COMMUNITY HEALTH CHOICE

MAJOR DEPRESSIVE DISORDER

Overview:
An estimated 16 million Americans (or 7%)—had at least one major depressive episode in the past year. People of all ages and all racial, ethnic and socioeconomic backgrounds experience depression, but it does affect some groups more than others. Women are twice as likely to experience depression. Major Depressive Disorder, referred to colloquially as depression, is not equivalent to feeling down, sorrowful, or to the experience of legitimate grief. Down days are normal and occur in health individuals. Similarly, despite loud complaints to the contrary, the teenager who is acutely upset after being denied the use of a car – is not experiencing depression. Mood disorders are characterized by abnormal extremes of mood states which are prolonged, stubborn, not fleeting, and not obviously related to a single stressor (when symptoms are directly related to a major stressor, a diagnosis of Adjustment Disorder is usually appropriate.

Depression is not a disorder of will power nor is at an indicator of low self-efficacy or laziness. Depression is a serious, biologically mediated, genetically heritable illness, which can result in significant deleterious effects if not addressed. Depression treatment requires empathic medical care providers and prompt initiation of care, preferably started early in the course of the illness. When depression diagnosis is made reliably and early on and there is consistent use of medication, psychotherapy and lifestyle changes, many individuals can and do recover.

Recognizing Depression – Symptoms and Diagnosis: A change in an individual's level of function as indicated by**:**

1. Changes in sleep
2. Changes in appetite
3. Lack of concentration
4. Loss of energy
5. Lack of interest or pleasure in activities
6. Hopelessness or guilty thoughts
7. Changes in movement (less activity or agitation)
8. Physical aches and pains
9. Suicidal thoughts

Often, depressed patients will also present with voluntary and increasing levels of social isolation (in part from loss of interest). Depressed patients often describe a lack of motivation to do an activity despite a self -awareness of wanting to participate. This symptom is often referred to as amotivation. A related symptom, asthenia refers to an individual's subjective experience of feeling "stuck," or "glued to their chair." Despite being parked and in front of their favorite restaurant, the depressed person may feel an inability to make their body walk in. This symptom may be crippling to those who experience it, and this symptom may lead the individual to question their sanity, as this symptom often makes little sense of the individual.

Other unique symptoms of depression may include early morning awakening, anhedonia or a loss of pleasure from things which were previously joyful.

Depressed individuals may lose the energy, will, or general attention to their hygiene and may stop changing their clothing, or forego showers. In particularly serious cases of depression, individuals may experience significant slowing of psychomotor functions, with extreme sedentary lifestyle, slowed speech, and few if any unnecessary movements. In the most extreme cases, patients may become essentially mute or immobile, or they may develop symptoms of

catatonia. Because of the risks of blood clots, PE, bedsores, and infection, extreme vegetative symptoms of depression like these are considered medical emergencies.

Additionally, individuals with psychomotor slowing will often experience cognitive symptoms of depression. They may have difficulty making decisions, even regarding small or inconsequential choices. They may become more forgetful and have trouble recalling events from recent days. Individuals' ability to calculate is often impaired and some patients note that they are clumsier.

Note: Symptoms of depression must be present for 2 weeks or more for a Dx of Major Depressive Disorder. Mild, moderate, and severe qualifiers may be assessed by quantifying the number of symptoms endorsed, however the use of objective screening tests may be more reliable, allow for establishment of a baseline and for ongoing monitoring of severity over time. The most common tests utilized include the Beck Depression Inventory (BDI) The Hamilton Depression Scale (HAM-D) or the Patient Health Questionnaire PHQ-9, linked below.

(Please keep in mind that self-report screening tests or simple, brief screens do not meet coding criteria for psychological testing and are considered inclusive of the E and M code, though reviewing these may increase the time or complexity of the encounter.)

