

Affective disorders (Mood disorders)

Mood: It is an internal emotional state of an individual.

Affect: It is the external expression of emotional content.

Mood disorders

Mood disorders are classified into :

- 1- Major depression.
- 2- Bipolar affective disorder (Mania+ Depression or Mania alone)
- 3- Hypomania.
- 4- Dysthymia (Neurotic depression)
- 5- Cyclothymia.

Incidence:

Life time expectancy of developing unipolar depression is 20% in women and 10% in men. Time expectancy of developing bipolar disorder is about 1% in both sexes.

Sex:

In unipolar depression women: men is 2:1.

Age:

The age of developing unipolar disorder is 20-50 y, but the mean age is 40y.

The age of developing bipolar disorder is started from childhood to 50 y..

Marital status:

Unipolar depression is more in divorced ,and separated persons

Bipolar disorder is more common in divorced and single individual.

Social and cultural consideration

No correlation between social class and unipolar depression.

In bipolar disorder there is higher incidence among the upper socioeconomic classes.

Etiology

Theories of affective disorders are:

1) Biological theory:

Biogenic amine theory

Dopaminergic activity may be reduced in depression and increased in mania. There is evidence of dysregulation of acetylcholine in mood disorders.

2) Other neurochemical considerations

GABA, Vasopressin, endogenous opiates have been in the pathophysiology of some mood disorders .

3) Neuroendocrine regulation

Many researches found that there are abnormalities in limbic -hypothalamic

pituitary -adrenal (LHPA) axis are the most consistently reported neuroendocrine dysregulation.

Other researchers found hypersecretion of cortisone in some depressed patients.

DST is abnormal in 50% of depressed patients

.

Diminished release of TSH upon administration of (TRH), decrease GH on noradrenergic stimulation with Clonidine, decreased nocturnal secretion of melatonin to tryptophan administration.

4) Other biological data

Depression is a disorder of chronobiological regulation .

CT picture shows enlarged cerebral ventricles in some patients with Mania, and psychotic depression .

Positron Emission Tomography scans shows reduced brain metabolism ,reduced blood flow in depression to basal ganglia.

Genetic

- Research found that 50% of bipolar patients at least one parent with a mood disorder (Depression). One parent have bipolar disorder 27% chance that any child will have mood disorder.

Both parents have bipolar disorder there is 50-70 % chance that the child will have a mood disorder.

-Twin studies has shown a concordance rate of 0.67 for bipolar disorder in Monozygotic twins and 0.20 for bipolar disorder in dizygotic twins. A dominant gene located on the short arm of chromosome 11 has been found in bipolar disorder in one amish family.

2) Psychosocial factors

1- Life events and environmental stress.

Some clinician believe that life events play the primary role in depression.

- Loss of parent before age 11 and the loss of spouse at onset of illness are correlated with major depression.

2- Premorbid personality theory : Centrax personality type -oral-dependent , obsessive-compulsive, hysterical may at great risk for depression.

3- Psychoanalytic theory: Loss of libidinal object -ego retreats from it's mature functioning state to one in which the infantile trauma of the oral sadistic stage of libidinal development dominates because of a fixation process in earliest childhood.

4- Cognitive theory: Misinterpretation involve negative distortion of life experience, negative self evaluation, pessimism, and hopelessness.

9- a. Depressive episode:

Diagnostic criteria for major depressive episode

A. At least five symptoms present in the last two weeks period, at least one of the symptoms either:

1- Depressed mood. or 2- Loss of interest or pleasure.

1. Depressed mood .

2. Markedly diminished interest or pleasure in all , nearly every day.

3. Significant weight loss or gain more than 5% of body weight in a month, or decrease or increase in appetite.

4. Insomnia or hypersomnia.

5. Psychomotor agitation or retardation.

6. Fatigue or loss of energy.

7. Feelings of worthlessness or excessive inappropriate guilt(May be delusional) .

8. Diminished ability to think or concentrate or indecisiveness.

9. Recurrent thoughts of death.

recurrent suicidal ideation, suicide attempt or a specific plan for committing suicide.

B.

1. Exclusion of organic factor.

2. The disturbance is a normal reaction to the death of a loved one.

C. Absence of delusion or hallucinations for as long as 2 weeks in the absence of prominent mood symptoms.

D. Not superimposed on schizophrenia, schizophreniform disorder, delusional disorder or psychotic disorder (NOS)

Types of major depressive episode

1. Mild: Few symptoms, only result in only minor impairment in occupational functioning or usual social activities or relationships with others.

