Psycho

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MOOD DISORDER

CONCEPTS IN MOOD DISORDERS

A **mood is a description of one's internal emotional state. Both external and** internal stimuli can trigger moods, which may be labeled as sad, happy, angry, irritable, and so on. It is normal to have a wide range of moods and to have a sense of control over one's moods.

Patients with mood *disorders experience an abnormal range of moods and lose* some level of control over them. Distress may be caused by the severity of their moods and their resulting impairment in social and occupational functioning.

Mood disorders have also been called **affective disorders.**

Mood Disorders Versus Mood Episodes

Mood episodes are distinct periods of time in which some abnormal mood is present.

Mood disorders are defined by their patterns of mood episodes.

Types of Mood Episodes

- Major depressive episode
- Manic episode
- Mixed episode
- Hypomanic episode

The Main Mood Disorders

- Major depressive disorder (MDD)
- Bipolar I disorder
- Bipolar II disorder
- Dysthymic disorder
- Cyclothymic disorder

Symptoms of major depression :-

SIG E. CAPS

- Sleep
- Energy
- psychomotor activity
- Interest
- concentration
- Guilt
- Appetite
- Suicidal ideation

MOOD EPISODES

Major Depressive Episode (DSM-IV Criteria)

- Must have at least five of the following symptoms (must include either number 1 or number 2 or both) for at least a 2-week period:

criteria of major depressive episode

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**

   → more (mc terminal insomnia)
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**

* it should be primary symptoms

→ hypothyroidism

Symptoms cannot be due to substance use or medical conditions, and they must cause social or occupational impairment.

- **SUICIDE AND MAJOR DEPRESSIVE EPISODES**

A person who has been previously hospitalized for a major depressive episode has a 15% risk of committing suicide later in life.

What's DMS-IV criteria of major depression episode?

QUESTION

SIG E CAPS (at least 5) for 2 weeks or more

1- Depressed mood
2. SIG E. CAPS

DIAGNOSIS AND DSM-IV CRITERIA OF MMD :
least one major depressive episode
No history of manic or hypomanic episode

Sleep - Insomnia or hypersomnia
Interest- Anhedonia (loss of interest in pleasurable activities)
Guilt- Feelings of worthlessness or excessive guilt
Energy- Fatigue or loss of energy
Concentration- Diminished concentration
Appetite - Change in appetite or body weight (increased or decreased)
Psychomotor activity- Psychomotor agitation or retardation (i.e., restlessness or slowness)
Suicidal ideation- Recurrent thoughts of death or suicide

3- Symptoms cannot be due to substance use or medical conditions, and they must cause social or occupational impairment.

Manic Episode (DSM-IV Criteria)

- 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 (shopping 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. (delusions or hallucinations).

- A manic episode is a *psychiatric emergency;* severely impaired judgment makes patient dangerous to self and others.
- **Symptoms of mania: DIG FAST**

Distractability% Insomnia% Grandiosity %Flight of ideas %Activity/agitation% Speech (pressured) %Thoughtlessness

- **Mixed Episode**

Criteria are met for both manic episode and major depressive episode. These criteria must be present nearly every day for at least 1 week. As with a manic episode, this is a psychiatric emergency.

What's DMS IV criteria of manic episode?

QUESTION

DIG FAST (at least 3) for 1 weeks or more

DIG FAST

(4) If mood is irritable.

1- Distractability
2- Insomnia - Decreased need for sleep
3- Grandiosity - Inflated self-esteem or grandiosity
4- Flight of ideas- Flight of ideas or racing thoughts
5- Activity/agitation- goal directed activities (socially, at work, or sexually)
6- Speech (pressured)- More talkative
7- Thoughtlessness- Excessive involvement in pleasurable activities that have a high risk of negative consequences (e.g., shopping 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. (delusions or hallucinations).

ANS

Mixed episode

QUESTION

Criteria are met for both manic episode and major depressive episode. These criteria must be present nearly every day for at least 1 week.

