Early psychosis and depression

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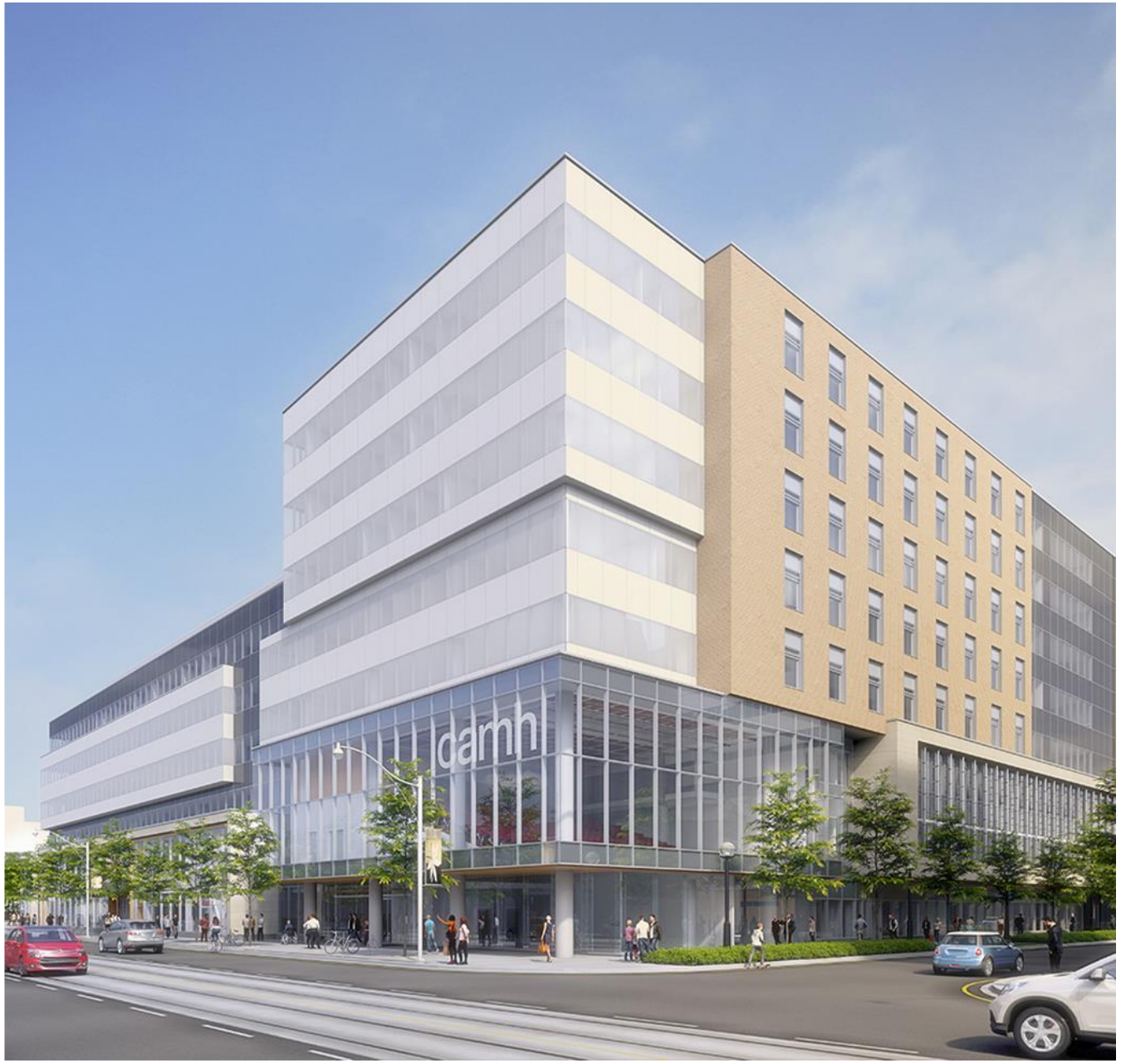
EPI-SET Echo presentation

camh



Objectives

Provide brief overview of the link between psychosis and depression

Discuss implications for assessment and treatment

Introduction

Depression in early psychosis

Overlap:

