Mood Disorders

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A. Definitions

1. The mood or affective disorders are characterized by a primary **disturbance** in **internal emotional state**, causing subjective distress and problems in social and occupational functioning.

2. Given the patient's current social and occupational situation he or she emotionally feels

- **somewhat worse than would be expected (dysthymia)**
- **very much worse than would be expected(depression)**
- **somewhat better than would be expected (hypomania)**
- **very much better than would be expected(mania)**

Definitions

• accurate diagnosis of a mood disorder requires a careful past medical and psychiatric history to detect past mood episodes and to rule out whether these episodes were secondary to substance use, a medical condition, a loss, etc

- mood episodes represent a combination of symptoms comprising a predominant mood state that is abnormal in quality or duration (e.g. major depressive, manic, mixed, hypomanic).
- types of mood disorders include:
  - depressive (major depressive disorder, persistent depressive disorder)
  - bipolar (bipolar I/II disorder, cyclothymia)
  - secondary to general medical condition, substances, medications, other psychiatric issue

  Medical Workup of Mood Disorder

  •routine screening: physical exam, CBC, thyroid function test, extended electrolytes, urinalysis, drug screen, medications list

  • additional screening: neurological consultation, chest X-ray, ECG, CT head

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Text Revision (DSM-V-TR)* ***categories*** *of primary mood disorders are:*

a. Major depressive disorder: *Recurrent episodes of depression, each continuing for at least 2 weeks.*

b. **Bipolar disorder: Episodes of both mania (continuing for at least 1 week) and depression (bipolar I disorder) or both hypomania (continuing for at least 4 days) and depression (bipolar II disorder).**

c. Dysthymic disorder: Dysthymia continuing over a 2-year period(1 year in children)with no discrete episodes of illness.

d. disorder: Hypomania and dysthymia occurring over a 2-year period(1year in children) with no discrete episodes of illness.

e. Mood disorder due to a general medical condition and substance-induced mood disorder are secondary mood disorders.

B. Epidemiology

1. There are **no differences** in the occurrence of mood disorders associated with ethnicity, education, marital status, or income.

2. The **lifetime prevalence** of mood disorders is
a. Major depressive disorder: 5%–12% for men;10%–20% for women.

- **Bipolar disorder: 1% overall; no sex difference.**
- **Dysthymic disorder: 6% overall; up to three times more common in women.**
- **Cyclothymic disorder: Less than 1% overall; no sex difference.**

CLASSIFICATION OF MOOD DISORDERS

A. Major depressive disorder

1. Characteristics

a. SWAG is a mnemonic device that can quickly identify depression and differentiate it from normal sadness. If one of the following symptoms is present, it is most likely that the patient is depressed:

(1) S – Suicidality (having a plan or a means of self-destruction).
(2) W – Weight loss (>5% of body weight).

(3) A – Anhedonia (loss of pleasure or interest in usually pleasurable activities).

(4) G–Guilt(feelings of responsibility for negative life events when little or none exists).

b. These and other symptoms of depression are listed and described in Table 12.1

DSM-5 Diagnostic Criteria for Major Depressive Episode

- A. ≥5 of the following symptoms have been present during the same 2 wk period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (anhedonia)
  Note: do not include symptoms that are clearly attributable to another medical condition

1. depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly everyday
3. significant and unintentional weight loss/weight gain, or decrease/ increase in appetite nearly everyday
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. diminished ability to think or concentrate, or indecisiveness, nearly every day
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. the episode is not attributable to the direct physiological effects of a substance or a GMC

table 12.1 Signs and Symptoms of Depression and Mania

Depression	Likelihood of Occurrence
SWAG (suicidality, weight loss, anhedonia, guilt) symptom	++++
Sadness, hopelessness, helplessness, low self-esteem	++++
Reduced energy and motivation	++++
Anxiety (is apprehensive about imagined dangers)	++++
Sleep problems (wakes frequently at night and too early in the morning)	++++
Cognitive problems (has difficulty with memory and concentration)	+++
Change in physical activity (psychomotor retardation or agitation)	+++
Decreased or increased (in atypical depression) appetite for food and sex	+++
Poor grooming	++
Diurnal variation in symptoms (worse in the morning, better in the evening)	++
Suicidal ideation (has thoughts of killing oneself)	++
Suicide (takes one's own life)	+
Psychotic symptoms (has delusions of destruction and fatal illness)	+

