MOOD DISORDERS

INTRODUCTION

- Mood is a pervasive and sustained feeling tone that is experienced internally and that influences a person's behavior and perception of the world. Affect is the external expression of mood. Mood can be normal, elevated, or depressed. Healthy persons experience a wide range of moods and feel in control of their moods and affects.

- Mood disorders are a group of clinical conditions characterized by a loss of that sense of control and a subjective experience of great distress.
- *mood disorders* are so called because one of their main features is abnormality of mood. Nowadays the term is usually restricted to disorders in which this mood is depression or elation, but in the past some authors have included states of anxiety as well.

- **The Main Mood Disorders**
- _ Major depressive disorder (MDD)
- _ Bipolar I disorder
- _ Bipolar II disorder
- _ Dysthymic disorder
- _ Cyclothymic disorder

DEPRESSION

DIAGNOSIS

- Must have at least five of the following symptoms (must include either number1 or number 2) for at least a 2-week period:
- **1.** Depressed mood
- **2.** Anhedonia (loss of interest in pleasurable activities)
- **3.** Change in appetite or body weight (increased or decreased)
- **4.** Feelings of worthlessness or excessive guilt
- **5.** Insomnia or hypersomnia
- **6.** Diminished concentration
- **7.** Psychomotor agitation or retardation (i.e., restlessness or slowness}
- **8.** Fatigue or loss of energy
- **9.** Recurrent thoughts of death or suicide

UNIQUE TYPES AND FEATURES OF DEPRESSIVE DISORDERS

- **Melancholic**—40 to 60% of hospitalized patients with major depression. Characterized by anhedonia, early morning awakenings, psychomotor disturbance, excessive guilt, and anorexia.
- **Atypical**—characterized by; hypersomnia, hyperphagia, reactive mood, leaden paralysis, and hypersensitivity to interpersonal rejection
- **Catatonic**—features include catalepsy (immobility), purposeless motor activity, extreme negativism or mutism, bizarre postures, and echolalia. May also be applied to bipolar disorder.

- **Psychotic**—10 to 25% of hospitalized depressions. Characterized by the presence of delusions or hallucinations.
- **Agitated depression**
- This term is applied to depressive disorders in which *agitation* is prominent. Agitation occurs in many severe depressive disorders, but in agitated depression it is particularly severe. Agitated depression is seen more commonly among middle-aged and elderly patients than among younger individuals.

CLASSIFICATION OF DEPRESSION

- Classification by presumed aetiology
- Historically, depressive disorders were sometimes classified into two kinds, those in which the symptoms were caused by factors within the individual, and were independent of outside factors (*endogenous depression),* and those in which the symptoms were a response to external stressors *(reactive depression).* However, it has been recognized for many years that this distinction is unsatisfactory.

- Classification by symptomatic picture
- Melancholic depression.
- Psychotic depression.
- Non-melancholic depression
- Atypical depression.
- Agitated depression
- Retarded depression

•Classification by course

•1-Unipolar and bipolar disorders.

•2-Seasonal affective disorder: Some patients repeatedly develop a depressive disorder at the same time of year, usually the autumn or winter. Although these seasonal affective disorders are characterized mainly by the time at which they occur, some symptoms are said to occur more often than in other mood disorders. These symptoms include:

•• hypersomnia

•• increased appetite, with craving for carbohydrate

•• an afternoon slump in energy levels.

•The most common pattern is onset in autumn or winter, and recovery in spring or summer.

- 3- Brief recurrent depression. Some individuals experience recurrent depressive episodes of short duration, typically 2 to 7 days, that are not of sufficient duration to meet the criteria for major depression or depressive episode.

DIFFERENTIAL DIAGNOSIS

- 1-normal sadness: the distinction is made on the basis of the presence of other symptoms of the syndrome of depressive disorder.
- 2-Adjustmrnt disorder.
- 3-Anxiety disorders: Mild depressive disorders are sometimes difficult to distinguish from anxiety disorders. Accurate diagnosis depends on assessment of the relative severity of anxiety and depressive symptoms, and on the order in which they appeared.
- 4- Schizophrenia: Difficult diagnostic problems may arise when the patient has *depressive psychosis,* but here again the distinction can usually be made on the basis of a careful examination of the mental state, and of the order in which the symptoms appeared.

