Depressive disorders

Depressive disorders are commonly characterized by the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function.

What differs among them are aspects of duration, timing, or presumed etiology.

Depressive disorders according to DSM V can be classified into:

– Disruptive mood dysregulation disorder
– Major depressive disorder
– Persistent depressive disorder (dysthymia)
– Premenstrual dysphoric disorder
– Substance and medication-induced depressive disorder
– Depressive disorder secondary to other medical conditions
– Other specified and unspecified

Affective and mood disorders

A disorder characterized by mood disturbance is usually accompanied by abnormalities in thinking and perception arising from mood disturbance.

Classification

- Major depressive disorder
- Bipolar I disorder

Major depressive disorder

Definition: This is the presence of depressed mood or loss of interest in pleasure with four or more of the following symptoms:-

1. Feeling of worthlessness or guilt
2. Impaired concentration
3. Loss of energy or fatigue
4. Suicidal thoughts
5. Loss or increase of appetite and weight

6. Insomnia or excessive sleep.
7. Psychomotor retardation or agitation.

The above symptoms are required to be present for at least 2 weeks.

Major depression may be present with or without psychotic features like delusions, hallucinations, or bizarre behavior.

Sleep impairment may involve initial insomnia, middle insomnia, or terminal insomnia.

Suicidal ideation may range from passive ideas e,g wishing one was death to active plans on how to kill oneself.

Psychotic features are most often mood-congruent. i.e the content of delusion or hallucination reflects depression.E.G a mood-congruent delusion might be the belief that one has committed a terrible crime or sin.

A mood-congruent hallucination might be a voice that tells one to die or that says you have failed life.

Epidemiology

The lifetime risk of developing MDD is 15% overall.

It is more common in women than men in a ratio of 2:1

The range of onset ranges from childhood to old age. The mean age is 4oyrs

Recurrence is common.50% of people who have one episode of MDD will have one or more additional episodes.

Pathophysiology

Depression results from the low level of mono-amines specifically serotonin and norepinephrine.

Etiology of depression

The exact cause is unknown however some of the implicated factors include:-

Genetic factors: the incidence of MDD is higher among relatives of individuals with the disorder than among the general population. 50% of the people with MDD have a first-degree relative with a mood disorder.

Biochemical factors: The level of mono-amines Serotonin and Norepinephrine are reduced in individuals with major depressive illness

Cognitive factors; narrow negative view of self, the environment, and future

Psychosocial factors like unemployment, loss of loved one, stress,

Predisposing factors to major depressive disorder

1. Family history of depression
2. Gender: women are twice likely to get depression as men
3. Health conditions like cancer, heart disease, and thyroid disorder
4. Violence, physical or emotional abuse such as rape
5. Unemployment
6. Divorce
7. Changes and stressful events such as relationship breakups, starting of a new job.

Somatic symptoms of depression

Significant decrease in appetite and weight

Early morning awakening at least 2 or more hours before usual time of waking up.

Lack of interest and lack of reactivity to pleasurable stimuli.

Psychomotor agitation or retardation

Forms of depression

Reactive depression (exogenous depression) : state of depression that people experience in response to external stressor. Caused in reaction to external event or circumstance. e.g death of a family member, divorce or break up.

Endogenous depression: depression that has no obvious cause. Believed to be originating from within an individual. Linked with genetic nature of individual

Treatment modalities

Antidepressants : SSRIs , TCAs , MOAi,

Physical therapies: ECT indicated for severe depression with suicidal risk

Psychotherapy: Emphasizes helping patients gain insight into the cause of their depression

Cognitive therapy: aims at correcting the depressive negative cognitions like hopelessness and pessimistic ideas

Supportive psychotherapy: various techniques are employed to support the patient. They are reassurance, occupational psychotherapy, relaxation

Group Therapy: sharing experiences to improve the expression of their feelings

Behavior therapy: includes social skill training.

Family therapy: used to reduce or modify stressors.

Acute management

First-line treatment in severe depression is a TCA unless it is contra-indicated. The main contra-indications are coexisting cardiac disease and intolerance to anticholinergic side effects like urine retention

The main alternatives to TCAs are the SSRIs which do not have side effects, are not sedating, and are safe in overdose. The main s/e are nausea, diarrhea and agitation

If the patient does not respond to 6 weeks of treatment on a therapeutic dose of TCA or an SSRI, consider increasing the dose of current medication or changing to anti-depressant

Anti-psychotics should be used if the depression is accompanied by a psychotic episode

ECT is indicated in the management of resistant depression and where anti-depressants are contra-indicated or when patients' life may be at risk from suicide or dehydration arising from the refusal to eat or drink.

Relapse prevention

Anti-depressants should be continued for a minimum of 6 months after the resolution of an acute episode

Nursing management of a patient with depression

Encourage the patient to express emotions. Provide the patient opportunity to cry out and ventilate their anger.

Assess if there is any suicidal tendency. Take safety measures and keep vigil if the patient has suicidal ideas.

Administer prescribed antidepressants in time and monitor food intake.

Provide non-intellectual activities e.g cleaning physical exercises provide safe and effective methods of discharging vent up tension.

Promote sleep and food intake. Most patients have insomnia and lack appetite

Keep a strict record of sleeping patterns. Discourage sleep during the day to promote more restful sleep at night.

Promote or interact with the patient and focus and not far in future.

Provide health education to patient and relatives regarding disease and drugs.

Health education shared on drugs

Take medications regularly and the right dose.

Teach the patient when therapeutic effects will be seen.At least 2 to 3 weeks must elapse before he feels better

Inform the patient of the side effects of antidepressants

Teach the patient to avoid alcohol as it causes drug interaction and may cause harm.

Not to stop medication without medical advice

Health messages shared to family members

Advise the family to watch for any suicidal ideas or gestures and inform the clinician immediately.

To give adequate support and encouragement to the patient

To give accept the patient as he is and give him hope and care

To give medication regularly as prescribed.

To provide the correct history to a clinician

Bipolar disorder

A disorder characterized by episodes of mania and depression.

Mania

A condition characterized by excessive happiness with inflated self-esteem (grandiosity)

It is quite common for a patient in a manic state to believe that he or she is special. A person may believe that he is on a special mission from God.

Presenting features of mania

Expansive or irritable mood. The person feels extremely high.

He or she may describe the experience as feeling on top of the world. The patient may shift from highly elated mood to being angry and irritable if they perceive to have been obstructed.

Hyperactivity or psychomotor agitation

Delusions of grandiosity.

Pressured speech.

Flight of ideas.

Easy distractibility. respond to multiple unimportant stimuli

Dress on bright colors often that do not match

Excessive make-up and jewelry

Marked impairment in occupational functioning, social activities or relationships

Hallucinations most commonly auditory

Etiology

Genetic factors: Mania run through families.

Biochemical factors: Mania is considered to be due to excessive biogenic amines (excess norepinephrine and serotonin)

Psychological factors (stress commonly precedes the 1st episode of both major depression and mania.

Medical management

?Mood stabilizers: drugs with mood stabilizers properties e.g sodium valproate, carbamazepine, lamotrigine, and lithium should be instituted early in treatment