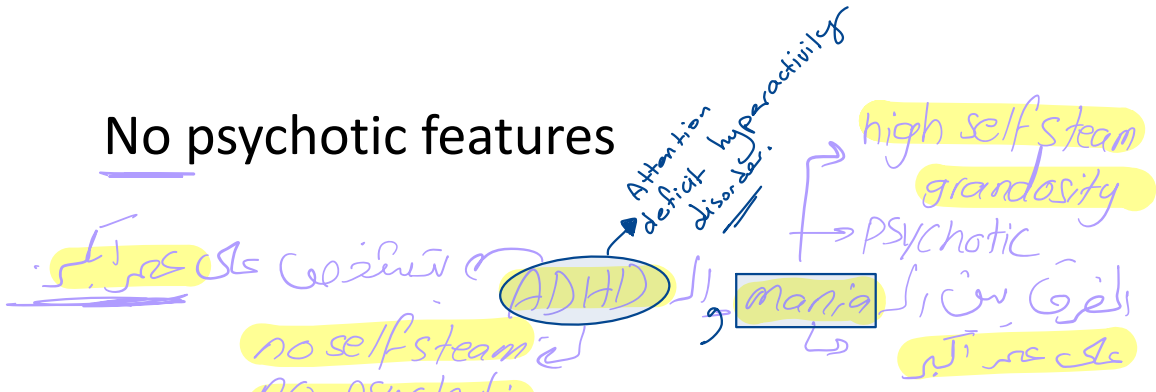
ANSWER

Hypomanic Episode

weaker than mania

- 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**
1 Lasts at least 7 days	Lasts at least 4 days
2 Causes severe impairment in social or occupational functioning	No marked impairment in social or occupational functioning
3 May necessitate hospitalization to prevent harm to self or others	Does not require hospitalization
4 May have psychotic feature	No psychotic features



MOOD DISORDERS

- Mood disorders often have chronic courses that are marked by relapses with relatively normal functioning between episodes. Like most psychiatric diagnoses, they may be triggered by a medical condition or drug (prescribed or illicit). Always investigate medical or substance-induced causes (see below) before making a diagnosis

- **Differential Diagnosis of Mood Disorders Secondary to General Medical Conditions**

Medical Causes of a Depressive Medical Episode

Cerebrovascular disease

Endocrinopathies (Cushing's syndrome, Addison's disease,hypoglycemia, hyper/ hypothyroidism,hyper/hypocalcemia)

hyperadrenalism

Parkinson's disease/Viral illnesses (e.g., mononucleosis)/Carcinoid syndrome/Cancer (especially lymphoma and pancreatic carcinoma) Collagen vascular disease (e.g.,systemic lupus erythematosus)

Medical Causes of a Manic Episode

Metabolic (hyperthyroidism)/Neurological disorders (temporal lobe seizures, multiple sclerosis)/Neoplasms/HIV

- **Mood Disorders Secondary to Medication or Substance Use**

Medication/Substance-Induced Depressive Episodes

EtOH/Antihypertensives/Barbiturates/Corticosteroids/Levodopa/Sedative/hypnotics/Anticonvulsants/Antipsychotics/Diuretics/Sulfonamides/Withdrawal from psychostimulants/(e.g., cocaine, amphetamines)

Medication/Substance-Induced Mania

Corticosteroids/Sympathomimetics/ Dopamin AgonisT/ Antidepressants /Bronchodilators/ Levodopa

MAJOR DEPRESSIVE DISORDER (MDD)

- MDD is marked by episodes of depressed mood associated with loss of interest in daily activities. Patients may be unaware of their depressed mood or may express vague, somatic complaints. (fatigue, headache abdominal pain, muscle tension)
- **DIAGNOSIS AND DSM-IV CRITERIA**

At least one major depressive episode

No history of manic or hypomanic episode

- ***Seasonal affective disorder*** *is a subtype of MDD in which major depressive* episodes occur only during winter months (fewer daylight hours). Patients respond to treatment with light therapy.

major depressive + mania → bipolar 1 (with drugs.)

major depressive + hypomania bipolar 2

MAJOR DEPRESSIVE DISORDER (MDD)

- **EPIDEMIOLOGY**

Lifetime prevalence: 15%
Onset at any age, but average age of onset is 40
Twice as prevalent in women than men
No ethnic or socioeconomic differences
Prevalence in elderly from 25 to 50%

significant in anxiety.

