

Depression: an Overview

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How big a problem?

- Prevalence in Canada:
 - 5% (1 in 20)
 - Lifetime: ~ 8%
- Female : male = 2:1
- > young adults
- < over 65's
- > low income / unemployed
- > unmarried / divorced

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Depression is common in all countries. It's considered a major public health problem. In Canada, about one in twenty adults is likely to have a depression at any given time. During your lifetime, your risk of having a depression at some point is about 8%. Women are twice as likely to become depressed as men.

Depression rates appear to be higher in young adults, and lower in the elderly. Low income or unemployed status, and being single or divorced, also implies a greater risk for depression.

A Canadian study showed that parental psychopathology and a history of childhood abuse were more common among depressed people.

How disabling?

- Leading cause of disability
 - 1.8 x physical disability
 - 23 x social disability
 - 3 x more likely to have sick days
 - Employers less likely to hire, cf other chronic illnesses
- Increased use of medical & emergency services
- 2 x risk of death
- 26 x risk of suicide

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In developed countries, depression is a leading cause of disability.

A World Health Organization study found that depressive illness increased the risk of onset of physical disability by 1.8 times after one year.

Also, depression caused a 23 times increase in the risk of social disability, after controlling for physical disease and disability.

Work productivity is also markedly affected. Ontario residents with a history of depression during the year prior to the study, were nearly 3 times more likely than control subjects to have sick days during the preceding month.

Employers have been shown to hold negative attitudes toward mental illness and to be less likely to hire persons with depression than persons with other chronic illnesses, such as diabetes.

Both major depression and dysthymia are associated with an increased use of general medical services or emergency services for emotional problems.

In a study of 4000 patients with depressive disorders, the standardized mortality rate doubled for all cases of death but was increased 26 times for suicide.

Impact on others

- Cohabitant caregivers of elderly depressives:
 - High psychiatric morbidity, esp. depression and anxiety
- Children of depressed mothers:
 - Fussy infants
 - Slow mental, motor development
 - School, behaviour problems
 - Lack of social competence

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The social and emotional costs of depression are also seen in the mental health of family members and caregivers.

Living with an elderly individual with depression was associated with high levels of psychiatric morbidity, particularly depression and anxiety symptoms, in caregivers.

Parents with depression can negatively affect their children: large numbers of studies have linked maternal depression to infant fussiness, slow mental and motor development, school problems, lack of social competence, behaviour problems, and low levels of self-esteem in children.

Costs of depression

- U.S., 1990: US\$44 billion
 - 12 billion direct costs
 - 8 billion mortality costs
 - 24 billion absenteeism/loss of productivity
- Ontario, 1990: CAD\$476 million

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Depression is more prevalent than other major public health problems and imposes significant costs on society.

In the U.S. in 1990, the total annual cost of depression was estimated to be 44 billion US dollars; that's 803 gazillion Canadian dollars. Direct costs were 12 billion, 8 billion for mortality costs, and costs due to loss of productivity and absenteeism were 24 billion. These figures do not include out-of-pocket family expenses, costs of minor depression, or excessive hospitalization or diagnostic tests.

An Ontario study found the the total annual cost of depressive disorders to be almost half a billion dollars. Again, this does not take into account the impact on overall general medical service use and family burden costs.

Symptoms & Signs

	Mild (blues)	Major depression	Psychotic depression
Mood:	Sad, low, discouraged	Loss of interest or pleasure	Delusional worthlessness or guilt
Thinking:	Difficulty concentrating	Slowed, indecisive	Thoughts of death, suicide, homicide
Speech:	Normal	Slowed, low, monotonous	Decreased, muteness
Sleep:	Insomnia	Insomnia or hypersomnia	More severe
Activity:	Normal, but feels tired	Slowed; sustained fatigue	Agitation or catatonia
Appetite:	May be decreased	Decreased / increased; wght chnge	More severe
Senses:	Normal	Decreased awareness / distractible	Hallucinations

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A classic depression is easy enough to recognize, but there are enough variations that even experienced psychiatrists can be fooled.