Mania	Likelihood of Occurrence
Elevated mood (has strong feelings of happiness and physical well-being)	++++
Grandiosity and expansiveness (has feelings of self-importance)	++++
Irritability and impulsivity (is easily bothered and quick to anger)	++++
Disinhibition (shows uncharacteristic lack of modesty in dress or behavior)	++++
Assaultiveness (cannot control aggressive impulses; causes legal problems)	++++
Distractibility (cannot concentrate on relevant stimuli)	++++
Flight of ideas (thoughts move rapidly from one to the other)	++++
Pressured speech (seems compelled to speak quickly)	++++
Impaired judgment (provides unusual responses to hypothetical questions, [e.g., says she would buy a blood bank if she inherited money])	++++
Psychotic symptoms (has delusions of power and influence)	+++

Approximate percentage of patients in which the sign or symptom is seen: + <25%; ++ 50%; +++ 70%; ++++ >70%.

CLASSIFICATION OF MOOD DISORDERS

1. **Masked depression**

   a. As many as 50% of depressed patients seem unaware of or deny depression and thus are said to have "masked depression."

   - **Patients with masked depression often visit primary care doctors complaining of vague physical symptoms.**

   - **In contrast to patients who have somatoform disorders (physical symptoms resulting from psychological factors) depressed patients show at least one SWAG symptom in addition to their physical complaints.**

2. **Seasonal affective disorder (SAD)**

   a. SAD is a subtype of major depressive disorder associated with the winter season and short days.
   b. SAD is characterized by atypical symptoms of depression (e.g., oversleeping and over-eating) and a heavy feeling in the limbs ("leaden paralysis").

c. Many SAD patients improve in response to full-spectrum **light exposure**.

4. Suicide risk

- **Patients with mood disorders are at increased risk for suicide.**

- **Certain demographic, psychosocial, and physical factors affect this risk.**
- **The top five risk factors for suicide from higher to lower risk are:**
  (1) serious prior suicide attempt
  (2) age older than 45 years
  (3) alcohol dependence
  (4) history of rage and violent behavior
  (5) male sex.

CLASSIFICATION OF MOOD DISORDERS

B. Bipolar disorder

1. In bipolar disorder, there are episodes of **both mania and depression (bipolar I disorder)** or **both hypomania and depression (bipolar II disorder)**.

2. There is no simple manic disorder because depressive symptoms eventually occur.Therefore, one episode of symptoms of mania (Table 12.1) alone or hypomania plus one episode of major depression defines bipolar disorder.

3. Psychotic symptoms, such as delusions, can occur in depression (depression with psychotic features) as well as in mania.

- **In some patients (e.g., poor patients with low access to health care), a mood disorder with psychotic symptoms can become severe enough to be misdiagnosed as schizophrenia.**

- **In contrast to schizophrenia and schizoaffective disorder, in which patients are chronically impaired, in mood disorders the patient's mood and functioning usually return to normal between episodes.**

DSM-5 Criteria for Manic Episode

- A. a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting ≥1 wk and present most of the day, nearly every day (or any duration if hospitalization is necessary)

- B. during the period of mood disturbance and increased energy or activity, ≥3 of the following symptoms have persisted (4 if the mood is only irritable) and have been present to a significant degree and represent a noticeable change from usual behaviour
  - inflated self-esteem or grandiosity
  - decreased need for sleep (e.g. feels rested after only 3 h of sleep)
  - more talkative than usual or pressure to keep talking
  - flight of ideas or subjective experience that thoughts are racing
  - distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)
  - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  - excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained shopping sprees, sexual indiscretions, or foolish business investments)

  C. the mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features D.the episode is not attributable to the physiological effects of a substance or another medical condition

Hypomanic Episode

criterion A and B of a manic episode is met, but duration is≥4d

- episode associated with an uncharacteristic change in functioning that is observable by others but not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization
- absence of psychotic features(if these are present the episode is, by definition, manic)
- **Mixed Features**
  • an episode specifier in bipolar or depression that indicates the presence of both depressive and manic symptoms concurrently, classified by the disorder and primary mood episode component (e.g. bipolar disorder, current episode manic, with mixed features)
- clinical importance due to increased suicide risk
- if found in patient diagnosed with major depression, high index of suspicion for bipolar disorder
- while meeting the full criteria for a major depressive episode, the patient has on most days≥ 3 of criteria B for a manic episode
- while meeting the full criteria for a manic/hypomanic episode, the patient has on most days≥3 of criteria A for a depressive episode (the following criterion A cannot count: psychomotor agitation, insomnia, difficulties concentrating, weight changes)

C. Dysthymic disorder and cyclothymic disorder. In contrast to major depressive disorder and bipolar disorder, respectively, dysthymic disorder and cyclothymic disorder are

1. less severe

2. nonepisodic
3. chronic
4. not associated with psychosis or suicide.

