MOOD DISORDERS

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BACKGROUND

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), "mood disorders" is a term describing a group of diagnoses where a disturbance of a person's mood is the main feature. In ICD-10, this category is known as mood (affective) disorders.

There are basically two subdivisions of mood disorder, depending on the presence/absence of manic / hypomanic episodes. These are major depressive disorder (MDD)**,** commonly called *clinical depression* or *major depression*, and bipolar disorder (BD), formerly known as *manic depression* and characterized by intermittent episodes of mania or hypomania, usually interlaced with depressive episodes.

Depressive and manic disorders have certain common characteristics:
Periodicity: I.e. acute episodes, single or recurrent.
A return to normal after the acute phase: I.e. a return to the previous level of functioning. (This contrasts with schizophrenia, where the course of the illness is usually chronic and progressive).

CLASSIFICATIONS AND DEFINITIONS:

Mood: A persistent emotion that colours the individual's entire attitude. The mood may be normal, depressed, or elevated (euphoric).

Depressive episode: Persistent depressed mood (for at least two weeks), plus other symptoms such as impaired concentration, insomnia, weight loss.

Euphoria: An abnormally elevated mood.

Manic episode: A manic episode is not a disorder in and of itself but rather is a part of a type of bipolar disorder. Thus, anyone experiencing a manic episode will be diagnosed with a type of bipolar disorder. Symptoms of a manic episode include abnormally elevated, expansive or notably irritable mood, lasting for at

least one week, and causing significant difficulty or impairment in occupational, social, educational or other important functioning. Other symptoms of mania include decreased need for sleep, being more talkative than usual or pressure to keep talking, the subjective experience that thoughts are racing, easily distracted, and overactivity.

MAJOR DEPRESSIVE DISORDER / DEPRESSION

Major depression is one of the most important illnesses that we deal with, and is frequently referred to as "the illness of our time." The reason for this is because the condition is very common, and if not diagnosed and treated correctly, it results in severe emotional suffering for the patient and the family.

The essential characteristic of major depressive disorder (diagnosed as *single episode* or *recurrent*) is one or more major depressive episodes without a history of a manic or hypomanic episode.

a) Major depressive disorder (MDD): One or more major depressive episodes.

b) Dysthymic disorder: Depressive mood most of the time for at least two years, but not meeting criteria for a major depressive episode.

Diagnostic criteria for major depressive episode:

(a) Persistent depressed mood, most of the day, almost every day.

(b) Decreased interest and pleasure in all or almost all activities.

(c) Significant loss of appetite or loss of weight, or increased appetite and weight gain. Insomnia or hypersomnia, almost every day.

(d) Psychomotor agitation or retardation.

(e) Tiredness, listlessness.

(f) Feelings of worthlessness, self-reproach, guilt feelings.

(g) Concentration impairment.

(h) Recurrent thoughts of death, suicidal ideas or suicidal gestures.

Associated characteristics of major depression:

1) Functional shift: The most important associated symptoms of depression are known as the functional shift (also known as physiological symptoms or vegetative symptoms). The classical functional shift consists of the following five cardinal symptoms.

(a) Loss of appetite

(b) Loss of weight

(c) Diurnal mood swing (the patient usually feels worse in the morning, and the depressed mood improves slightly as the day progresses).

(d) Terminal insomnia, or early morning waking (this is a specific disorder of the sleep pattern and is associated with specific electro-physiological changes in the sleep architecture).

(e) Decreased libido

2) Another associated symptom of major depression comprises psychomotor changes. This can either be psychomotor retardation, or agitation (restless anxiety).

3) Lastly, in rare cases, psychotic symptoms may occur in a major depressive episode. These are mood congruent delusions or hallucinations (e.g., delusions of guilt, or voices telling the patient to commit suicide).

Dysthymic disorder:

The essential characteristic of dysthymic disorder is a chronic low-grade disorder of mood:

(a) In the form of depressed mood for most of the time for at least two years.

(b) Some of the following symptoms may be present in addition to the depressed mood.

- Loss of appetite or excessive appetite
- Insomnia or hypersomnia
- Tiredness and reduced energy
- Poor concentration
- Difficulty in making decisions
- Feelings of hopelessness and helplessness
- Decreased self-confidence

(c) Never symptom-free for longer than two months over a period of two years.

(d) No indication of a major depressive episode during the first two years.

(e) No previous manic or hypomanic episodes.