The essential feature is feeling bad, and continuing to feel bad for too long.

This table presents the symptoms, that is, those things that the person complains of, and the signs, defined as what the doctor observes, for a mild depressive state, what most people would call the blues, and contrasts these with signs and symptoms of full-blown depression, and finally , with a severe depression with psychotic features.

Under low mood, I would add that depressed people may feel hopeless, that there is no future for them. The loss of interest or pleasure may be a complaint of “not caring anymore” or even an inability to experience pleasure. The family may notice withdrawal from friends and family, and a neglect of hobbies or interests.

The so-called psychomotor retardation is most noticeable with slowed speech, often with long pauses before answering, and a low tone of voice, sometimes even a whisper.

Severely depressed people may begin to believe that they are evil or worthless, and that the world would

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The classic pattern of insomnia associated with depression is early morning awakening. There is some evidence that this may actually be the brain's attempt to treat the depression, since it is known that late partial sleep deprivation is an effective treatment for depression. Unfortunately, these individuals that complain of waking at 3 or 4 am will often fall asleep at 5 or 6 am and then sleep until 8 or 9 am or even later, thus possibly perpetuating the depression.

Some people sleep more than usual. This pattern is often associated with increased appetite, especially craving for carbohydrates.

The fatigue experienced by depressed people is often crippling and pervasive, and occurs even in the absence of any physical exertion.

Agitation may show itself as an inability to sit still, or pacing, handwringing, pulling of hair, rubbing the skin or the clothing, or outbursts of complaining or shouting.

Catatonia is a state of being totally unmoving, sometimes even to the point of rigidity.

Associated Features

- Depressed appearance
- Tearfulness
- Anxiety
- Irritability
- Fear
- Brooding
- Excessive concern with physical health
- Panic attacks
- Phobias
- Delusions:
 - Persecutory
 - Nihilistic
 - Somatic
 - Of poverty
 - Of guilt
- Hallucinations

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Most of these associated features don't need any explanation. However, I do want to mention some of the types of delusions that people with depression might have. As you know, a delusion is a false belief that you can't talk the person out of. It needs to be distinguished from beliefs which are held by a group that you are a member of, but often the boundaries are blurry. For example, many Christians look forward to going to heaven at the end of their lives. Is this much different from that sect that believed they were going to be picked up from the earth by aliens? How do you decide if it's a delusion or not?

Nihilistic delusions might be along the lines of, the world is going to be destroyed. Somatic delusions include the belief that you have cancer or some other serious illness, or that your insides are rotting.

Well-off individuals may believe that they are destitute, in a delusion of poverty. Finally, it is quite frequent that a depressed person begins to believe that he is being punished for something, such as padding an expense account or overstating your expenses when filing your income tax return.

Hallucinations when they occur are usually of short duration. The person may hear voices which criticize her and run her down for sins or shortcomings.

Age-related Features

- In children:
 - Separation anxiety
- In adolescents:
 - Antisocial behaviour
 - Sulkiness
 - Withdrawal
 - School difficulties
- In the elderly:
 - "Pseudo-dementia"

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Depression looks different in different age groups. For example, in children, separation anxiety may cause the child to cling, to refuse to go to school, or express fears of dying or of the parents dying.

In adolescents, there might be antisocial behaviour, such as shoplifting or bullying others. Sulkiness, for example, refusing to do things with the family.

He might withdraw from social activities by retreating to his room. School difficulties are likely.

the elderly may have symptoms which suggest dementia, such as not knowing the time of day or the date, or where one is; difficulty remembering or concentrating, apathy or inattentiveness.

Bipolar Affective Disorder

- Also known as manic-depressive illness
- 1 - 2% of the population
- bipolar spectrum disorder:
 - Up to 5% of the population
- Patterns:
 - Periods of normal mood between manic and depressed episodes
 - Mania alternates with depression
 - Unipolar mania (rare)

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Many people who present with depression, may actually be suffering from what used to be called manic-depressive illness, now known as bipolar affective disorder. The proportion of depressives who are unipolar, as opposed to those who are bipolar, seems to be dropping all the time, as we become better at recognizing bipolar disorder. When we include milder forms of the disorder such as cyclothymia, and also include entities such as dysphoric mania, we get a prevalence of about 5% of the adult population who may have disorders in the bipolar spectrum.

