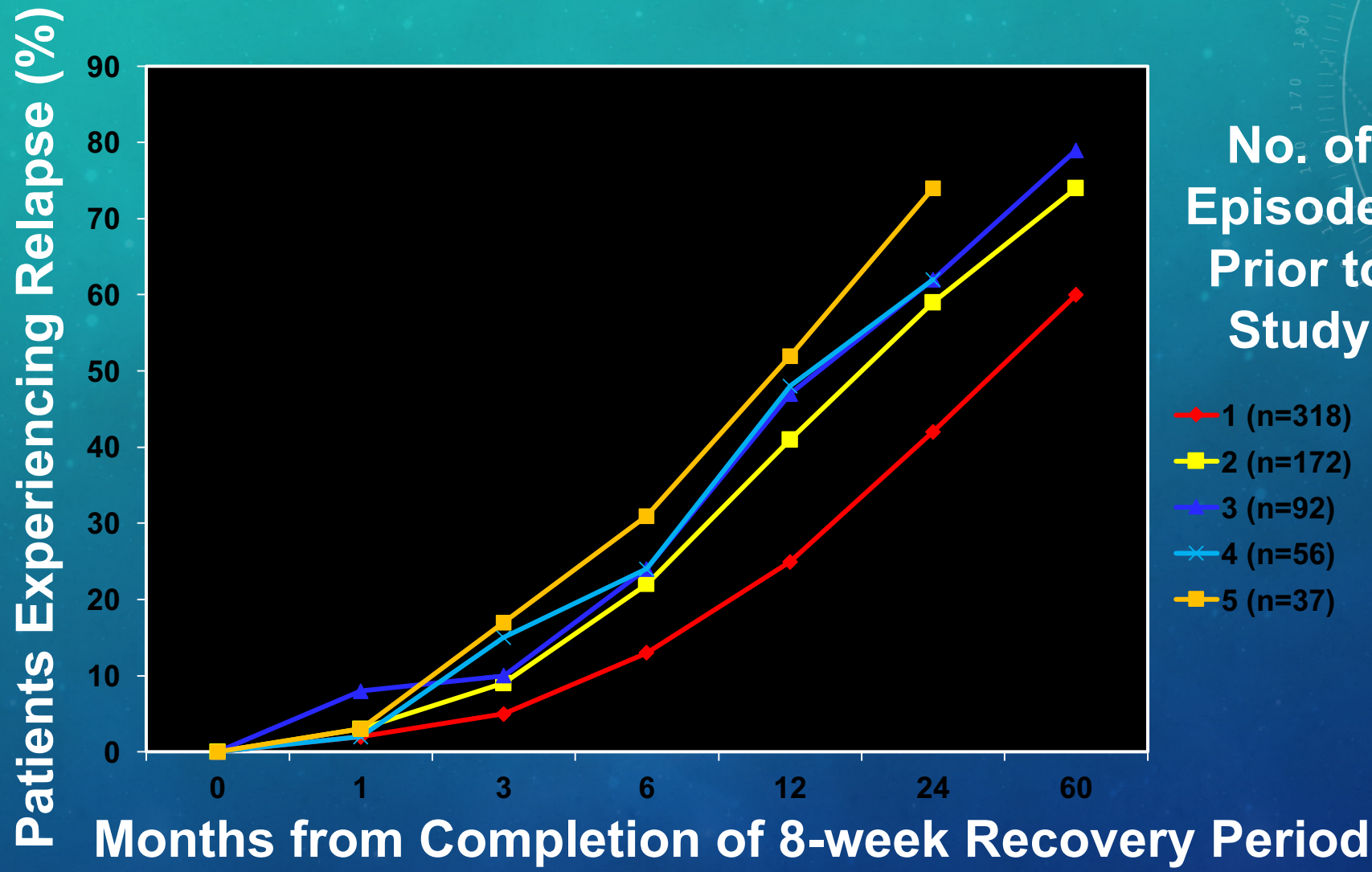
Chronic and Recurring Nature of Depression

