Psychology

Sheet

Depression disorders

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**التبييض باللون الاخضر

INTRODUCTION

We live it on a daily basis but with less aggressive symptoms , Its the second most common mental disorder after anxiety , Depression mostly associates with mood, when anxiety is associated with behaviors & moo There's a good level of anxiety that we need to maintain a normal life

Depression is the oldest and one of the most frequently diagnosed psychiatric illnesses.

- **"The blues" are normal, healthy responses to everyday disappointments in life.**
- **Pathological depression occurs when:**
  - **Adaptation is ineffective** When you cannot adopt to life situations and issues
  - **Symptoms impair functioning** Won't eat ,sleep or do anything

We have fluctuation, which are the mood swings, depending on what happens during the day if there's a disappointment normally, you would feel sad if there's something good happened you would feel happy you should have a reaction to life situations , if you don't that's abnormal and it's called apathy

INTRODUCTION CONTINUED

The mood (symptoms) is the subjective data that the patient gives like the e.g : when patient talk about suicidal thoughts. While the affects (signs)are the objective data that detector can see on the patient e.g facial expressions.

Mood

- **Pervasive and sustained emotion that may have a major influence on perception**
  - **Depression, joy, elation, anger, and anxiety**
  - **Affect describes the observable emotional reaction.**

- Depression Combined with all depression disorders
- Alteration in mood expressed by sadness, despair, and pessimism Lack of motivation, hygiene and self-care
  -Changes in appetite, sleep patterns, and cognition (Perception) are common.

we have atypical and typical symptoms of depression the atypical ones like excessive eating, and oversleeping ,the typical symptoms are the generally recognized, this differs from person to person

EPIDEMIOLOGY

short Movie suggested the black dog E pidemiology by the world health organization (who) on youtube

- Major depressive disorder (MDD) is one of the leading causes of disability in the United States.
- Depression is one of the most common psychiatric disorder.
- Up to 50 percent of all depression diagnoses may be bipolar illness.

50% of the patient diagnosed by depression are diagnosed with bipolar

EPIDEMIOLOGY (CONTINUED)

- 3.1 million (12.8 percent) American teens aged 12 to 17 reported having at least one major depressive episode, and 70 percent of those had severe impairment.
- Age and gender
- Many factors influence age-related depressive symptoms

depression is not related to age it's related to the stressors of which phase

- Depressive disorder is twice as high in women than in men.
  - Gender difference less pronounced between 44 and 65

The woman gets into the menopausal and then she won't have as much hormonal changes

- **Age and gender (continued)**

• Biological factors

most specifically (Hypothyroidism)

– Monoamine oxidase; thyroid dysfunction; hormonal changes

TSH ,T3,T4, electrolytes,vitamins, other medications that may have this side effects

• Psychosocial factors

– Stress sensitivity; multiple social roles; poorer coping mechanisms

Easily broken

• Socioeconomic factors

– Social class; poverty; education level

Depression is most common in poor people, while bipolar is most common in rich people

- **Race and culture**

• No consistent association between race and depressive disorders have been identified.

• Racial comparison studies are hampered by multiple variables including

– Access to health resources and accurate diagnosis

– Geographic location, immigrant versus nonimmigrant nativity, and discrimination

– Underdiagnosis of mood disorders/overdiagnosis of schizophrenia with patients of different race or cultural background

It's not affected by the race or color or the culture ,it's affected by the quality of life on specific areas (that might not have a psychiatrist clinic) or the cultural barrier that can stop people from going to the clinic (stigma)

- **Marital status**

• Studies have mixed results regarding the effect of marriage on psychological well-being.

– Lack of social connectedness rather than marital status may be associated with a higher incidence of depression.

Fall and winter

- **Seasonality**

Can be treated by the phototherapy, which is letting thepatient inside a room with excessive light, closing the eyes and covering the skin

- **Studies have yielded varying results.**

– **Seasonal affective disorder is referred to as a separate condition, although the DSM-5 does not list it as a separate diagnosis.**

DSM3 DSM4

Diagnostic and Statistical Manual of Mental Disorders

TYPES OF DEPRESSIVE DISORDERS

- **Major depressive disorder**

- **Characterized by depressed mood**
- **Loss of interest or pleasure in usual activities**
- **Symptoms present for at least 2 weeks**
- **No history of manic behavior** If the patient got manic behavior, it will be diagnosed as a bipolar
- **Cannot be attributed to use of substances or another medical condition**