Considering the classic form of bipolar illness, what some call Bipolar I, there are 3 main patterns, as shown on this slide.

Symptoms & Signs of Mania

	Mild (hypomania)	Mania	Severe mania
Mood:	Cheerful	Elated or irritable	Euphoric or angry
Speech:	Overtalkative	Pressured	Incoherent
Thinking:	Rapid	Racing, flight of ideas	Disorganized
Sleep:	Decreased sleep time	Days without sleep	Impossible to sleep
Activity:	Increased (socially, sexually, at work)	Distractible, physically restless	Agitated, combative
Ideas:	Sense of wellbeing	Grandiose	Delusional
Senses:	Sense of increased acuity	Responds to irrelevant stimuli	hallucinates

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It is often helpful in making a diagnosis of depression, to ask about any episodes of mania. The family may be helpful here.

Even though this table attempts to divide mania into three levels of severity, it usually considerably more complicated because there's so much overlap of symptoms and signs.

Mood in mania is often described as unusually good or high; there is often an infectious quality, called infectious good humour. Individuals who know the patient well are able to recognize the good humour as being excessive.

While we usually think of euphoria as the predominant mood in manic states, irritability or anger is probably even more common. Unfortunately, these people may be misdiagnosed as schizophrenic.

Manic speech is typically loud, rapid, and difficult to interrupt. It may be full of jokes, puns, plays on words, and amusing irrelevancies. It may become theatrical, with dramatic mannerisms and singing.

Flight of ideas is a nearly continuous flow of accelerated speech with abrupt changes from topic to topic. You can usually follow the rapid changes, which may be based on plays on words. In severe mania, the thinking becomes disorganized, and may resemble schizophrenic thought.

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The hyperactivity seen in mania often involves excessive planning of and participating in multiple activities, whether work-related, sexual, political, or religious. The person is usually excessively social, for example, calling friends or family at all hours of the day or night, perhaps running up incredible long distance telephone charges.

The grandiosity may be an uncritical self-confidence. For example, despite an absence of talent, the person may try to write a book, compose music, or sell an invention. When grandiosity becomes delusional, it may involve a belief of a special relationship with God or with wellknown political, religious, or entertainment stars. The person may believe he has a special mission in life. Frequently there are persecutory delusions - this is particularly likely to lead to a misdiagnosis of paranoid schizophrenia. Keep in mind, however, that, almost by definition, being paranoid also means being grandiose. After all, you have to be somebody pretty special if people are after you!

The manic person is unable to recognize how intrusive, domineering, and demanding his or her behaviour is. Frequently, the unwarranted optimism, grandiosity, and lack of judgment lead to buying sprees, reckless driving, foolish business investments, and sexual behaviour unusual for the individual. The activities can be disorganized, flamboyant, or bizarre, for example, wearing strange & colourful costumes, wearing

Forms of Bipolar Disorder

- Bipolar I:
 - Classic form, with clear episodes of mania & depression
- Bipolar II:
 - Never become manic to the point of needing treatment
- Rapid cycling:
 - At least 4 mood episodes in 12 months (~10% of bipolars)
- Dysphoric mania:
 - Depressed mood, morbid thoughts, but Sx of mania
- "Soft bipolar":
 - (cyclothymic personality)

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Besides the classic form of bipolar disorder, now referred to as Bipolar I disorder, the bipolar spectrum includes the entities shown on this slide.

Dysphoric mania is find the most interesting. These individuals will complain of being very depressed, even to the point of suicide. However, when talking to them, they present with agitation, anger and irritability. On the inpatient unit, these people wait for you by the nursing station. When you go by, they sort of grab you and say emphatically, "I'm so depressed, Doc! You gotta do something!" Their speech is often rapid and hard to interrupt. They may be aggressive with staff or other patients. They often sleep little, waking up early in the morning but not returning to bed as more typical depressives often do.