DR NICK DE FELICE

26TH MAY 2018

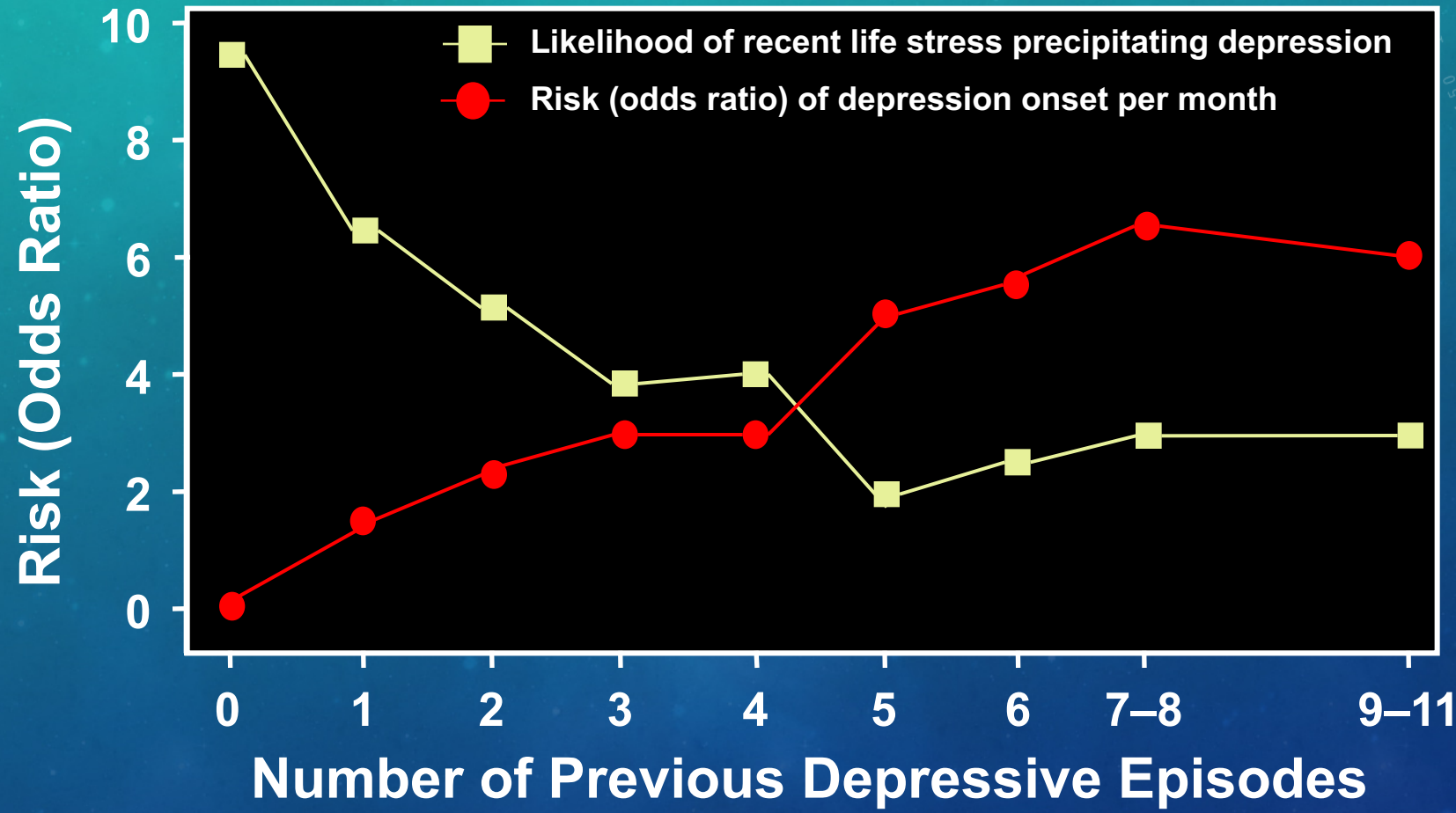
THE NUMBER OF PAST DEPRESSIVE EPISODES INCREASES THE LIKELIHOOD OF RECURRENCE



Risk of relapse increased by 16% with each successive recurrence

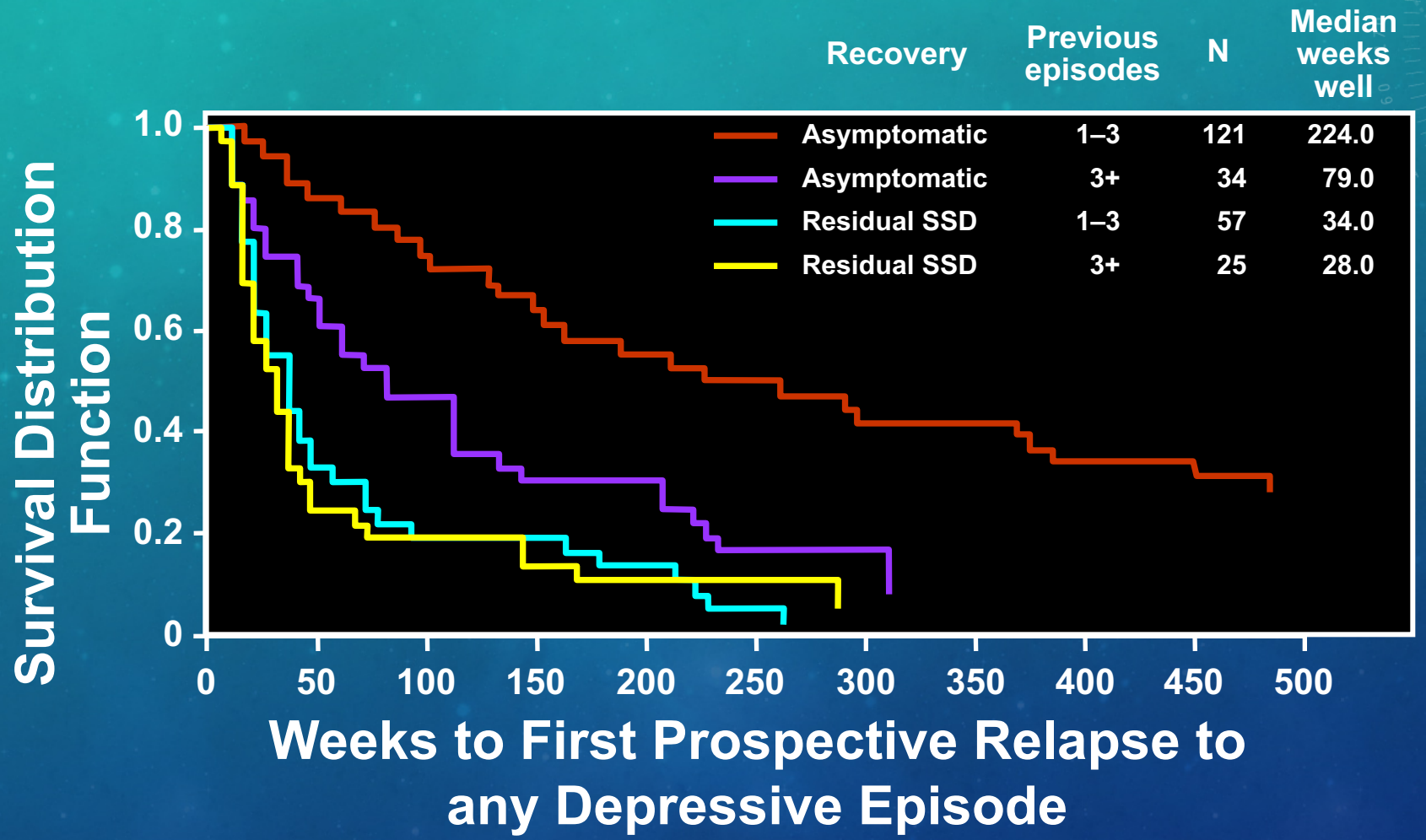
Solomon et al. *Am J Psychiatry* 2000;157(2):229-33.

Progression of Depression – "Kindling" Phenomenon: Adverse Effects of Each Successive Episode



Kendler et al. *Am J Psychiatry* 2000;157(8):1243-51. Copyright American Psychiatric Association (2000) .