Complicated grieving (if grieving take too much time) ,may lead to depression

symptoms are less in severity (or mild) ,but last for a longer duration of time

- **Persistent depressive disorder (Dysthymia)**

- **Sad or "down in the dumps"** Monotonic
- **No evidence of psychotic symptoms**
- **Essential feature is a chronically depressed mood for:**

– **Most of the day**
– **More days than not**
– **At least 2 years**

- **Premenstrual dysphoric disorder (PMDD)**

- **Characterized by:**

– **Markedly depressed mood, excessive anxiety, mood swings, decreased interest in activities during the week prior to menses, improving shortly after the onset of menstruation, and becoming minimal or absent in the week postmenses**

there is typical changes in hormones that can lead to aggression, sadness or a bad mood in general which happens in normal cases but the atypical changes which referred to as premenstrual dysphoric disorder, have the same symptoms as the depression and can lead to dysfunction in life

- **Premenstrual dysphoric disorder (PMDD) (continued)**

• **Difference between PMDD and typical premenstrual mood changes is a matter of intensity and frequency of symptoms.**

  – **PMDD symptoms interfere with ability to function socially, at work, or school.**

- **Substance/Medication-Induced Depressive Disorder**

it can be cause either by the substance itself and the chemical changes (toxicity) that it cause or by the withdrawal after quitting

• **Considered the direct result of physiological effects of a substance (drug of abuse, medication, toxin exposure)**

• **The depressed mood is associated with intoxication or withdrawal from several substances or adverse side effects from many different medications.**

Quitting does not mean, necessarily curing the depression

*Addiction in general can lead to depression either on gambling ,substance abuse or gaming treating addicted people depression is harder than the other types

- **Depressive disorder associated with another medical condition**

• **Attributable to the direct physiological effects of a general medical condition**

e.g : thyroid dysfunction & hypothyroidism treating the cause, does not mean, necessarily tearing the depression Before treating the depression, you should do a full health check up if you didn't do the health check up you may give the patient antidepressants the he doesn't need and it won't be effective also cause worsening the disease that caused the depression from the first place

PREDISPOSING FACTORS TO DEPRESSION

- **Biological theories**

• Genetics depression is not an acquired trait

– Hereditary factor may be involved

– Twin studies

– Adoption studies

• Biochemical influences

– Deficiency of norepinephrine, serotonin, and dopamine an issue in the Neurotransmitters

has been implicated

Adoption

parents with history of depression adopt a kid compared to other parents (with the same history of depression) who have a biological kid ,, is there genital effect? if the kids have a physiological parent with a depression history they have a higher chance of having depression,, they are not blood related the depression won't be transferred to the adopted kids

Twins

If one of the monozygotic children had a depression there's a high chance that the other one will have depression too .If they are dizygotic, the chance still high, but lower than the monozygotic ones

- **Physiological influences**
  - **Secondary depression is related to:**

– **Medication side effects**

It's so important to ask the patient if they are taking any medication because sometimes depression is the side effect of the drug or it is a drug-drug interaction

– **Neurological disorders**

sometimes dementia is confused with depression cause it have the same symptoms as the depression. Also, you should take to consideration if the patient got chronic inflammation ,deficiencies , disturbance electrolytes ,hormones, neurocognitive disorders (e.g dementia) especially elders

– **Electrolyte disturbances**
– **Hormonal disorders**
– **Nutritional deficiencies**
– **Other physiological or psychological conditions**
– **Inflammation**

- **Psychosocial theories**
  - **Psychoanalytical theory**
    – **A loss is internalized and becomes directed against the ego.**

in psychoanalytic theory, an imbalance between ego and superego can lead to depression

- **Learning theory**

Raising a child to be helpless

  – **Learned helplessness**
  – **The individual who experiences numerous failures learns to give up trying**

• Cognitive theory Expectations

– Views primary disturbance in depression as cognitive rather than affective

– Three cognitive distortions that serve as the basis for depression

1. Negative expectations of the environment
2. Negative expectations of the self
3. Negative expectations of the future

DEVELOPMENTAL IMPLICATIONS

- Childhood depression
  - Symptoms The the depressed child does not need to take antidepressants until acertain age

1. Less than age 3: Feeding problems, tantrums, lack of playfulness and emotional expressiveness
2. Ages 3 to 5: Accident proneness, phobias, excessive self-reproach blame himself for problems that he may didn't cause
3. Ages 6 to 8: Physical complaints, aggressive behavior, clinging behavior back pain, headache
4. Ages 9 to 12: Morbid thoughts and excessive worrying more anxious

- Childhood depression (continued)