These patients in the past were often diagnosed as having an agitated depression. They didn't respond well to antidepressants, which would usually just increase the agitation. ECT was often the only effective treatment.

We now are more likely to recognize this pattern as dysphoric mania, and recognize that antidepressants would simply worsen the manic symptoms without helping the depressed mood. More effective are mood stabilizers, possibly in combination with antidepressants. An anticonvulsant medication called lamotrigine may be more helpful in this kind of disorder than other mood stabilizers.

What causes Depression?

- No one knows
- Vulnerability factors:
 - Biological:
 - genetic
 - Family history → 15-20%
 - Identical twin → 50%
 - Medications affecting serotonin, norepinephrine
 - Medical illness increases risk
 - Disturbance of diurnal rhythms (eg shift work, recurrent jet lag)

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No one knows why depression occurs. Some think that depression is the final outcome of a variety of clinical conditions.

Depression occurs in all cultures, races, and ages, and affects individuals at all income levels, amount of education, status, or gender.

However, at least four major factors are known to affect vulnerability to depression: biological factors; early life experiences; personality styles, and social support systems.

Inherited, that is, genetic, biological factors clearly contribute to vulnerability. About 15-20% of people with family histories of depression are likely to develop depression. For an individual with an identical twin who has suffered from depression, the likelihood of becoming depressed goes up to 50%.

Because medications which affect serotonin and norepinephrine systems in the brain have been found useful in treating depression, it is believed that these neurotransmitters are implicated in depression.

Because of correlations between certain physical illnesses and depression, additional biological factors are thought to be involved.

Finally, disturbance of circadian rhythms seems to be implicated. Sleep loss is known to trigger mania, and

What causes Depression? -2

- Early life experiences:
 - Major losses in early years
 - Poor relationships throughout childhood
 - History of abuse or neglect
- Personality factors:
 - Highly self-critical
 - Chronic low self-esteem
- Social support system:
 - Isolation, loneliness (eg divorce)
 - Major life change
 - Stress

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In terms of certain early life experiences which increase vulnerability to depression, having suffered a major loss such as the death of a parent or extreme neglect before the age of 5 years, seems to be particularly important.

Poor relationships throughout childhood, or a history of abuse or neglect, often influences personality development in such a way as to increase vulnerability to depression in adulthood.

Personality styles are another influence. For example, highly self-critical individuals or those who suffer from chronic low self-esteem are more likely to become depressed.

Finally, the presence or absence of a social support system exerts a major influence on depression vulnerability. People who are isolated and lonely are at high risk not only for depression but particularly for suicide. Major life changes, such as divorce, a move to a new home, change of job, or the loss of a loved one, increase risk of depression for several months after the event.

Research shows that having even one close friendship helps protect against depression. Interestingly, marriage exerts a protective effect for men, but probably not for women.

Finally, stress. However, lots and lots of people have major stresses in their lives and do not become

Associated Medical Conditions

- Alzheimer's & other dementias
- Cancer
- Cerebral infarctions
- Cushing's Syndrome
- Multiple Sclerosis
- Myocardial Infarction

Associated Medical Conditions - 2

- Chronic Fatigue Syndrome
- Chronic pain
- Diabetes
- Fibromyalgia
- Hypo/hyperthyroidism
- Infectious diseases
- Irritable Bowel Syndrome
- Menopause/post-partum
- Metabolic imbalances
(calcium, uremia)

Associated Medical Conditions - 3

- Migraines
- Nutritional imbalances:
folate, vitamin B12, iron
- Parkinson's Disease
- Psychiatric illnesses:
schizophrenia & related,
obsessive compulsive
disorders, panic disorder,
substance abuse disorders
- Sleep apnea

Medications causing Depression

- Anabolic steroids
- Interferon
- Systemic corticosteroids
- Substances of abuse:
 - Alcohol
 - Barbiturates
 - Benzodiazepines
 - Hallucinogens
 - Narcotics
- Hormones

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Hormones include birth control pills.