(f) Not superimposed on a chronic psychotic condition (e.g., schizophrenia, delusional disorder).

(g) No indication of a general medical condition or substance-induced disorder that could cause or perpetuate the disorder.

Masked depression:

Masked depression, together with the functional shift, are very important concepts that allow us to better identify patients with major depressive episodes. Not all patients with major depression present with classical symptoms of the disorder. There are frequently misleading, vague and atypical symptoms, and some patients may even deny feeling depressed.

The following masks of depression are of importance:

1) In children:

Major depression usually does not present with typical symptoms in children, particularly younger children. Changes in behaviour are usually the first symptoms. The child may become more anxious and uncertain, may display social withdrawal, and there may also be a deterioration in the level of performance at school.

2) In the elderly:

Major depression in the elderly may often be confused with dementia.

3) Somatization:

Patients with major depression may sometimes present with mainly physical complaints. There may be a hypochondriacal preoccupation with specific symptoms, or there may be various non-specific complaints. Patients with somatization of their depressive disorder are frequently seen in the primary care sector. Most of these patients are unfortunately not diagnosed correctly, with resultant incorrect treatment and sometimes disastrous consequences.

4) Agitation

If agitation is a prominent feature, it may easily be confused with symptoms of anxiety and lead to an incorrect diagnosis and treatment.

5) Chronic fatigue

So-called “Yuppie flu” has received widespread media attention. Various studies show that a substantial percentage of these patients meet criteria for a major depressive episode. In these cases, antidepressant medication is indicated.

Suicidal ideas:

Major depressive disorder is the most important cause of successful suicide.

Factors predisposing to depression:

Chronic medical illness

Alcohol- and substance abuse

Psychosocial stressors, e.g., bereavement, divorce or pregnancy.

Etiology (causality) of major depressive disorder:

1) Genetic:

There now is clear-cut evidence for a genetic contribution to major depressive episodes. A positive family history frequently exists in such patients.

2) Biochemical:

There now is overwhelming evidence that the neurotransmitters serotonin and noradrenaline are involved in major depression.

3) Endocrinological:

Various endocrinological changes have been documented during the major depressive episode. Patients with mood disorders often manifest symptoms suggestive of abnormalities in hypothalamic loci (controlling appetite, sexual function, circadian rhythms, and anterior pituitary function).

4) Psychosocial:

Major depressive episodes occur more frequently in people who have lost a parent before the age of 11 years. There is also a fairly strong association with recent losses, particularly the loss of a loved one.

TREATMENT OF MOOD DISORDERS

Treatment of a major depressive episode:

The majority of patients with major depressive episode are treated by general practitioners. Most cases of major depressive episode are treated as outpatients.

1) Hospitalisation:

Sometimes patients with major depressive episode are hospitalised (general or psychiatric hospital), for example in the following situations:

(a) when the depression is of a severe degree;

(b) where there is a high risk of suicide;

(c) when severe medication side-effects occur;

(d) in cases where electroconvulsive treatment is applied;

(e) when the patient's support systems are inadequate;

(f) further special investigations are required; or

(g) other associated psychiatric or physical disorders that require hospitalisation are present.

Hospitalisation is usually of short duration; it could be for a few days or for weeks. In the case of admission to a psychiatric hospital, this is usually as a voluntary patient. In rare situations, for example in the presence of a clear-cut psychotic depression, there may be impaired insight, and refusal of hospitalisation. In such cases, certification in terms of the Mental Health Care Act may be indicated.

2) Pharmacotherapy / medication:

Antidepressants are the cornerstone of treatment for major depressive episode. Studies show that 70 - 80% of patients with major depressive episode improve or recover when treated with antidepressants.

Contrary to previous belief, there is now good evidence to indicate that the treatments that are used for the major mood disorders are also effective in the minor mood disorders (such as dysthymia).

3) Psychotherapy:

Strictly speaking, the explanation, reassurance and encouragement that occurs within the doctor-patient relationship is not regarded as psychotherapy. However, a good doctor-patient relationship is of critical importance in treating patients with mood disorders.

Psychotherapy is often the first form of treatment recommended for depression. Called "therapy" for short, the word psychotherapy actually involves a variety of treatment techniques. During psychotherapy, a person with depression talks to a licensed and trained mental health care professional who helps him or her identify and work through the factors that may be causing their depression.

Psychotherapy helps people with depression (http://www.webmd.com/depression/psychotherapy-treat-depression):

1) Understand the behaviors, emotions, and ideas that contribute to his or her depression.