• Precipitated by a loss

• Focus of therapy: Alleviate symptoms and strengthen coping skills

• Parental and family therapy

Because we cannot give the child antidepressants, we give him another type of treatment like psychotherapy ,psychological support ,family therapy or play therapy

Which break the wall between you and the kid and allow the kid to be comfortable enough to share

Adolescence

- Symptoms include
  - Anger, aggressiveness
  - Running away
  - Delinquency (Crime)
  - Social withdrawal
  - Sexual acting out
  - Substance abuse
  - Restlessness, apathy

normal teenager has a stability in his mood (or signs in general) e.g: if he is angry, he would be angry mostly every day ,if he is aggressive, he would be aggressive every day and so on, but the teenager who got depression will have episodes so a week he will be depressed and down and the other week he would be normal or less depressed

in this case if there is fluctuating = psychological disorder
we give the patient antidepressants & psychological therapy

the most important side effect of the antidepressants that the teenagers take is the suicide thoughts which is unfortunate

↓

paradoxical reaction

- Best clue that differentiates depression from normal stormy adolescent behavior
  - A visible manifestation of behavioral change that lasts for several weeks
- Most common precipitant to adolescent suicide
  - Perception of abandonment by parents or close peer relationship

• Treatment

– Supportive psychosocial intervention

– Antidepressant medication

▪ NOTE: All antidepressants carry a Food and Drug Administration black-box warning for increased risk of suicidality in children and adolescents.

▪ Senescence 60-70

• Bereavement overload

• High percentage of suicides among elderly

• Symptoms of depression often confused with symptoms of neurocognitive disorder

• Treatment Hard to deal with and treat

– Antidepressant medication

– Electroconvulsive therapy

there is two types of ECT Unipolar and bipolar ,, both cause brief seizures ,lead to improving the mood, works on serotonin (each case differs from the others)

Most countries have discontinued its use due to various side effects, including memory impairment, myocardial infarctions, heart attacks, and bone fractures. It is now recommended that patients use it only 10 to 12 times throughout their lives.

– Psychosocial therapies

in Baby blues got more mood swings at first hours to days and it's the most common

The "baby blues" do not last for more than 2 weeks after giving birth. If symptoms last longer or start later, you could have postnatal depression

- Postpartum depression

• May last for a few weeks to several months

• Associated with hormonal changes, tryptophan metabolism, or cell alterations 15% of women have postpartum depression

• Treatments of antidepressants and psychosocial therapies

• Symptoms include

– Fatigue, Irritability

– Loss of appetite

– Sleep disturbances, Loss of libido

– Concern about inability to care for infant

*if there's no psychological support it might progress to depression disorder especially if she got the risk factors

ASSESSMENT

- All individuals become depressed from time to time, and these symptoms tend to be transient.
- Severe depression is marked by distress that interferes with social, occupational, cognitive, and emotional functioning.
- Four spheres of human functioning

• Affective

• Behavioral

• Cognitive

• Physiological

- **Transient depression**

• Symptoms at this level of the continuum are not necessarily dysfunctional Considered normal

– Affective: The "blues"

– Behavioral: Some crying

– Cognitive: Some difficulty getting mind off of one's disappointment

– Physiological: Feeling tired and listless

Can last for a couple hours in a day

- **Mild depression**

• Symptoms of mild depression are identified by clinicians as those associated with normal grieving

– Affective: Anger, anxiety

– Behavioral: Tearful, regression

– Cognitive: Preoccupied with loss

– Physiological: Anorexia, insomnia

- **Moderate depression**

• Symptoms associated with dysthymic disorder

– Affective: Helpless, powerless

– Behavioral: Slowed physical movements, slumped posture, limited verbalization Poor eye contact

– Cognitive: Retarded thinking processes, difficulty with concentration

– Physiological: Anorexia or overeating, sleep disturbance, headaches physical pain

- **Severe depression**

• **Includes symptoms of major depressive disorder and bipolar depression**

– **Affective: Feelings of total despair, worthlessness, flat affect** apathy

–**Behavioral: Psychomotor retardation, curled-up position, absence of communication** Fatal position

–**Cognitive: Prevalent delusional thinking, with delusions of persecution and somatic delusions; confusion; suicidal thoughts** The patient might gets in psychosis

– **Physiological: A general slow-down of the entire body**

because the depressed patient may have psychotic symptoms(same as schizophrenic patient).

It might be confused with schizoaffective disorder, how to tell the difference between these two?

that depends on the depression symptoms and the schizophrenia phases. because they both differs.