Many other medications, including a large number of medications people take for high blood pressure or angina, are also believed to cause depression in some people.

Natural History of Depression

- Untreated major depression: 10 mos.
- Successfully treated: 2-3 months
- Risk of a second depression: 75% (lifetime)
- Highest risk for recurrence: first 6 months
- Outcome of a depression:
 - 50% full recovery
 - 30% partial recovery
 - 20% chronic depression
- Suicide:
 - 20% make attempts
 - 15% die from suicide

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Mild depressions typically last a few months and may go away by themselves. However, moderate and severe depressions tend to last significantly longer. On average, an untreated major depression lasts about 10 months which can be reduced to 2 to 3 months with successful treatment.

Once an individual has had a depression, he or she has a 75% risk of having another during their lifetime. The risk for recurrence is highest during the first 6 months after the first episode.

For those who have recurrent depressions, the average number of episodes over a lifetime is about 5.

Half of people who become depressed can expect full recovery from their episode. Another 30% will mostly recover, while the remaining 20% go on to have chronic depression.

Suicidal thoughts are extremely common in individuals with depression. About 20% of people with major depression attempt suicide. Approximately 15% of people who experience severe recurrent depressions do die by suicide.

When should depression be suspected?

- Frequent, unexpected physical symptoms
- Higher risk due to:
 - Chronic medical illness
 - Other psychiatric disorders
 - Family history
 - Past depression
 - Stressful life event
 - Poverty, unemployment, etc.
 - Isolation
 - Certain medications
 - Substance abuse, esp. alcohol

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If you suspect that someone may be depressed, based on one or more of the factors as shown in this slide, how do you go about screening for depression?

Interviewing for Depression

- Evaluation questions:
 - Have you felt sad, low, down, depressed, or hopeless? On a scale of 0 to 10 how have you been feeling lately?
 - Have you lost interest or pleasure in the things you usually like to do? Have you been as social as usual? Have you been less interested in interacting with others (family, coworkers)?

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This slide and the next two provide a series of questions you might ask to assess whether an individual is depressed. The first two evaluate for depressed mood and loss of interest.

If the person answered yes to one or both of these questions, go on to the following questions.

- Have you been sleeping much more than usual or had difficulty falling asleep or staying asleep?
- Have you lost your appetite or had an unusual increase in appetite? Any cravings for junk food?
- Have you been feeling tired or having little energy?
- Does your thinking seem slower or more confused than usual? Are you making more mistakes?
- Have you felt that you are a failure or that you let yourself or your family down? What are you looking forward to? Have you felt guilty about things that happened in your life?

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These questions find out about sleep disturbance, appetite disturbance, loss of energy, difficulty concentrating, feelings of worthlessness...

- Have you been moving or talking more slowly than usual? Have you felt agitated or on edge? Do you feel like you have to keep talking or moving all the time? (also can be observed)
- Have you thought that you or your family would be better off if you were dead? Have you thought of killing yourself? Have you tried to hurt/kill yourself before? When? How many times? What did you do? Are you thinking of killing yourself? Do you have a plan? How will you do it? What stops you from acting on your thoughts?
- (for adolescents) Are you bored with life? Did you used to have more excitement in your life?

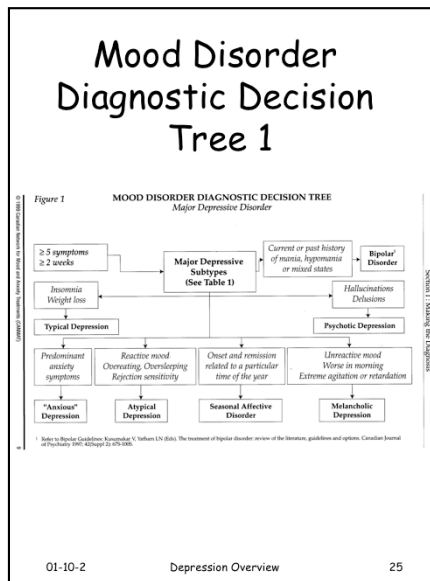
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Psychomotor retardation or agitation, and finally, suicidal thoughts. Note that for adolescents, suicidal tendencies may manifest as boredom.