2) Understand and identify the life problems or events -- like a major illness, a death in the family, a loss of a job or a divorce -- that contribute to their depression and help them understand which aspects of those problems they may be able to solve or improve.

3) Regain a sense of control and pleasure in life.

4) Learn coping techniques and problem-solving skills.

Cognitive behavioral therapy (CBT) is a type of psychotherapy which includes a focus on how thinking affects the way a person feels and acts. The underlying theory of CBT is that you can change your way of thinking about a situation, and when you do, you also change the way you feel and behave. As a result, you can feel better, or at least remain calm, even when the situation stays the same.

While other approaches to therapy rely heavily on analyzing and exploring people's relationship with the world around them, the focus of CBT is on learning. The therapist functions as a teacher. He or she guides the client through the process of learning what his thoughts are, which are the “problematic” or irrational thoughts, and how to change these thought patterns and then how to act on that learning. Because there is a specific goal and a process for arriving at it, CBT is often more narrowly focused. It also is typically completed in less time than other therapies (http://www.webmd.com/depression/psychotherapy-treat-depression?page=2).

4) Electroconvulsive treatment (ECT):

Electroconvulsive therapy (also called ECT or shock therapy) is a procedure given by a psychiatrist and used to help treat certain mental illnesses like depression. During ECT, electric currents are passed through the brain in order to trigger a seizure (a short period of irregular brain activity), lasting about 40 seconds. ECT is given

during a hospital stay, or a person can get ECT on an outpatient basis. ECT is given up to 3 or 4 times a week and usually no more than 12 treatments are needed to relieve depression.

In the context of depression, ECT is usually used for patients with severe depression with insomnia (trouble sleeping), weight changes, feelings of hopelessness or guilt, and thoughts of suicide or homicide, that do not respond to antidepressants (medicines used to treat depression) or counseling, or for patients with severe depression who can't take antidepressants.

It is believed that the seizure in the brain caused by ECT works to release many chemicals in the brain. These chemicals, also called neurotransmitters, deliver messages from one brain cell to another. The release of these chemicals makes the brain cells work better. Thus a person's mood will improve when his or her brain cells and chemical messengers work better (http://familydoctor.org/online/famdocen/home/common/mentalhealth/treatment/058.html#ArticleParsysMiddleColumn75750). However, ECT may cause a switch from a depressive phase into a manic episode in a patient with a bipolar disorder.

BIPOLAR DISORDERS:

The essential characteristic is one or more manic (or hypomanic) episodes.

A manic episode is characterised by the following symptoms:

A. A period of clearly abnormal and persistently elevated, expansive or irritable mood.

B. During the period of disordered mood the following symptoms may appear:

- Heightened importance of one's self, or grandiosity.
- Decreased need for sleep, e.g., feeling wide-awake after 3 hours of sleep.
- More talkative than usual, or an urge to keep on talking.
- Flight of ideas, or the subjective experience of accelerated thoughts.
- Distractibility.
- Increased involvement in goal directed activities e.g., on social, professional or sexual levels, or psychomotor agitation (anxious restlessness).
- Excessive involvement in pleasurable activities with a high potential for painful consequences e.g., excessive buying, sexual indiscretions, poor business decisions.

C. The mood disorder is severe enough to cause a significant impairment in social and occupational functioning, or to warrant hospitalisation to protect the patient or the community.

D. Symptoms are not due to substances or a general medical condition. A hypomanic episode does not include criterion C. Hypomania is a milder degree of mania.

Accompanying characteristics:

- Impaired insight and refusal of treatment.
- Labile mood, with sudden mood changes from euphoria to irritability, anger, depression. These mood changes may last minutes to hours, exceptionally for days.
- When delusional ideas and hallucinations are present, they are usually mood congruent, in other words, grandiose.

Precipitating factors:

- Psychosocial stressors (divorce, bereavement, etc.)
- The post-partum period
- Antidepressant medication

There are basically 4 types of bipolar disorder:

1) Bipolar I disorder conforms to the classic concept of manic-depressive disorder. Bipolar I disorder is characterized by one of one or more manic episodes or mixed episodes (i.e. one or more manic episodes with or without one or more major depressive episodes).

2) Bipolar II disorder is characterized by one or more hypomanic episodes together with one or more major depressive episodes. This is arguably an under-diagnosed disorder since hypomania is often experienced as high-functioning behavior. Patients usually only present for evaluation and treatment when they develop depression.

