Depressive Disorders

Mood is a pervasive, sustained emotion operating in the background of mental life that colors the person's outlook on the world (APA 2000).

American Psychiatric Association, (2000). "Practice guidelines for the treatment of psychiatric disorders". Washington, D.C.: American Psychiatric Press.

The predominant feature in depressive disorders is a disturbance of mood manifested by a loss of interest in personally valued activities in all cases. The loss of pleasure when the individual anticipated and engaged in these activities eventuates in the collapse of this emotional background. A sense of pain pervades the person's life and all of the activities in which they engage. They cannot adequately put the pain they feel into words.

Physically they lose or gain weight; have sleep disturbances, either sleeping less or more than usual; feel too tired to do engage in everyday activities, and have less of an appetite for intimacy. They feel guilty for no good reason. Thoughts of dying, death and of taking their own lives come to plague them. Many may have attempted to kill themselves.

Sleep abnormalities occur in ninety percent of persons hospitalized for treatment of major depressions (APA 2000). People treated in outpatient settings have a 40 to 60 percent chance of experiencing sleep disturbances. Sleep abnormalities persist after recovery from a depressive episode (Thase 1999).

Thase, M. E., (1999). "Mood disorders and Neurobiology". In H. I. Kaplan and B. J. Sadock (Eds.), Comprehensive textbook of psychiatry (7th ed., pp. 1318-1327), Vol. I. Philadelphia: Lippincott, Williams & Wilkins.

Ninety seven percent of all cases report a loss of energy. Anxiety occurs in 60 percent of the cases (Zajecka (1995).

Zajecka, J., (1995). "Treatment strategies to treating depressions complicated by anxiety disorder". Presented at the U.S. Psychiatric and Mental Health Congress. New York: November 16, 1995.

Thinking, concentration, and memory are impacted. They view themselves as failures in life. They recount their faults and flaws, but do not see their strengths and virtues. They say and say they are terrible persons. A sense of guilt, that has no realistic basis, fills their days. They feel worthless and helpless to change things around in their lives.

They pace about endlessly. They get no rest even when they do nothing at all. They have headaches, backaches, the blahs, constipation, and an all-pervasive sense of

discomfort. Activities, which once gave them pleasure no longer, do so. All looks black to them.

Their health deteriorates. Complicated physical conditions arise. Their ability to work is impaired. Social activities are no longer important to them. A general decline in life activities takes place.

The community base rate for major depression in the United States is 3 to 5 percent. The lifetime risk for depression is 5 to 12 percent for men and 10 to 25 percent for women (Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision 2000). Unipolar depression is twice as common I women as in men (Dubovsky and Buzan 1999).

Dubovsky, S. L., and Buzan, R., (1999). "Mood Disorders in Hales", R. E., Yudofsky, S. C., & Talbott, J. A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in preadolescents are 18 percent (Dubovsky and Buzan 1999). Young people between the ages of 9 to 17 yield a 6 percent rate of depression (Varcaroles, E. M., (1999).

Varcaroles, E. M., (1999). "The invisible disease: Depression". Washington, DC: National Institute of Mental Health.

Depression rates for the elderly living in the community is 3.5 percent; 16 percent for medically hospitalized elderly; 15 to 20 percent for our elderly living in nursing homes; and as high as 40 percent in selected groups of elderly (Dubovsky and Buzan 1999).

Dubovsky, S. L., and Buzan, R., (1999). Mood disorders, In R. E. Hales, S. C. Yudofsky, and J. A. Talbott (Eds.) Textbook of Psychiatry, (pp. 479-566). Washington, D.C.: American Psychiatric Press.

Depression is associated with general medical conditions, substance-induced mood disorders following the use of recreational and misuse of prescription drugs, bereavement and reaching the end-of-live.

Medical conditions and syndromes associated with Mood Disorders:

System	Diagnoses
Neurologic	Dementias Hydrocephalus Huntington's Chorea Infections, i.e., HIV, neurosyphilis

	Migraines
	Multiple Sclerosis
	Myasthenia Gravis
	Parkinson's Disease
	Seizure Disorders
	Stroke
	Trauma
	Tumors
	Vasculitis
	Wilson's Disease
Endocrine	Addison' Disease
	Cushing's Syndrome
	Diabetes Mellitus
	Hyperparathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression
Metabolic/Nutritional	Folate Deficiency
	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency
Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis
	Sjoegren's Disease
	Systematic Lupus Erythematosus
	Tuberculosis
Mixed	Anemia
	Cardiopulmonary Disease
	Neoplasm
	Sleep Apnea

Mulner, K. K., Florence, T., & Clark, R. R., (1999). "Mood and anxiety syndromes in emergency psychiatry". Psychiatric Clinics of North America 22 (4): 761.

