help patients recognize early signs of mood changes, so that early intervention may prevent a mild depression from becoming severe.

SUICIDE PREVENTION

When the patient is thinking or talking about suicide, seek help immediately.

- Call the physician or mental health worker, or go to a hospital emergency room to seek help.
- Call a suicide prevention center in your area.
- Talk to a friend, a relative, or a member of the clergy.
- In an emergency, if the individual is in the act of attempting suicide, call the police.

If you have any questions about this handout, please consult your physician.

SUPPORT AND ADVOCACY GROUPS

Depression Awareness, Recognition, and Treatment Program (D/ART)
National Institute of Mental Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (800) 421-4211
Web site: http://www.nimh.nih.gov/HealthInformation/Depressionmenu.cfm

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
Phone: (800) 950-NAMI; (703) 524-7600
Web site: http://www.nami.org

National Foundation for Depressive Illness, Inc.
P.O. Box 2257
New York, NY 10116
Phone: (800) 239-1265
Web site: http://www.depression.org

Depressives Anonymous
329 E. 62nd Street, Suite 50
New York, NY 100021
Phone: (212) 689-2600

Depression After Delivery, Inc.
91 East Somerset Street
Raritan, NJ 08869
Phone: (800) 944-4PPD (4773) Information
Web site: www.depressionafterdelivery.com