•5- Dementia and other organic conditions: patients with severe depression can perform very badly on tests of cognitive function, and distinction between the two conditions purely in terms of the nature of the cognitive impairment may not be possible. Here the presence of depressive symptoms is the key to diagnosis, which should be confirmed with improvement of the memory disorder as normal mood is restored. Numerous other general medical conditions can present with depressive features like CVA, Cushing disease, Addison's disease, hypothyroidisim, some infections & cancer.

EPIDEMIOLOGY

•• the lifetime rates in different studies vary considerably (in the range 4-30%). The true figure probably lies in the range 10- 20%

•• the mean age of onset is about 27 years

•• rates of major depression are about twice as high in women as in men, across different cultures

••rates of depression are higher in the unemployed and divorced

•• major depression has a high comorbidity with other disorders, particularly anxiety disorders and substance misuse.

ETIOLOGY OF DEPRESSION

- The exact cause of depression is unknown, but biological and psychosocial factors each contribute.
- Biological factors:
- *Abnormalities of Serotonin/Catecholamines*
- **1.** Decreased brain and cerebrospinal fluid (CSF) levels of serotonin and its main metabolite, 5-hydroxyindolacetic acid (5-HIAA), are found in depressed patients. Abnormal regulation of beta-adrenergic receptors has also been shown.
- **2.** Drugs that increase availability of serotonin, norepinephrine, and dopamine often alleviate symptoms of depression.

OTHER NEUROENDOCRINE ABNORMALITIES

- **1. High cortisol:** Hyperactivity of hypothalamic–pituitary–adrenal axis as shown by failure to suppress cortisol levels in dexamethasone suppression test.
- **2. Abnormal thyroid axis:** Thyroid disorders are associated with depressive symptoms, and one third of patients with MDD who have otherwise normal thyroid hormone levels show blunted response of thyroid stimulating hormone (TSH) to infusion of thyrotropin-releasing hormone (TRH).
- These abnormalities are also associated with other psychiatric disorders; they are not specific for major depression.
- *Genetic Predisposition*
- First-degree relatives are two to three times more likely to have MDD. Concordance rate for monozygotic twins is about 50%, and 10 to 25% for dizygotic twins.

PSYCHOLOGICAL APPROACHES TO ETIOLOGY

- **cognitive theories**

- Depressed patients characteristically have recurrent and intrusive *negative thoughts ('automatic thoughts').* Beck

(1967) proposed that these depressive cognitions reveal negative views of the *self,* the *world,* and the *future.*

- **Psychoanalytical theory**

- In his paper 'Mourning and melancholia',Freud drew attention to the resemblance between the phenomena mourning and symptoms of depressive disorders, and suggested that their causes might be similar.
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SOCIAL FACTORS

- **1-Parental deprivation:**
- Psychoanalysts have suggested that childhood deprivation of maternal affection through separation or loss predisposes to depressive disorders in adult life.
- **2- Relationships with parents:**

It is clear that gross disruption of parent-child relationships, as occurs, for example, • in *physical and sexual abuse,* is a risk factor for several kinds of adult psychiatric disorder, including major depression

- **3-Recent life events:**
- It is an everyday clinical observation that depressive disorders often follow *stressful events.*
- In general, ‹loss' events are associated with depression and 'threat' events are associated with anxiety. life events are important antecedents of all forms of depression, but appear to be relatively less important in established melancholic-type disorders and where there is a strong family history of depression.
- Events that lead to feelings of *entrapment and humiliation* may be particularly relevant to the onset of depression.