Symptoms of depressive disorders

Negative symptoms of schizophrenia

Side effects of antipsychotics

Model	Comment
Intrinsic to the illness itself	A Jacksonian hierarchy: all 'lesser' neurobiological abnormalities will be common when mental illness severe enough to produce psychotic symptoms exists
Medication effects	For example: bradykinesia, loss of spontaneity, sedation, akathisia
An expression of negative symptoms	The overlap of biological symptoms of depression with negative symptoms (e.g. motor retardation) and symptoms of apathy
Psychological response model	Emphasis on the personal significance of psychosis and positive symptoms. Appraisals of loss, shame and entrapment common

Etiology

Mood symptoms are common features in prodromal phase

Established in schizophrenia

Also, psychotic symptoms frequently occur with severe mood disorders

prevalence of depression in attenuated psychosis syndrome: ~ 45%

prevalence of depression in schizophrenia: 30% to 80%

post psychotic depression: ~50%

Depression in psychosis related to suicide, especially early psychosis

Poorer outcomes

Symptoms

Negative symptoms: a loss of motivation to act and a lack of the elements that make up the normal repertoire of social and emotional responsiveness

Negative symptom domain include blunted affect, alogia, anhedonia/social withdrawal and avolition/apathy and attention

2 sub-domains: (1) avolition-amotivation and (2) diminished expression: blunted affect and alogia

Symptoms such as low mood, pessimism, suicidal ideation and impaired tolerance to stress -> specific to depression

Anhedonia, emotional blunting, anergia, amotivation, social withdrawal and avolition occurred in both the negative and depressive domains

Alogia, blunted affect -> negative symptom domain

Symptom	Depressive symptoms	Depressive and negative symptoms	Negative symptoms
Anhedonia		X	
Emotional blunting		X	
Anergia		X	
Amotivation		X	
Asociality		X	
Avolition		X	
Low mood	X		
Pessimism	X		
Suicidal ideation	X		
Observed sadness			X
Alogia			X
Poor attention and concentration			X
Blunted affect			X

Side effects of antipsychotic medication

MHS: anxious, excitable, agitated, aggressive, depressed, restless.

Other overlap: sedation, insomnia, cognitive dulling, sexual side effects, increased appetite, weight gain.

Adverse effects	AMI	ARI	CPZ	CLO	HAL	LUR	OLA	PAL	PER	QUE	RIS	SER	ZIP
Anticholinergic effects	0	0	++	+++	0	0	++	0	0/+	+/++	0	0	0
Acute parkinsonism	+	+	+	0	+++	+/++	0/+	++	++	0	++	0/+	+
Akathisia	+	++	+	+	+++	+/++	+	+	++	+	+	+	+/++
Tardive dyskinesia	0/+	0/+	++	0	++	0/+	0/+	0/+	++	0/+	0/+	0/+	0/+
Diabetes	0/+	0/+	+++	+++	0/+	0/+	+++	+	+	++	+	+	0/+
Weight gain	0/+	0/+	+++	+++	+	0/+	+++	++	++	++	++	++	0/+
Increased lipids	+	0/+	+++	++	0/+	0/+	+++	+	+	++	+	+	0/+
Sialorrhea	0	0	0	++	0	0	0	0	0	0	0	0	0
Neutropenia	0/+	0/+	0/+	+++	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+
Orthostatic hypotension	0/+	0/+	++	++	0	0/+	+	+	+	++	+	++	0
Hyperprolactinemia	+++	0	+	+	++	+	+	+++	++	0	+++	+	+
Increased QTc interval	++	0/+	0/+	++	0+	0/+	0/+	+	+	+	+	++/+++	++
Sedation	0/+	0/+	++	+++	+	+/++	+/++	0/+	+	++ b	+	0/+	+
Seizures	0/+	0/+	0/+	++	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+	0/+