Depressions recur. Sixty percent of those people who have suffered on depressive episode can expect a second episode; seventy percent can expect a third episode; and ninety percent can expect three or more episodes (APA 2000).
American Psychiatric Association, (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterase
	Antipsychotics
	Baclofen
	Barbiturates
	Benzodiazepines
	Bromocriptine
	Carbamazepine
	Disulfiram
	Ethosuximide
	Levodopa
	Phenytoin
Antibacterical/Antifungals	Corticosteroids
	Grieseofulvin
	Metronidazole
	Nalidix Acid
	Trimethoprim
Anti-inflammatory/Analgesic	Corticosteroids
	Indomethacin
	Opiates
	Sulindac
Antineoplastic	Aspariginase
	Azothioprine
	Bleomycine
	Hexamethylamine
	Vincristine
	Vinblastine
Cardiovascular	Clonidine
	Digitalis
	Guanethidine
	Methyldopa
	Propranolol

	Resperine
Gastrointestinal	Cimetidine
	Ranitidine
Mixed	Alcohol
	Anxiolitics
	Cocaine
	Heroin
	Marijuana

(Mulner, et al 1999).

Mulner, K. K., Florence, T., & Glick, R. L., (1999). "Mood and anxiety syndromes in emergency psychiatry". Psychiatric Clinics of North America 22(4): 761.

Research studies: Franklin et al., (2002) using Taxometric analyses tested directly whether the MMPI-2 depression scales could differentiate 2000 psychiatric patients with depressive symptoms from patients with other disorders. Taxometric analyses did not find a MMPI-2 Depression scale cut point that categorizes patients with depressive symptoms form other patients. The findings support the assumption that there is an underlying dimensionality to
depression.

Franklin, C. L., Strong, D. R., & Greene, R. L., (2002). "A Taxometric analysis of the MMPI-2 Depression Scales". Journal of Personality Assessment August 79(1), 110-121.

Rohling et al., (2002) examined the effect of depression on neurocognitive performance in patients who passed symptom validity testing. No differences occurred on objective cognitive and psychomotor measures in-groups sorted based on their self-reported depression. These data suggest that depression have no impact on objective neurocognitive functioning.

Rohling, M. L., Green, Paul, Allen, L. M. III, & Iverson, G. L., (2002). "Depressive Symptoms and neurocognitive test scores in-patients passing symptom validity tests". Archives of Clinical Neuropsychology 17(3), 205-222.

Scale 2 (Dep)

Scale 2 (Dep) measures the presence of clinical depression (Dahlstrom et al., 1972). The MMPI has 60 items. The MMPI-2 has 57 items. Thirty-seven of these items are scored in the false direction, 20 in the true direction. A false response set will elevate Scale 2 (Dep), along with Scale 1 (Hs) and Scale 3 (Hy). Item overlap is: **L (2), F (2), K (8), 1 (10), 3 (13), 4 (7), 5 (2), 6 (2), 7 (13), 8 (10), 9 (5), and Sie (8).**

Dahlstrom, W.G., Welsh, G. S., & Dahlstrom, L. E., (1972). “An MMPI Hand-Book: Vol. 1. Clinical Interpretation” (Rev. Ed.) Minneapolis: University of Minnesota Press.

Hunsley et al., (1988) provided meta-analytic derived test-retest data for retest intervals of 1 day to 2 years. An average interval consistency of .87 was reported for 74 Scale 2 (Dep) studies. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlations in the 0.79 ranges for the MMPI-2.

Hunsley, J., Hanson, R. K., & Parker, C. H. K., (1988). “A summary of the reliability and stability of MMPI Scales”. Journal of Clinical Psychology 44, 44-46.

Butcher, J. N., Dahlstrom, W. G., Graham, J .R., Tellegen, A., & Kaemmer, B., (1989). “Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Manual for administration and scoring”. Minneapolis: University of Minnesota Press.