TREATMENT

- **Hospitalization**
- _ Indicated if patient is at risk for suicide, homicide, or is unable to care for self.
- **Pharmacotherapy**
- *Antidepressant Medications* Usually indicated in moderate & severe depression & their effect in mood elevation start after 10 days to 3 weeks of intake. There are several groups of antidepressants the most important of which are:
- _ Selective serotonin reuptake inhibitors (SSRIs)— (examples: fluoxetine, paroxetine, citalopram & sertraline) safer and better tolerated than other classes of antidepressants, that's why now considered first line; side effects mild but include headache, gastrointestinal disturbance, sexual dysfunction, and rebound anxiety.

- _ Tricyclic antidepressants (TCAs)— (examples: imipramine, clomipramine and amitriptyline). Most lethal in overdose; that's the main reason they became second line in spite of having equal efficacy to SSRIs. Side effects include sedation, weight gain, orthostatic hypotension, cardiotoxicity and anticholinergic effects.
- _ Monoamine oxidase inhibitors (MAOIs)—useful for treatment of refractory depression; risk of *hypertensive crisis* when used with sympathomimetic or ingestion of tyramine-rich foods (such as wine, beer, aged cheeses, liver, and smoked meats).

- _other antidepressants like mirtazapine and venlafaxine.
- _ Antipsychotics—useful in patients with psychotic features & sometimes in severe cases
- _In cases of resistant depression some drugs are used which are not antidepressants like Lithium and stimulants

PSYCHOTHERAPY

- _ Behavioral therapy, cognitive therapy, supportive psychotherapy, dynamic psychotherapy, and family therapy
- _ May be used in conjunction with pharmacotherapy

ELECTROCONVULSIVE THERAPY (ECT)

- *Convulsive therapy* was introduced in the 1930s on the basis of the mistaken idea that epilepsy and schizophrenia do not occur together. It seemed to follow that induced fits should lead to improvement in schizophrenia.
- However, when the treatment was tried it became apparent that the most striking changes occurred not in schizophrenia but in *severe depressive disorders*, in which it brought about a substantial reduction in chronicity and mortality.

- **Mode of action**
- Clinicians have generally been convinced that the patient does not improve unless a convulsion is produced during the ECT procedure. This impression has been confirmed by several double-blind trials which, taken together, show that ECT is strikingly more effective than a full placebo procedure that includes anaesthetic and muscle relaxant.

- **Indications**
- _ Indicated if patient is unresponsive to pharmacotherapy, if patient cannot tolerate pharmacotherapy, or if rapid reduction of symptoms is desired (suicide risk, or the patient is stuperous due to dehydration etc.)
- _ ECT is safe and may be used alone or in combination with pharmacotherapy. _
- Approximately eight treatments are administered over a 2- to 3-week period, but significant improvement is often noted after the first treatment.
- _ Retrograde amnesia is a common side effect, which usually disappears within 6 months.

COURSE AND PROGNOSIS

- If left untreated, depressive episodes are self-limiting but usually last from 6 to 13months. Generally, episodes occur more frequently as the disorder progresses.
- The risk of a subsequent major depressive episode is 50% within the first 2 years after the first episode. About 15% of patients eventually commit suicide.
- Antidepressant medications significantly reduce the length and severity of symptoms. They may be used prophylactically between major depressive
- episodes to reduce the risk of subsequent episodes. Approximately 75% of patients are treated successfully with medical therapy.

:OTHER TYPES OF MOOD DISORDERS

- ***:Bipolar I disorder***

involves episodes of mania and of major depression; however, episodes of major depression are *not* required for the diagnosis. It is traditionally known as **manic depression**.

- ***Bipolar II disorder:***
- Alternatively called *recurrent major depressive episodes with hypomania*.

- ***Dysthymic disorder:***
- Patients with dysthymic disorder have chronic, mild depression most of the time with no discrete episodes. They rarely need hospitalization.
- ***Cyclothymic disorder:***
- Alternating periods of hypomania and periods with mild to moderate depression.
- **Rapid cycling**
- is defined by the occurrence of four or more mood episodes in 1 year (major depressive, manic, mixed, etc.).