3) Cyclothymic disorder or cyclothymia is characterized by a chronic mood disorder of at least two years duration (one year for children and adolescents) with frequent episodes of hypomania and frequent episodes of depressed mood (or a loss of interest and pleasure) that do not meet criteria for either a manic episode or a

major depressive episode. The diagnosis of cyclothymic disorder is not made when there is a history of mania or major depressive episode or mixed episode. Unlike most other forms of bipolar disorder, people with a diagnosis of cyclothymia are almost always fully functioning.

4) Bipolar disorder (Not otherwise specified) does not meet the criteria for any of the abovementioned disorders.

Aetiological factors (causality)

Bipolar disorder occurs more frequently in first degree relatives of people with bipolar disorder than in the general public. Approximately 50% of patients with bipolar disorder have at least one parent with a mood disorder.

TREATMENT OF BIPOLAR DISORDERS:

There are a number of psychotherapeutic and pharmacological techniques used to treat bipolar disorder.

Psychotherapy is aimed at alleviating core symptoms, recognizing triggers of manic episodes, reducing negative expressed emotion in relationships, recognizing prodromal symptoms (that could indicate that an episode is imminent) before full-blown recurrence, and, practicing the factors that lead to maintenance of remission (Lam et al., 1999; Johnson & Leahy, 2004; Basco & Rush, 2005; Miklowitz & Goldstein, 1997; Frank, 2005).

Pharmacotherapy:

Mood stabilising agents are the basis of treatment for bipolar illness. At the basis of medication treatment for bipolar mood disorder is a mood stabilizer such as lithium carbonate or lamotrigine. The "gold standard" mood stabilizers are firstly lithium, and secondly, sodium valproate. (Sodium valproate is also used as an anticonvulsant.) Other anticonvulsants used in bipolar disorder include carbamazepine, reportedly more effective in *rapid cycling* bipolar disorder (when a person “cycles” through mood episodes of a different nature – i.e. manic, hypomanic, depressive episodes – rapidly and usually within a relatively short time span), and lamotrigine, which is the first anticonvulsant shown to be beneficial in bipolar disorder.

Agitation often presents during the acute manic episodes and requires treatment. Such treatment usually requires use of antipsychotics such as chlorpromazine, quetiapine and olanzapine. More recently, quetiapine

and olanzapine (known as atypical antipsychotics) have been approved as effective monotherapy for the maintenance of bipolar disorder.

Importantly, the use of antidepressants in bipolar disorder has been debated over the years, with some studies reporting a worse outcome with their use triggering manic, hypomanic or mixed episodes, especially in cases where a mood stabilizer is not used. Also, rapid cycling can be induced or made worse by antidepressants, unless there is adjunctive treatment with a mood stabilizer. Most mood stabilizers are of limited effectiveness in depressive episodes.

There are studies that show that Omega 3 fatty acids may have beneficial effects in patients with bipolar disorder.

Topiramate is another anticonvulsant that is often prescribed as a mood stabilizer. It is an off-label use when used to treat bipolar disorder (meaning that it has not been officially approved for use in this condition). Unfortunately, its side effects - such as significant cognitive impairment - undermine its efficacy (Kushner, et al. 2006; Chengappa, et al. 2006).

Importantly, when medication is effective, i.e. causes a reduction in symptoms or a complete cessation of symptoms (remission), it is important for someone with a bipolar disorder to understand they should continue to take the medicine as prescribed. This can be complicated, as effective treatment may result in the reduction of manic or hypomanic symptoms and/or the medicine can cause their mood to be come blunted, or the medication may be sedative, resulting in the person feeling they are *stifled* or that the medicine isn't working. Either way, relapse of symptoms is likely to occur if the medicine is discontinued in an uncontrolled manner (http://en.wikipedia.org/wiki/Manic_depression#Management).

Hospitalisation:

The manic patient usually requires hospitalisation, except when the condition is of a very mild degree. Hospitalisation in a psychiatric unit in a general hospital is possible if the patient is willing to undergo treatment. Admission to a psychiatric hospital is however usually necessary, and frequently as a certified patient (in accordance with the Mental Health Care Act).

After discharge the patient is followed up as an outpatient for ongoing evaluation and adjustment of medication. It is important to understand that bipolar illness is a lifelong condition and that treatment, particularly with mood stabilisers, is long-term.