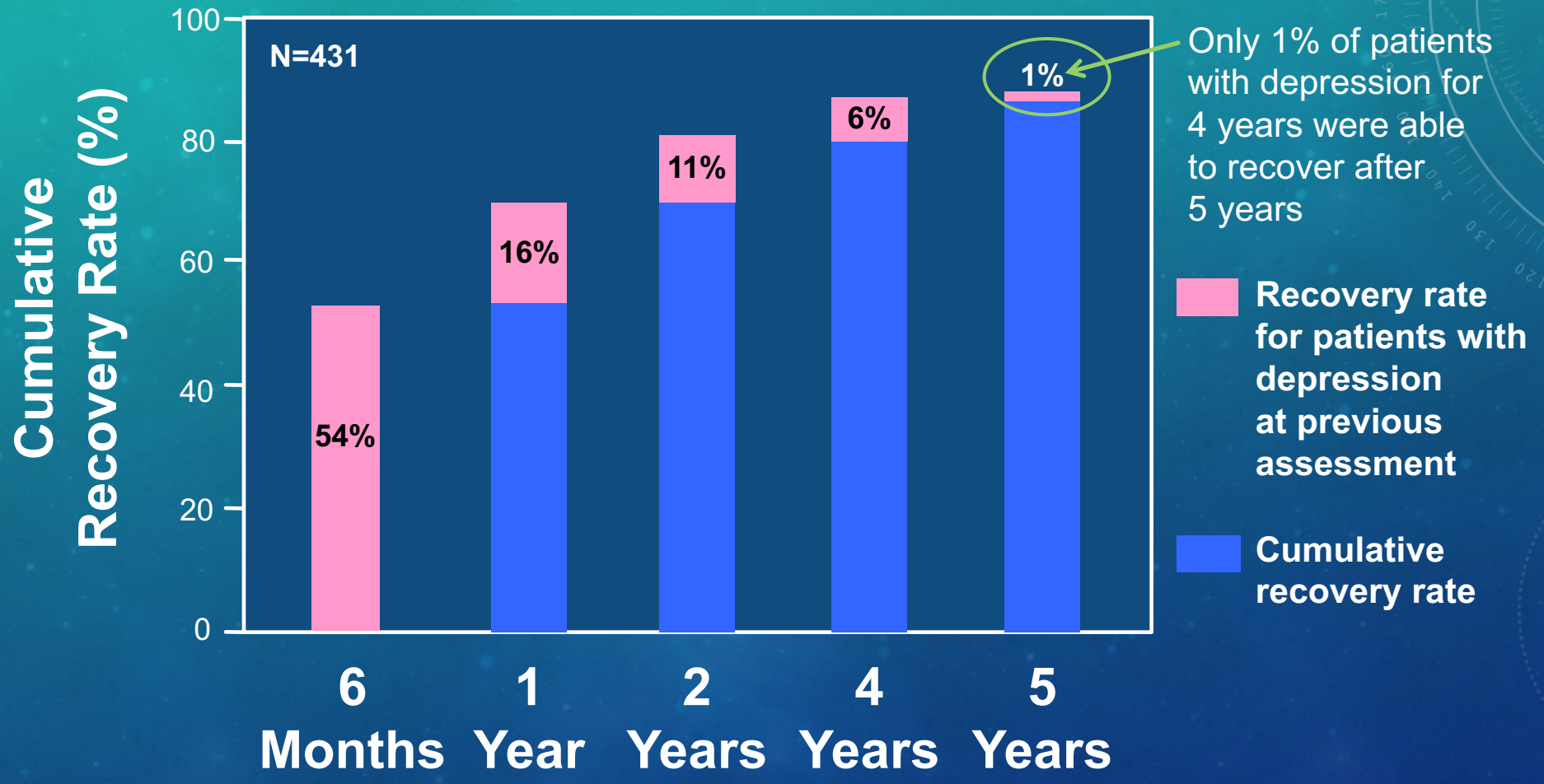
Residual Symptoms and Number of Episodes in MDD May Influence the Course of Illness



MDD=Major depressive disorder; SSD=Subsyndromal symptoms of depression;
Survival distribution function=Cumulative proportion of cases surviving to given time interval.

Judd et al. *J Affect Disord* 1998;50(2-3):97-108. Copyright Elsevier (1998).

Rates of Recovery Diminish with Duration of Major Depressive Episode



Recovery = 8 weeks of Psychiatric Status Rating (PSR) 1 or 2
Recovery = sustained remission

Keller et al. *Arch Gen Psychiatry* 1992;49:809-16.

THE ROLE OF GLIA IN MOOD DISORDERS

- Glial cells – astroglia, oligodendroglia, and microglia – represent 90% of brain cells
- Glial cells have monoamine, amino acid, neurotrophin, and cytokine receptors
- Monoamine uptake sites can be found on glial cells
- Glial cells synthesise and release neurotrophic factors and inflammatory cytokines

Rajkowska et al. *CNS Neurol Disord Drug Targets* 2007;6(3):219-33.