MANIA

:DIAGNOSIS OF A MANIC EPISODE

- **A period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week and including at least three of the following (four if mood is irritable):**
- **1. Distractibility**
- **2. Inflated self-esteem or grandiosity**
- **3. Increase in goal-directed activity (socially, at work, or sexually)**
- **4. Decreased need for sleep**
- **5. Flight of ideas or racing thoughts**
- **6. More talkative or *pressured speech* (rapid and uninterruptible)**
- **7. Excessive involvement in pleasurable activities that have a high risk of negative consequences (e.g., buying sprees, sexual indiscretions)**

- These symptoms cannot be due to substance use or medical conditions, and they must cause social or occupational impairment. Seventy-five percent of manic patients have psychotic symptoms.
- The elevated mood is euphoric and often infectious . Although uninvolved persons may not recognize the unusual nature of a patient's mood, those who know the patient recognize it as abnormal. Alternatively, the mood may be irritable, especially when a patient's overtly ambitious plans are thwarted. Patients often exhibit a change of predominant mood from euphoria early in the course of the illness to later irritability.

HYPOMANIC EPISODE

- A hypomanic episode is a distinct period of elevated, expansive, or irritable mood that includes at least three of the symptoms listed for the manic episode criteria (four if mood is irritable). There are significant differences between mania and hypomania.

DIFFERENCES BETWEEN MANIC AND HYPOMANIC EPISODES

• **Mania**	**Hypomania**
• Lasts at least 7	Lasts at least 4 days
• Causes severe impairment in social or occupational functioning	No marked impairment in social or occupational functioning
• May necessitate hospitalization to prevent harm to self or others	Does not require hospitalization
• May have psychotic features	No psychotic features

EPIDEMIOLOGY

- _ Lifetime prevalence: 1%
- _ Women and men equally affected
- _ No ethnic differences seen
- _ the mean age of onset is about 17 years in community
- studies

ETIOLOGY

- Biological, environmental, psychosocial, and genetic factors are all important.
- First-degree relatives of patients with bipolar disorder are 8 to 18 times more likely to develop the illness. Concordance rates for monozygotic twins are approximately75%, and rates for dizygotic twins are 5 to 25%.

TREATMENT

- **Hospitalization:** needed in many cases especially when the patient is exhausted, suicidal, violent or simply to start pharmacotherapy
- **Pharmacotherapy**
- Drug treatment plays a pivotal role in the management of mania, and has the aim of reducing physical and mental overactivity, improving features of psychosis, and preventing deterioration in health due to exhaustion, sleep deprivation, and poor fluid intake. It is worth noting that before the advent of modern drug treatment the mortality of mania in the hospital setting was over 20%; nearly 50% of these patients died from exhaustion

- Drugs used:
- **Mood stabilizers:** the main line of treatment especially on the long term but should be included in the treatment of the acute stage, they may include the following:
- _Lithium: narrow margin of safety, serum level not always available
- _ Anticonvulsants (carbamazepine or valproic acid)—also mood stabilizers, especially useful for rapid cycling bipolar disorder and mixed episodes
- _ B-Antipsychotics: usually needed in most patients especially the atypical drugs. In the acute stage they are considered to be first line
- C-Anxiolytics like Benzodiazepines are sometimes used to decrease overactivity

- **Psychotherapy**
- _ Supportive psychotherapy, family therapy, group therapy (once the acute manic episode has been controlled)
- **ECT**
- ECT has been widely used to treat mania, it was found to be superior to lithium.
- Retrospective investigations have shown ECT to be effective in acute mania, with the overall response rate being about 80%. Many of these patients had been unresponsive to medication. ECT is also effective in *mixed affective states*.
- It is often given at shorter intervals in the treatment of mania than in the treatment of depression.

:COURSE AND PROGNOSIS

- It has been estimated that about 10% of patients who present with a depressive disorder will eventually have a manic illness.
- Untreated manic episodes generally last about 3 months. The course is usually chronic with relapses; as the disease progresses, episodes may occur more frequently.
- Only 7% of patients do not have a recurrence of symptoms after their first manic episode.
- Bipolar disorder has a worse prognosis than MDD, as only 50 to 60% of patients treated with lithium experience significant improvement in symptoms.
- Lithium prophylaxis between episodes helps to decrease the risk of relapse.