- **SLEEP PROBLEMS ASSOCIATED WITH MDD**

Multiple awakenings
Initial and terminal insomnia (hard to fall asleep and early morning awakenings)
Hypersomnia
Rapid eye movement (REM) sleep shifted to earlier in night and stages 3 and 4 decreased

MAJOR DEPRESSIVE DISORDER (MDD)

- **ETIOLOGY**

The exact cause of depression is unknown, but biological, genetic, environmental,and psychosocial factors each contribute.

1. *Abnormalities of Serotonin/Catecholamines*
2. High cortisol
3. Abnormal thyroid axis
4. *Psychosocial/Life Events* Loss of a parent before age 11 is associated with the later development of major depression.
5. *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.

- **COURSE AND PROGNOSIS**

If left untreated, depressive episodes are self-limiting but usually last from 6 to 13 months. 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.

MAJOR DEPRESSIVE DISORDER (MDD)

- **Hospitalization**

Indicated if patient is at risk for suicide,homicide, or is unable to care for self.

- **Pharmacotherapy**

1)Antidepressant Medications

Selective serotonin reuptake inhibitors (SSRIs)—safer and better tolerated than other classes of antidepressants; side effects mild but include headache, gastrointestinal disturbance, sexual dysfunction, and rebound anxiety.

Tricyclic antidepressants (TCAs)—most lethal in overdose; side effects include sedation, weight gain, orthostatic hypotension, and anticholinergic effects. Can aggravate prolonged QTC syndrome.

Monoamine oxidase inhibitors (MAOIs)—useful for treatment of refractory depression; risk of *hypertensive crisis when used with sympathomimetics* or ingestion of tyramine-rich foods (such as wine, beer, aged cheeses, liver, and smoked meats); risk of *serotonin syndrome when* used in combination with SSRIs. Most common side effect is orthostatic hypotension. (Tyramine is an intermediate in the conversion of tyrosine to norepinephrine.)

MAJOR DEPRESSIVE DISORDER (MDD)

2)Adjuvant Medications

Stimulants (such as methylphenidate) may be used in certain patients, such as the terminally ill or patients with refractory symptoms. Though action is rapid, potential for dependence limits use.

Antipsychotics—useful in patients with psychotic features

Liothyronine (T3), levothyroxine (T4), lithium, or L-tryptophan (serotoninprecursor) may be added to convert nonresponders to responders.

- **Psychotherapy**

Behavioral therapy, cognitive therapy, supportive psychotherapy, dynamicpsychotherapy, and family therapy

May be used in conjunction with pharmacotherapy

MAJOR DEPRESSIVE DISORDER (MDD)

- **Electroconvulsive therapy (ECT)**

Indicated if patient is unresponsive to pharmacotherapy, if patient cannot tolerate pharmacotherapy, or if rapid reduction of symptoms is desired (suicide risk, etc.)

- ECT is safe and may be used alone or in combination with pharmacotherapy.
- ECT is performed by premedication with atropine, followed by general anesthesia and administration of a muscle relaxant. A generalized seizure is then induced by passing a current of electricity across the brain (either unilateral or bilateral); the seizure lasts < 1 minute.
- 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.

MAJOR DEPRESSIVE DISORDER (MDD)

- **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. For example, you may diagnose "major depressive disorder with melancholic features."
- **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.

BIPOLAR I DISORDER

- **DIAGNOSIS AND DSM-IV CRITERIA**

The only requirement for this diagnosis is the occurrence of one manic or mixed episode (10 to 20% of patients experience only manic episodes). Between manic episodes, there may be interspersed euthymia, major depressive episodes, dysthymia, or hypomanic episodes, but none of these are required for diagnosis.