RECOMMENDATION BOX 1: PSYCHOLOGICAL THERAPY FOR MDD	Grade
1.1. Psychological interventions should only be delivered by clinicians trained in the relevant evidence-based approach.	CBR
1.2. Treatment should be guided by a published manual, tailored to the individual, and should pay particular attention to establishing and maintaining the therapeutic alliance.	CBR
1.3. Patients with acute mild-moderate depression should be offered one of the evidence-based psychotherapies as first line treatment.	EBR I
1.4. Patients with acute moderate-severe acute depression should be offered, both pharmacotherapy and psychotherapy and pharmacotherapy as first line treatment.	EBR I
1.5. Patients with chronic depressive disorders should be offered both psychotherapy and pharmacotherapy as first line treatment.	EBR I

CBR: Consensus Based Recommendations
EBR: Evidence Based Recommendations; strength of evidence was rated using the NHMRC levels of evidence for intervention studies (e.g., EBR I, II, III, or IV)

RECOMMENDATION BOX 2: ANTIDEPRESSANT THERAPY FOR MDD	Grade
2.1. An adequate trial antidepressant therapy for MDD should be a minimum of three weeks at the recommended therapeutic dose using a suitable medication.	EBR III
2.2. When commencing antidepressant therapy clinical response and side effects should be closely monitored from the outset.	CBR
Footnote: Tolerability (side effect profile) is as important as efficacy when choosing an antidepressant. Tricyclics, MAOIs and dual action agents may be more efficacious than newer agents in the treatment of moderate-severe depression.	

CBR: Consensus Based Recommendations
EBR: Evidence Based Recommendations; strength of evidence was rated using the NHMRC levels of evidence for intervention studies (e.g., EBR I, II, III, or IV)

DISCUSSION POINTS

- Can stimulants treat depression?
- Do antidepressants trigger (cause) bipolar disorder and /or affective lability?
- Should antidepressants be prescribed to children?
- Are antidepressants psychologically addictive?

ECT IN WA- OVERALL

(MENTAL HEALTH INFORMATION SYSTEM, DEPARTMENT OF HEALTH, WA)

- Total number of people in WA treated with ECT in 2013:
  - ***561 people*** - 6255 treatments

  (cf 2009: 307 people- 3776 treatments)
  - >50% in private hospitals

  - 49 people received involuntary ECT

NEW MHA 2014: ECT(PARTS 14 & 21)

- Voluntary patients (**or Guardian**) can consent to ECT
- Involuntary patients prescribed ECT now require the **Mental Health Review Tribunal (MHRT)** approval **prior to ECT**
- CP can approve emergency ECT for adult patients (involuntary or Mentally Impaired Accused only- to save a life or for imminent risk)

MHA 2014: CHILDREN AND ECT

- ECT prohibited under 14 years

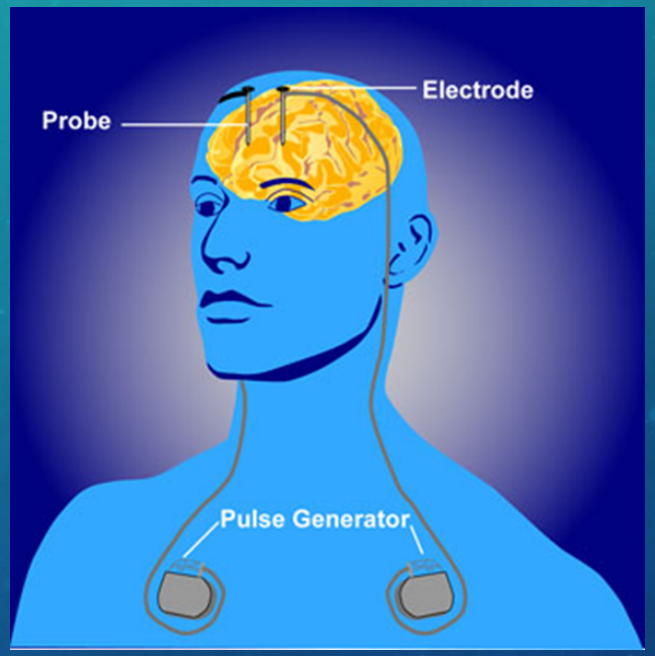
- 14-17 years:
  - Guardian can approve ECT
  - If child is a mature minor (ie capacity to consent) they can consent to ECT
  - **All** ECT in children (voluntary or involuntary) must be approved first by the **Mental Health Review Tribunal**