AMI – amisulpride, ARI – aripiprazole, CPZ – chlorpromazine, CLO – clozapine, HAL – haloperidol, LUR – lurasidone, OLA – olanzapine, PAL – paliperidone, PER – perphenazine, QUE – quetiapine, RIS – risperidone, SER – sertindole, ZIP – ziprasidone, 0: none or equivocal, 0/+: minimal/rare, +: mild/sometimes occurs, ++: moderate/occurs frequently, +++: severe/occurs very often

Assessment: scales

Depression in psychosis:

Calgary Depression Scale for Schizophrenia

- Hamilton Rating Scale for Depression
- Beck Depression Inventory

Negative symptoms:

Scale for the Assessment of Negative Symptoms (SANS) /
negative subscale of the Positive and Negative Syndrome Scale (PANSS)
negative subscale of the Brief Psychiatric Rating Scale (BPRS)

Side effects:

Side effects self report

- Focus on timeline

CDSS

Free accessible:

https://psychscenehub.com/wp-content/uploads/2020/02/schizophrenia_cdss.pdf

Population:

adolescents and adults

in people with a schizophrenia spectrum disorder including the attenuated psychosis syndrome

Scoring:

A score above 6 has an 82% specificity and 85% sensitivity for predicting the presence of a major depressive episode.

Calgary Depression Scale for Schizophrenia (CDSS)

Interviewer: Ask the first question as written. Use follow up probes or qualifiers at your discretion. Time frame refers to last two weeks unless stipulated. **N.B.** The last item, #9, is based on observations of the entire interview.

1. **DEPRESSION: How would you describe your mood over the last two weeks? Do you keep reasonably cheerful or have you been very depressed or low spirited recently? In the last two weeks how often have you (own words) every day? All day?**
   - 0. Absent
   - 1. Mild — Expresses some sadness or discouragement on questioning.
   - 2. Moderate — Distinct depressed mood persisting up to half the time over last 2 weeks: present daily.
   - 3. Severe — Markedly depressed mood persisting daily over half the time interfering with normal motor and social functioning.

2. **HOPELESSNESS: How do you see the future for yourself? Can you see any future? - or has life seemed quite hopeless? Have you given up or does there still seem some reason for trying?**
   - 0. Absent
   - 1. Mild — Has at times felt hopeless over the last two weeks but still has some degree of hope for the future.
   - 2. Moderate — Persistent, moderate sense of hopelessness over last week. Can be persuaded to acknowledge possibility of things being better.
   - 3. Severe — Persisting and distressing sense of hopelessness.

3. **SELF DEPRECIATION: What is your opinion of your self compared to other people? Do you feel better, not as good, or about the same as others? Do you feel inferior or even worthless?**
   - 0. Absent
   - 1. Mild — Some inferiority; not amounting to feeling of worthlessness.
   - 2. Moderate — Subject feels worthless, but less than 50% of the time.
   - 3. Severe — Subject feels worthless more than 50% of the time. May be challenged to acknowledge otherwise.

4. **GUILTY IDEAS OF REFERENCE: Do you have the feeling that you are being blamed for something or even wrongly accused? What about? (Do not include justifiable blame or accusation. Exclude delusions of guilt.)**
   - 0. Absent
   - 1. Mild — Subject feels blamed but not accused less than 50% of the time.
   - 2. Moderate — Persisting sense of being blamed, and/or occasional sense of being accused.
   - 3. Severe — Persistent sense of being accused. When challenged, acknowledges that it is not so.

5. **PATHOLOGICAL GUILT: Do you tend to blame yourself for little things you may have done in the past? Do you think that you deserve to be so concerned about this?**
   - 0. Absent
   - 1. Mild — Subject sometimes feels over guilty about some minor peccadillo, but less than 50% of time.
   - 2. Moderate — Subject usually (over 50% of time) feels guilty about past actions the significance of which he exaggerates.
   - 3. Severe — Subject usually feels s/he is to blame for everything that has gone wrong, even when not his/her fault.

