MOOD DISORDER

EMOTIONS CAN BE DESCRIBED AS TWO MAIN TYPES

- MOOD :A sustained and pervasive emotional attitude which colors the whole psychic life
- AFFECT A short-lived emotional response to an idea or an event (what people observe)
- Mood: internal amp　　　　　Affect: speaker
- Classification of mood disorders:
- 1. Manic episode
- 2. Depressive episode
- 3. Bipolar mood (affective) disorder
- 4. Recurrent depressive disorder
- 5. Persistent mood disorder
- 6. Other mood disorders

MANIC EPISODE

- Life-time risk:
- 0.8-1.0%
- • Tends to occur in episodes lasting usually 3-4 months → followed by complete clinical recovery → future episodes (manic/depressive/mixed)
- Characterised by the following features :
- – Elevated, expansive or irritable mood
- – Psychomotor activity
- – Speech and thought
- – Goal-directed activity
- – Other features
- – Absence of underlying organic cause (which should last for at least 1 week and cause disruption in occupational & social activities)

STAGES

The elevated mood can pass through 4 stages:

Euphoria
(mild elevation of mood)

an increased sense of psychological well-being and **happiness**

Hypomania (stage I)

Elation
(mod elevation of mood)

A feeling of **confidence** and enjoyment, increase in psychomotor activity

Mania (stage II)

Exaltation
(sev elevation of mood)

Intense elation with delusion of ***grandeur***

Severe mania (stage III)

Ecstasy
(very sev elevation of mood)

Intense sense of rapture or **blistfullness**

Stupurous mania (stage III)

- Speech and thought
  - More talkative than usual
  - Describes thoughts racing in mind
  - Develops pressure of speech
  - Uses playful language (joking/teasing)
  - Speaks loudly
  - Flight of ideas
  - Delusion of grandeur
  - Delusion of persecution • Hallucinations, often with religious content Since these psychotic symptoms are in keeping with the elevated mood state, these are called mood-congruent psychotic features
- Goal-directed activity Unusually alert, trying to do many things at one time
- •Hypomania
  - the ability to function becomes much better & marked increase in productivity and creativity

- Mania
- • Marked increase in activity with excessive planning
- • Marked increase in sociability even with previously unknown people
- • Poor judgement. Often involve in high risk activities such as reckless driving, distributing money to strangers • Usually dressed up in gaudy and flamboyant clothes
- Other features:
- • Decreased need of sleep • Increased appetite → later decreased food intake d/t overactivity
- • Absent insight into illness
- • Psychotic features → delusions, hallucinations (mood incongruent psychotic features)

DEPRESSIVE EPISODE

- Life time risk of common depression: • 8-12% (in males) • 20-26% (in females) • Life time risk of major depression/ depressive episode is about 8%
- Characterised by the following features : ⁻ Depressed mood ⁻ Depressive ideation / cognition ⁻ Psychomotor activity ⁻ Physical symptoms ⁻ Biological functions ⁻ Psychotic features ⁻ Suicide ⁻ Absence of underlying organic cause (which should last for at least 2 weeks for a diagnosis to be made)
- Depressed mood • Sadness of mood and loss of interest/pleasure in almost all activities (pervasive sadness) • Present throughout the day (persistent sadness) • Varies from day to day and often unresponsive to the environmental stimuli • Results in social w/drawal, decreased ability to function in occupational and interpersonal areas and decreased involvement in previously pleasurable activities • Severe depression → complete anhedonia (inability to experience pleasure)

Cont..

- Depressive ideation/cognition Sadness of mood usually associated with pessimism, which can result in 3 common types of depressive ideas:
- • Hopelessness (no hope in future)
- • Helplessness (no help is possible now)
- • Worthlessness (feeling of inadequacy/inferiority)
- Depressive ideation/cognition
- • Other features: • Difficulty in thinking/concentrating • Indecisiveness • Slowed thinking • Poor memory • Lack of initiative and energy • Thoughts of death • Suicidal ideas • Delusion of nihilism “My world is coming to an end” “My intestines have rotted away”

Cont...

- Psychomotor activity :
- • Young patient (<40 years) → retardation is common • Slowed thinking and activity, decreased energy, monotonous voice.
- • Severe → stuporous (depressive stupor)
- • Older patients → agitation is common • Marked anxiety, restlessness (inability to sit still, hand-wriggling)
- • Subjective feeling of unease
- • Anxiety is a frequent accompaniment of depression • Irritability (easy annoyance and frustration in day to day activities)
- Physical symptoms
- • Multiple physical symptoms (general aches and pain)
- • Complain of reduced energy and easy fatigability • Consult a physician instead of psychiatrist

- Biological functions
- • Insomnia (or sometimes increased sleep)
- • Loss of appetite and weight (or sometimes hyperphagia and weight gain)
- • Loss of sexual drive
- • Melancholia (somatic syndrome in ICD-10-DCR) → signifies higher severity and more biological nature of disturbance
- Psychotic features • 15-20% of depressed patients have psychotic features such as delusions, hallucinations, grossly inappropriate behavior or stupor • Mood-congruent psychotic features → nihilistic delusions, delusion of guilt, delusions of poverty, stupor • Mood-incongruent psychotic features → delusions of control
- Suicide • Should always be taken seriously • Factors increase the risk of suicide • Presence of marked hopelessness • Males; age>40; unmarried; divorced/widowed • Written/verbal communication of suicidal intention/plan • Early stages of depression • Recovering of depression • Period of 3 months from recovery

BIPOLAR MOOD (OR AFFECTIVE) DISORDER

- Characterized by recurrent episodes of mania and depression in the same patient at different times