PSYCHOSURGERY- DEEP BRAIN STIMULATION (DBS)

- DBS- electrodes implanted to stimulate brain (**not** ablative- electrodes can be removed)
- DBS is done now nearly **weekly** in WA for Parkinson's Disease as the most effective treatment where medications have stopped working
    - Note, DBS for physical illness ***not*** part of the MHA- done as a consented treatment

Implantation of Device

Wire planted under skin
Pulse generator planted under collarbone
High Frequency 100 times/sec
Implanted in both sides of brain
Programmed by wand held in front of generator



TRANSCRANIAL MAGNETIC STIMULATION (REPETITIVE)- RTMS

- New treatment- last 25 years
- For mild-moderate depression (it is not a replacement for ECT in severe depression)
- Heavy magnetic field generator (“coil”) held just over a certain area of the scalp
- No anaesthesia, no seizure
- 15 minutes?, 20 treatments

RTMS

RTMS

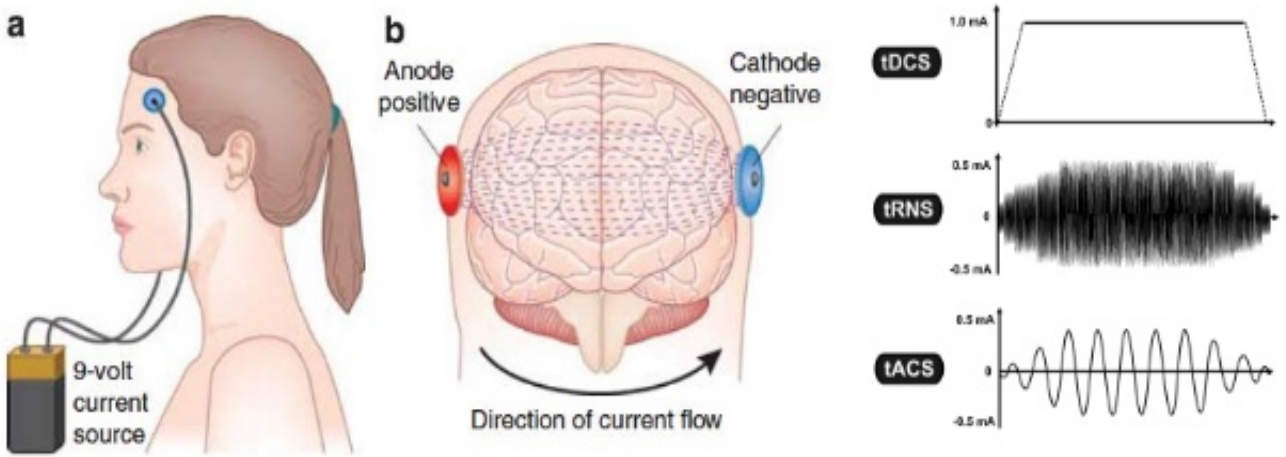
- It is not first line treatment
- Used throughout the world and it's use is increasing
- Available in WA
- rTMS is **not** covered by the MHA 2014- it is not ECT and not psychosurgery

DIRECT CURRENT

The electrode placement and direction of current flow has specific effects (George 2010)

Anodal current = depolarizing

Cathodal current = hyperpolarizing



George MS, Aston-Jones G. Noninvasive techniques for probing neurocircuitry and treating illness: VNS, TMS, and tDCS. Neuropsychopharmacology 2010; 35: 301-316. Saote C, Turi Z, Paulus W, Antal A. Combining functional magnetic resonance imaging with tDCS. Front Hum Neurosci 2013; 7 (435): 1-7.