6. **MORNING DEPRESSION: When you have felt depressed over the last 2 weeks have you noticed the depression being worse at any particular time of day?**
   - 0. Absent — No depression.
   - 1. Mild — Depression present but no diurnal variation.
   - 2. Moderate — Depression spontaneously mentioned to be worse in a.m.
   - 3. Severe — Depression markedly worse in a.m., with impaired functioning which improves in p.m.

7. **EARLY WAKENING: Do you wake earlier in the morning than is normal for you? How many times a week does this happen?**
   - 0. Absent — No early wakening.
   - 1. Mild — Occasionally wakes (up to twice weekly) 1 hour or more before normal time to wake or alarm time.
   - 2. Moderate — Often wakes early (up to 5 times weekly) 1 hour or more before normal time to wake or alarm.
   - 3. Severe — Daily wakes 1 hour or more before normal time.

8. **SUICIDE: Have you felt that life wasn't worth living? Did you ever feel like ending it all? What did you think you might do? Did you actually try?**
   - 0. Absent
   - 1. Mild — Frequent thoughts of being better off dead, or occasional thoughts of suicide.
   - 2. Moderate — Deliberately considered suicide with a plan, but made no attempt.
   - 3. Severe — Suicidal attempt apparently designed to end in death (i.e.: accidental discovery or inefficient means).

9. **OBSERVED DEPRESSION: Based on interviewer's observations during the entire interview. The question "Do you feel like crying?" used at appropriate points in the interview, may elicit information useful to this observation.**
   - 0. Absent
   - 1. Mild — Subject appears sad and mournful even during parts of the interview, involving affectively neutral discussion.
   - 2. Moderate — Subject appears sad and mournful throughout the interview, with gloomy monotonous voice and is tearful or close to tears at times.
   - 3. Severe — Subject chokes on distressing topics, frequently sighs deeply and cries openly, or is persistently in a state of frozen misery if examiner is sure that this is present

More information on adminstering and scoring the CDSS is available at: http://www.ucalgary.ca/cdss/

Management depression in early psychosis

Prodrome/Attenuated psychosis syndrome: treat depression

Acute psychotic episode: await effect antipsychotic treatment

Post psychosis depression: treat depression

Antidepressants effective without risk for increase positive symptoms

number-needed-to-treat-to-benefit: 9

Especially when predominant or more severe depressive symptoms

Mostly second-generation antidepressants (selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs)) or monoamine oxidase-inhibitor drugs

Evidence base to: duloxetine, trazadone, or sertraline

Medication treatment < 18 yo: fluoxetine

Of note: interaction fluoxetine, paroxetine, escitalopram / risperidone, haloperidol

Combination of antipsychotic medication + SSRI: risk for epilepsy

Mostly reported in combination AP + SSRI: abdominal pain, constipation, dizziness, and dry mouth.

Behavioural activation, sleep restoration, CBT

Management of negative symptoms

No specific treatment recommendation

lowest possible antipsychotic dose that maintains control of positive symptoms

Trial antidepressant; duloxetine, mirtazapine, and several of the SSRIs.

Therapy: CBT

CNS stimulants

Anticonsulvants etc

Management of side effects

1. Lower dose or adjust dosing schedule
2. Change the antipsychotic
3. Behavioral interventions
4. Concomitant medications

Sedation:

Shifting dosing to nighttime,

Reducing total daily dose,

Transitioning to a less sedating antipsychotic,

Other sedating medications should be discontinued or changed when possible,

The use of caffeine is common

Conclusion

It may be possible to distinguish depressive features from negative symptoms in schizophrenia when detailed phenomenology is considered.

However, in a proposed dimensional model, these two domains continue to share certain phenomena, highlighting their close relationship.

Summary:

Symptoms such as low mood, suicidal ideation and pessimism are cited within a depressive domain, whereas symptoms such as alogia and blunted affect appear to indicate negative symptoms. Anhedonia, anergia and avolition occur across both domains.

Detailed understanding of underlying phenomenology may provide potential treatment targets as well informing future research assessing underlying mechanisms.

Questions?

Thank You

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