  • Earlier known as manic depressive psychosis (MDP)
- • This episode can occur in any sequence.
- • The current episode in bipolar mood disorder is specified as one of the following (ICD- 10):
- • Hypomanic
- • Manic without psychotic symptoms
- • Manic with psychotic symptoms
- • Mild/mod depression
- • Severe depression, without psychotic symptoms
- • Severe depression, with psychotic symptoms
- • Mixed • In remission • Further divided into bipolar I & bipolar II disorders
- • Bipolar I: Charact. by episodes of severe mania and severe depression
- • Bipolar II: Charact. by episodes of hypomania and severe depression

RECURRENT DEPRESSIVE DISORDER

- • Characterized by recurrent (at least 2) depressive episodes (unipolar depression)
- • The current episode in recurrent depressive disorder is specified as one of the following:
- • Mild
- • Moderate
- • Severe, without psychotic symptoms
- • Severe, with psychotic symptoms • In remission

PERSISTENT MOOD DISORDER

- Characterized by persistent mood symptoms which last for >2 years (1 year in children) But not severe enough to be labelled as even hypomanic or mild depressive episode
- • Persistent mild depression → dysthymia
- • Persistent instability of mood between mild depression and mild elation → cyclothymia

OTHER MOOD DISORDER

- • Includes the diagnosis of mixed affective episode
- • Frequently missed diagnosis clinically
- • Full clinical picture of depression and mania is present either at the same time intermixed or alternates rapidly with each other (rapid cycling), without a normal intervening period of euthymia
- COURSE AND PROGNOSIS

  • Bipolar mood disorder has an earlier age of onset (3rd decade) than recurrent depressive (unipolar) disorder.
- • Unipolar depression is common in two age groups: late third decade & 5th – 6th decade
- • An average manic episode lasts for 3-4 months while a depressive episode lasts from 4-6 months
- • Unipolar depression usually lasts longer than bipolar depression
- • With rapid institution of treatment , the major symptoms of mania are controlled within 2 weeks and of depression within 6-8 weeks

MOOD DISORDER

- ETIOLOGY OVERALL

  • Biological theories • Genetic hypothesis • Biochemical theories • Neuroendocrine theories • Sleep studies • Brain imaging • Psychosocial theories • Psychoanalytic theories • Cognitive and behavioral theories • Stress (stressful life events)

- DIAGNOSIS
- • 1st step: exclude a disorder with known organic cause, e.g. organic (especially-drug induced) mood disorders and dementia
- • 2nd step: to rule out a possibility of acute and transient psychotic disorders, schizo-affective disorder and schizophrenia
- • 3rd step: exclude possibility of other non-organic psychoses such as delusional disorders
- • 4th step: exclude possibility of adjustment disorder with depressed mood, gen.anxiety disorder, normal grief reaction, obsessive compulsive disorder (with or without secondary reaction)
- • Important to look for comorbid medical and/or psychiatric disorders (anxiety, alcohol or drug misuse, personality disorder)

Cont..

- MANAGEMENT overall
- Somatic treatment Antidepressants
- • Treatment of choice for a vast majority of depressive episodes
- • It may take upto 3 weeks before any appreciable response may be noticed
- • Before stopping/changing a drug, the particular drug should be given in a therapeutically adequate dose for at least 6 weeks
- • Tricyclic antidepressants (TCAs) :

  Imipramine (75-150mg upto 300mg)

  • Amitryptyline is NOT USED due to dry mouth, blurry vision, post. HTN

  • Newer antidepressants

  • Selective serotonin reuptake inhibitors (SSRIs) → fluoxetine, sertraline, citalopram

  • Serotonin NE reuptake inhibitors (SNRIs) → venlafaxine, duloxetine

  • Mirtazapine

- Electroconvulsive therapy:
- • Indications :

  • Severe depression with suicidal risk

  • Severe depression with stupor, severe psychomotor retardation, or somatic syndrome • Severe treatment refractory depression

  • Delusional depression

  • Significant antidepressant side effects

  • In most clinical conditions, usually, 6-8 times ECTs are needed, given 3 times a week
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- Lithium :
- • Drug of choice for tx of manic episode (acute phase) as well as for prevention of further episodes in BPD
- • 900-1500mg of lithium carbonate/day
- • Need to be closely monitored by repeated blood levels, as the difference between the therapeutic and lethal blood levels is not very wide (narrow therapeutic index)
- •

Lithium toxicity

- Therapeutic blood lithium = 0.8-1.2mEq/L
- • Prophylactic blood lithium = 0.6-1.2mEq/L
- • Blood lithium level of >2.0mEq/L is often asst. with toxicity
- • A level >2.5-3.0 mEq/L may be lethal
- • The common acute toxic symptoms are neurological
- • The common chronic side effects are nephrological and endocrinal (usually hypothuroidism)
- • Most important investigations before starting lithium include→ complete GPE, CBC, ECG, urine R/E, RFT, TFT

Other drugs

- Antipsychotics
  - Important adjunct in the tx of mood disorder
  - Commonly used drugs:

  Risperidone • Olanzapine • Clonazepine • Quetiapine* • Haloperidol • Aripiprazole* *safe from metabolic syndrome agranulocytosis
- Other Mood Stabilizers
  - Sodium valproate (1000-3000mg/day)
  - Carbamazepine (600-1600mg/day)
  - Benzodiazepines (Lorazepam/clonazepam) as adjuvants
  - Lamotrigine • T3 and T4 as adjuncts

Therapeutic management

Psychosocial treatment

- Cognitive behavior therapy
- Interpersonal therapy
- Psychoanalytic psychotherapy
- Behaviour therapy
- Group therapy
- Family & marital therapy