That makes a total of 9 major symptoms for depression. If the person has experience 5 or more of these, for at least two weeks, we can look at this flowchart...



To assist in diagnosing a major depressive episode, which is what the presence of 5 symptoms for two weeks is called.

Any history of manic symptoms in the past suggests bipolar disorder.

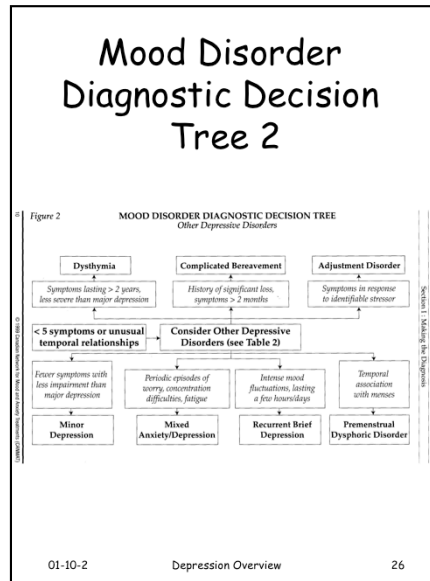
If insomnia and weight loss are present, this suggests a typical depression, while the presence of hallucinations or delusions means a psychotic depression.

When anxiety symptoms are prominent, it is sometimes called an “anxious” depression.

An atypical depression is characterized by a mood which does seem to improve with pleasurable events, and when increased appetite and sleep are present. Sensitivity to rejection has also been described as applicable to this diagnosis.

When the illness either starts or improves at particular times of the year, it is said to be a seasonal affective disorder.

Finally, those who have diurnal mood variation, in other words, feeling worse in the morning, together with a lot of agitation or slowing, may have what’s called a melancholic depression.



The middle boxes in this chart are the starting point for looking at depressive disorders with fewer than 5 symptoms. For example, when the illness has been present for longer than two years, and is not as severe as a major depression, it is called dysthymic disorder.

Complicated bereavement occurs when symptoms last longer than usual after a loss. What is normal? That depends on the importance of the loss and on the individual, so there are no hard and fast rules.

When there is an identifiable stressor, such as the death of a loved one, the bereaved person is expected to have symptoms. This is called an adjustment disorder. People who are experiencing a normal grieving process are given this label, even though their symptoms are not due to a “disorder”. I prefer the older term, adjustment reaction.

There are also categories called minor depression, mixed anxiety depression, recurrent brief depression, and premenstrual dysphoric disorder.

Risk Factors for Suicide

- Male
- Caucasian, aboriginal
- Elderly, adolescent
- Isolated, withdrawn, alienated
- Unemployed
- Single, divorced, separated
- Failure of support systems
- Prior attempts
- Impulsive behaviour
- Recent discharge from hospital
- Family history of suicide or substance abuse

Risk Factors for Suicide - 2

- Not in touch with reality (psychotic)
- Severe hopelessness
- Manic patient becoming depressed
- Presence of agitation, lack of self-care
- Alcohol or substance abuse
- Borderline or antisocial personality traits
- Chronic psychiatric disorder
- Concomitant or chronic medical illness (eg cancer, HIV, multiple sclerosis)

When to Hospitalize

- Psychotic symptoms
- Severe depression
- Definite suicidal plan
- Suicide attempt of high lethality
- Lack of reliable support system
- Recent drawing up of will, etc.

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A suicide attempt of low lethality, but that failed to produce a positive situational change, is also an indication for hospitalization.

Involuntary Admission

- Based on:
 - Threats or attempts to cause bodily harm to self
 - Violent behaviour or threat of violent behaviour toward another person
 - Lack of ability to care for self
- Physician believes that:
 - Person is apparently suffering from a mental disorder that may result in serious bodily harm to self, another person or imminent serious impairment to self.