UNM | Department of Psychiatry

IDEAS in Psychiatry

The Mind Research Network
For Neuroadaptive Discovery

New Mexico

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

Pre-existing

- Patient personality
- Family personality
- Supportive environment/networks
- Attitudes to death
- Previous experience of grief
- Previous experience of illness
- Religion

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

The Stressor

- Beliefs about cancer
- The type of cancer and its prognosis
- Facing the above
- The family facing above
- Presenting symptoms (eg breathlessness, pain, nausea)
- The physical effect of the tumour (cortical tumour, hormones, para-neoplastic syndromes)

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

Psychiatric disorders

- Pre-existing – anxiety, depression, bipolar, psychosis, dementia
- Delirium
- Depression
- Anxiety

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

Stages of grief

- Shock
- Denial
- Anger
- Depression
- Acceptance

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

Staff dynamics

- Personality, reasons for doing this work
- Non-clinical stuff
- Beliefs about what “should” happen

PSYCHOLOGICAL PROCESSES IN CANCER PATIENTS

- **Denial as a coping mechanism –**
- **need to confront it?**

WHAT ABOUT THE CONVERSATION?

- Bit by bit psychotherapy
- The power of touching
- The power of being consistent and reliable
- Start with questions, but you need courage, gentleness, readiness to listen

WHAT ABOUT THE CONVERSATION?

Diagnosis and prognosis

- Tell me about your illness
- What did the doctor say?
- Is it a cancer?
- What does that mean?
- When you hear about cancer, you usually worry “how long have I got”. So, have you asked?
- What did the doctor say?

WHAT ABOUT THE CONVERSATION?

Regarding treatment

- What did the doctor say that the treatment will do?
- So is it to cure the cancer or will it just relieve the symptoms?
- Will it give you more time?
- What are the chances of that?
- And what price will you pay in side effects?

WHAT ABOUT THE CONVERSATION?

Regarding death and dying

- Different people have different ideas about life and what it all means. Do you have a way of thinking about life or death that helps you?
- Is there some sort of belief system that makes sense to you?

WHAT ABOUT THE CONVERSATION?

- Are you scared?
- What are you afraid of?
- When you look back on your life, are there any regrets?
- Is there anything you need to say to anyone?

WHAT ABOUT THE CONVERSATION?

Regarding family

- Be careful that you are not rushing in where angels fear to tread
- Take care about commenting, about telling your observations
- Remember, every story sounds right until you hear the other side

WHAT ABOUT THE CONVERSATION?

Ask questions, gently

- Why don’t you think your mother should know the diagnosis?
- What do you fear?
- Do you think she knows?
- What does she think she is having treatment at the cancer centre for?
- Why does she think she had her breast off?

WHAT ABOUT THE CONVERSATION?

- Is it possible she knows but wants to protect you because you won't be able to cope?
- What's wrong with crying together?
- Is there anything you need to talk to mother/father/loved one about?
- When they die, is there anything you wish you had said or told them?

WHAT ABOUT THE CONVERSATION?

- All of this needs to be done within the context of the relationship.

CAPACITY – GENERAL COMMENTS

Assessing the person's ability to make a decision, not whether the decision is reasonable. The person has a right to take risks, to make the wrong decision.

Capacity assessment includes:

a. Global assessment of the person's mental state and cognitive function, ideally with assessment of judgement, reasoning and planning, relevant to the decision area.

b. Functional assessment of decision making, i.e.. whether the person can show, using their own words, an understanding of the decision.

TESTAMENTARY CAPACITY

Banks V. Goodfellow (1870). The testator should:

- Understand the nature of a will and its effects.
- Understand the extent of the property of which the person is disposing.
- Comprehend and appreciate the claims and the class of beneficiaries, to which the person ought to give effect –
- In that regard, no disorder of the mind should poison the person's affections, pervert the person's sense of right, or prevent the exercise of the person's natural faculties, and no insane delusion should influence the person's will in disposing of the person's property and result in a disposal which, if the mind had been sound, would not have been made.

POWER OF ATTORNEY (GENERAL AND ENDURING)

Appoints an attorney to make financial decisions when they lost capacity to manage their financial affairs.

Assessing capacity to make a power of attorney includes:

- What the attorney can make decisions about. What power they are given, authorising someone to look after and assume complete authority of their financial affairs. Do they understand the nature and extent of that power? Do they understand the sort of things the attorney can do? Do they understand that this will begin or continue when they're incapable of managing their affairs?

- Who are they appointing and why. Why has this person been selected? What's the history of the relationship, and has there been any radical change in that? Is this in keeping with previous appointments, or have there been frequent changes? NB: Especially if changing, this needs to be clear.

- Is the person making the appointment freely and voluntarily, without undue influence or being "schooled"?