Differential Diagnoses:

- Underlying Bipolar Disorder
- Comorbid ADHD? Anxiety? Eating Disorder?
- General Medical Conditions:
    - hypothyroidism, PCOS, lupus, some cancers,
    - chronic inflammatory disease +/- chronic pain
    - Hx of Trauma, Stroke, or Emerging Dementia (if suspect, due a MMSE and MOCA)
    - Perimenopausal Symptoms, Other hormonal concern
    - **Toxic Effects of Medications: Chantix, Interferon, Accutane, various chemo's and some contraceptives. Overuse of antihistamines, benzodiazepines, dextromethorphan etc.
        - Note iatrogenic opioid addiction will result in depressive symptoms in many.

- Patient =Victim of Abuse? Domestic Partner Violence, Elder Abuse, or Workplace Bullying (an increasingly common problem). In children, peer-bullying and online bullying.

- Substance Abuse, Alcohol Use D/O, Internet or Gambling Addiction: Depression can be treated concurrently, but unless underlying addiction is addressed, treatment is unlikely to be successful.

Treatment Options:

- Hospitalize if patient is acutely at risk, has 0 supports and comorbid medical or psychiatric disorders, especially substance abuse.
- Psychotherapies: cognitive behavioral therapy, and interpersonal therapy.
- Medications including antidepressants, mood stabilizers and antipsychotic medications.
    - SSRIs
    - SNRI's: venlafaxine, duloxetine
    - NDRI: Bupropion XL: No sexual SE or weight gain, beneficial in addiction and ADHD
    - NaSSA:Remeron: helpful for sleep and for weight gain, increases appetite.
    - Serotonin Modulators: Newest meds, expensive.
    - MAOi's: selegiline TD patch-requires few diet adjustments, good w/atypical depression.
    - TCA's: apart from anafranil, usually reserved for sleep, **Overdose risk = Cardiac
- Exercise/ Diet can help with prevention and mild-to-moderate symptoms.
- Brain stimulation therapies: ECT, TMS (transcranial magnetic stim), VNS (vagal nerve stim)

- Light therapy, which uses a light box to expose a person to full spectrum light in an effort to regulate the hormone melatonin.(now also available in glasses contraptions though not as well tested.
- Alternative approaches including acupuncture, meditation, faith and nutrition can be part of a comprehensive treatment plan, but do not have strong scientific backing.

Information on Depression in Adolescents: ‘

Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management
Texas HHS Resources for Youth Mental Health
Texas HHS Youth Assessment Services

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6083627/

“Our data indicate that being sedentary for ≥3 h/day is associated with increased odds for depressive symptoms in adolescence. Future longitudinal data are required to confirm/refute the findings to inform public interventions which aim to limit the time spent being sedentary in adolescents.”

Vancampfort, Davy et al. “Sedentary behavior and depressive symptoms among 67,077 adolescents aged 12-15 years from 30 low- and middle-income countries.” *The international journal of behavioral nutrition and physical activity* vol. 15,1 73. 8 Aug. 2018, doi:10.1186/s12966-018-0708-y

Resources/References:

For Providers:

- Practice Guideline (Nov 2010)
- Quick Reference Guide
- Screening Tools:
  - Beck Depression Inventory (BDI -II)
  - BDI INteractive Version
  - PHQ-9
- Texas HHM Resources for Adult MH and Substance Use
- Available Practice Guidelines:

Name/Organization	URL reference	Country, Year
World Federation of Societies of Biological Psychiatry (WFSBP) consensus papers and treatment guidelines	www.wfsbp.org	Worldwide, 2015, 2013, 2007
American Psychiatric Association Practice Guidelines (APA)	www.psychiatryonline.org/guidelines	USA, 2010
British Association for Psychopharmacology	www.bap.org.uk/guidelines	UK, 2015
Canadian Network for Mood and Anxiety Treatments (CANMAT)	www.canmat.org	Canada, 2016
Institute for Clinical Systems Improvement (ICSI) Healthcare Guideline for Major Depression in Adults in Primary Care	www.icsi.org	USA, 2016