- **EPIDEMIOLOGY**

Lifetime prevalence: 1%

Women and men equally affected

No ethnic differences seen

Onset usually before age 30

- **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 approximately 75%, and rates for dizygotic twins are 5 to 25%.

- **COURSE AND PROGNOSIS**

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.

- **TREATMENT**

Pharmacotherapy

Lithium—mood stabilizer

Anticonvulsants (carbamazepine or valproic acid)—also mood stabilizers,

especially useful for rapid cycling bipolar disorder and mixed episodes

Olanzapine—a typical antipsychotic

Psychotherapy

Supportive psychotherapy, family therapy, group therapy (once the acute manic episode has been controlled)

ECT

Works well in treatment of manic episodes

Usually requires more treatments than for depression

BIPOLAR I I DISORDER

- **DIAGNOSIS AND DSM-IV CRITERIA**

History of one or more major depressive episodes and at least one **hypomanic** episode. *Remember: If there has been a full manic episode even in the past,* then the diagnosis is *not bipolar II disorder, but bipolar I.*

- **EPIDEMIOLOGY**

Lifetime prevalence: 0.5%

Slightly more common in women

Onset usually before age 30

No ethnic differences seen

- **ETIOLOGY**

Same as bipolar I disorder

- **COURSE AND PROGNOSIS**

Tends to be chronic, requiring long-term treatment

- **TREATMENT**

Same as bipolar I disorder

DYSTHYMIC DISORDER

< 5 SIG E CAPS

Patients with dysthymic disorder have chronic, mild depression most of the time with no discrete episodes. They rarely need hospitalization.

- **DIAGNOSIS AND DSM-IV CRITERIA**

1. Depressed mood for the majority of time of most days for at least 2 years (in children for at least 1 year)

2. At least two of the following:

1. Poor concentration or difficulty making decisions
2. Feelings of hopelessness
3. Poor appetite or overeating
4. Insomnia or hypersomnia
5. Low energy or fatigue
6. Low self-esteem

3. During the 2-year period:

The person has not been without the above symptoms for > 2 months at a time.

No major depressive episode

- The patient must never have had a manic or hypomanic episode (this would make the diagnosis bipolar disorder or cyclothymic disorder, respectively).

DYSTHYMIC DISORDER

- **EPIDEMIOLOGY**

Lifetime prevalence: 6%

Two to three times more common in women

Onset before age 25 in 50% of patients

- **COURSE AND PROGNOSIS**

Twenty percent of patients will develop major depression, 20% will develop bipolar disorder, and > 25% will have lifelong symptoms.

- **TREATMENT**

Cognitive therapy and insight-oriented psychotherapy are most effective.

Antidepressant medications are useful when used concurrently (SSRIs,TCAs, or MAOIs).

CYCLOTHYMIC DISORDER

criteria. يعني bipolar II الخفيف

- Alternating periods of hypomania and periods with mild to moderate depressive symptoms
- **DIAGNOSIS AND DSM-IV CRITERIA**

Numerous periods with hypomanic symptoms and periods with depressive symptoms for at least 2 years

The person must never have been symptom free for > 2 months during those 2 years.

No history of major depressive episode or manic episode

- **EPIDEMIOLOGY**

Lifetime prevalence: < 1%

May coexist with borderline personality disorder

Onset usually age 15 to 25

Occurs equally in males and females

CYCLOTHYMIC DISORDER

- **COURSE AND PROGNOSIS**

Chronic course; one third of patients eventually diagnosed with bipolar disorder

- **TREATMENT**

Antimanic agents as used to treat bipolar disorder

- **OTHER DISORDERS OF MOOD IN DSM-IV**

Minor depressive disorder—episodes of depressive symptoms that do not meet criteria for major depressive disorder; euthymic periods are also seen, unlike in dysthymic disorder.

Recurrent brief depressive disorder

Premenstrual dysphoric disorder

Mood disorder due to a general medical condition

Substance-induced mood disorder

Mood disorder not otherwise specified (NOS)