Google :

Patients with majordepression with psychotic features (MDD with PF), only experience psychotic features during their mood episodes. In contrast, schizoaffective requires at least two weeks in which there are only psychotic symptoms (delusions and hallucinations) without mood symptoms.

OUTCOME IDENTIFICATION

- **Criteria used for measurement of outcomes in the care of the depressed patient**

• **The patient**

– **Has experienced no physical harm to self**

– **Discusses feelings with staff and family members**

– **Expresses hopefulness**

– **Sets realistic goals for self**

– **Attempts new activities**

– **Identifies aspects of self-control over life situation**

– **Expresses personal satisfaction and support from spiritual practices**

– **Interacts willingly and appropriately with others**

– **Maintains reality orientation**

– **Concentrates, reasons, solves problems, and makes decisions**

– **Eats a well-balanced diet with snacks, to prevent weight loss and maintain nutritional status**

– **Sleeps 6 to 8 hours per night and reports feeling well rested**

– **Bathes, washes and combs hair, and dresses in clean clothing without assistance**

OUR CONCERNS..

- **Risk for suicide**
- **Complicated grieving**
- **Low self-esteem/self-care deficit** **Important**
- **Powerlessness**

TREATMENT MODALITIES

- **Individual psychotherapy**
  - Focus is on interpersonal relations and proceeds through three phases and interventions.
- **Group therapy**
  - Types of groups include therapy, education, and self-help.
- **Family therapy**
  - Most effective when used in combination with psychotherapeutic and pharmacotherapeutic treatments
- **Cognitive therapy**
  - Focuses on changing "automatic thoughts" that contribute to distorted affect
- **Electroconvulsive therapy (ECT)**
  - Electrical currents are applied to the brain, causing a grand mal (generalized) seizure.
- **Light therapy**
  - Administered by a 10,000-lux light box with a screen that blocks ultraviolet rays Mostly used with Seasonal affective disorder
- **Psychopharmacology**
  - Tricyclics Second chioce
  - Selective serotonin reuptake inhibitors First chioce
  - Monoamine oxidase inhibitors (MAOIs) Last chioce

They fell out of favor because it works on all three neurotransmitters of the brain also concerns about interactions with certain foods and numerous drug interactions. it also interact with tyramine, which is in all diary products ,beans, yeast,smoked meat ,wines, soy, liver, etc..

Excessive tyramine can elevate blood pressure and cause a hypertensive crisis. Patients treated with MAOIs
should adhere to recommended dietary modifications that reduce the intake of tyramine. Critical case that might get the patient to ICU , causes heart, attack, strokes, and other life-threatening health problems

Google:
Drugs used for the treatment of depression include the following:

Selective Serotonin Reuptake Inhibitors (SSR|s)
Serotonin/Norepinephrine Reuptake inhibitors (SNRIs)
Atypical Antidepressants.
Serotonin Modulators.
Tricyclic Antidepressants (TCAs)
Monoamine Oxidase Inhibitors (MAOIs)
NMDA Antagonists.

PATIENT/FAMILY EDUCATION RELATED TO ANTIDEPRESSANTS

some patients see changes from the first day and others needs a month to see them

- **Continue to take medication for 4 weeks.**

we start with titration and discontinue by weaning

- **Do not discontinue medication abruptly.**
- **Report sore throat, fever, malaise, yellow skin, bleeding, bruising, persistent vomiting or headaches, rapid heart rate, seizures, stiff or sore neck, and chest pain.**
- **Rise slowly from sitting position.** because of Orthostatic hypotension
- **Maintain good oral care.**

)in both antidepressants and antipsychotic medications

Avoid foods and medications high in tyramine when taking MAOIs. These include:

- Aged cheese
- Wine; beer
- Chocolate; colas
- Coffee; tea
- Sour cream; yogurt
- Smoked and processed meats
- Beef and chicken liver
- Canned figs
- Caviar
- Raisins
- Pickled herring
- Yeast products
- Broad beans
- Soy sauce
- Cold remedies
- Diet pills

هل غيّرت الأحداث الأخيرة فيك شيئا، أو نويت التغيير على الأقل؟!

إذا كنت مُقيما على ذنب= اتركه لله.
إذا كنت لا تصلي= آن الأوان أن تصلي.
إذا كنت هاجرا للقرآن= ارجع له والزَمه.

تُنصرُ الأمةُ بصلاح أفرادها، وتُهزَم بذنوبهم،
فيا عباد ؛؛ انصروا أمَّتَكُم بصلاح أحوالكم.