ETIOLOGY

A. The **biologic** etiology of mood disorders includes
1. Altered neurotransmitter activity.
2. A **genetic component**, strongest in bipolar disorder.
3. Physical illness and related factors.
4. Abnormalities of the limbic–hypothalamic–pituitary–adrenal axis.

B. The **psychosocial** etiology of depression and dysthymia can include

1. Loss of a parent in childhood.
2. Loss of a spouse or child in adulthood.
3. Loss of health.

4. Low self-esteem and negative interpretation of life events.
5. “**Learned helplessness**” (i.e., because attempts to escape bad situations in the past have proven futile, the person now feels helpless)

C. Psychosocial factors are **not directly involved** in **the etiology of mania** or hypomania.

table 12.3 The Genetics of Bipolar Disorder

Group	Approximate Occurrence (%)
General population	1
Person who has one parent or sibling (or dizygotic twin) with bipolar disorder	20
Person who has two parents with bipolar disorder	60
Monozygotic twin of a person with bipolar disorder	75

table 12.4 Differential Diagnosis of Depression

Medical Conditions	Psychiatric and Related Conditions
Cancer, particularly pancreatic and other gastrointestinal tumors Viral illness (e.g., pneumonia, influenza, acquired immune deficiency syndrome [AIDS]) Endocrinologic abnormality (e.g., hypothyroidism, diabetes, Cushing's syndrome) Neurologic illness (e.g., Parkinson disease, multiple sclerosis, Huntington disease, dementia, stroke [particularly left frontal]) Nutritional deficiency (e.g., folic acid, B_{12}) Renal or cardiopulmonary disease	Schizophrenia (particularly after an acute psychotic episode) Adjustment disorder Anxiety disorder Normal reaction to a life loss, e.g., bereavement Somatoform disorder Eating disorder Drug and alcohol abuse (particularly use of sedatives and withdrawal from stimulants) Prescription drug use (e.g., reserpine, steroids, antihypertensives, antineoplastics)

Prognosis

- one year after diagnosis of MDD without treatment:40%of individuals still have symptoms that are sufficiently severe to meet criteria for MDD, 20% continue to have some symptoms that no longer meet criteria for MDD, 40% have no mood disorder.

MANAGEMENT

A. Overview

1. **Depression is successfully managed in most patients.**

2. **Only about 25% of patients with depression seek and receive treatment.**
   a. Patients do not seek treatment in part because patients often believe that mental illness indicates personal failure or weakness.

b. As in other illnesses, **women are more likely than men to seek treatment**.

3. **Untreated episodes of depression and mania are usually self-limiting and last approximately 6–12 months and 3 months, respectively.**

4. **The most effective management of the mood disorders is pharmacologic.**

B. Pharmacologic management

1. Treatment for depression and dysthymia includes **antidepressant agents** (e.g., heterocyclics, selective serotonin and selective serotonin and norepinephrine reuptake inhibitors [SSRIs and SNRIs], monoamine oxidase inhibitors [MAOIs], and stimulants).

MANAGEMENT

2. Mood stabilizers
a. Lithium and **anticonvulsants** such as carbamazepine(Tegretol) and divalproex(Depakote) are used to manage bipolar disorder.

b. Mood stabilizers in doses similar to those used to manage bipolar disorder are the primary treatment for cyclothymic disorder.

c. Atypical antipsychotics such as olanzapine (Zyprexa) and risperidone (Risperdal).

d. Sedative agents such as lorazepam (Ativan) are used to manage acute manic episodes because they resolve symptoms quickly.

MANAGEMENT

C. Psychological management

1. Psychological management for depression and dysthymia includes psychoanalytic, inter-personal, family, behavioral, and cognitive therapies .

2. Psychological management in conjunction with medication is more effective than either type of management alone.

D. Electroconvulsive therapy (ECT). The primary indication for ECT **is major depressive disorder**. It is used when
1. The symptoms **do not respond to antidepressant medications**.

2. Antidepressants are too dangerous or have intolerable side effects. Thus, ECT may be particularly useful for elderly patients.

3. Rapid resolution of symptoms is necessary (e.g., the patient is acutely suicidal or psychotic).

The End