2. Moderate: The symptoms or functional impairment are between mild and severe.

3. Severe without psychotic features: Several symptoms in excess. Those symptoms markedly interfere with occupational functioning or with usual social activities or relationship with others.

4. With psychotic features: Delusions or hallucinations if possible specify

whether the psychotic features are mood congruent or mood-incongruent.

A. Mood congruent psychotic features:

Delusions or hallucinations whose content is entirely consistent with typical depressive themes of personal inadequacy, guilt, disease, death, nihilistic, or deserved punishment.

B. Mood incongruent psychotic features:

Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment, included here are such symptoms as persecutor delusion (Not directly related to depressive themes) **thought insertion, thought broadcasting and delusions of control.**

Depression in children and adolescents

Excessive clinging to parents and school phobia may be symptoms of depression in children, poor academic performance, drug abuse, antisocial behavior, sexual promiscuity, running away may be symptoms of depression in adolescent and children.

Differential diagnosis

1) Major depressive disorder

A. Medical:

Parkinsonism, dementia, epilepsy, strokes, tumors.

Cardiac drugs, Antihypertensives, sedatives, hypnotic.

B. Psychiatric:

Anxiety disorders with depression and depressive disorders with marked anxiety, abnormal DST, presence of REM tendency or a sleep EEG, negative lactate infusion

Course and prognosis of major depressive disorder

1- Course:

- 1- Usually have no premorbid personality problem.
- 2- 50% of first episode of depression before age of 40 years.
- 3- Untreated episode of depression last 6-12 months ,but treated one last 3 months.
- 4- Over 20 years period the mean number of episode is 5-6.
- 5- 5-6% with diagnosis of unipolar depression have a manic episode 6-10 years after the first depression episode The mean age for this switch is 32 years, occur after 2-4 depressive episodes.

2- Prognosis:

It is a cyclic disorder with periods of illness separated by periods of mental health, 50-85% have a second episode very often in the next 4-6 months. The risk of recurrence is increased by coexisting Dysthymia, alcohol, drug abuse, anxiety symptoms, older age, history of more than one previous episode.

50% are mentally healthy at long term follow up.

20% have moderate impairment.

20 have significant impairment.

Management of Depression disorders

(1) Hospitalization:

This can applied to the following cases:

1. Risk of suicide or homicide.
2. Grossly reduced ability to care for food, shelter or clothing.
3. Rapidly progressing symptoms and rupture of the usual support systems are also.

(2) Somatic therapy

Depressive episode

Using antidepressants, the choice should be based on side effects, especially the presence or absence of sedating qualities.

The complete trial must be 4-6 weeks if symptoms still present. We add triiodothyronine (T3) and lithium for 2-3 weeks, if no response another HCA from another class should be used if two heterocyclic antidepressants fail a trial with MAOI or ECT,

combination of tricyclic with MAOI can be tried.

Lithium as first time in treating depressive in bipolar patient.

Patient with psychotic manifestation shall be given also antipsychotic.

Seasonal affective disorder treated by sleep deprivation or phototherapy.

(3) Psychosocial therapies:

Psychotherapy with antidepressants is more effective, psychoanalytic therapy and family therapy.

(4) Interpersonal therapy:

It is a short term psychotherapy for 12-16 weeks sessions (Discrete behaviors such as lack of assertiveness, social skills, or distorted thinking may be addressed.

(5) Cognitive therapy:

Alleviate depression and prevent recurrence by helping the patient to identify and test negative cognition, to develop alternative, more flexible and positive ways of thinking.

(6) Behavior therapy:

Reinforcement, changing behavior.

(7) Family therapy:

9-b. Manic Episode

Diagnostic criteria for manic episode

Manic syndrome (Criteria A, B, C)

Hypomanic syndrome (Criteria A, B, not C).

A. A distinct period of abnormally and persistently elevated expansive or irritable mood.

B. During the period of mood disturbance at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree.

1. Inflated self-esteem or grandiosity .

2. Decreased need for sleep e.g. rested after only three hours of sleep.

3. More talkative than usual or pressure to keep talking.

4. Flight of ideas.

5. Distractibility.

6. Increase in goal directed activity or psychomotor agitation.

7. Excessive involvement in pleasurable activities , have a high potential for painful consequences.

C. Mood disturbance sufficiently severe to cause marked impairment in

occupational or in usual social activities or relationships with others , or to necessitate hospitalization to prevent hurt to self or others.

D. At no time during the disturbance have there been hallucinations, or delusions for as long as two weeks in the absence of prominent mood symptoms .

E. Not superimposed on schizophrenia, schizophreniform disorder, delusional disorder or psychotic disorder(NOS).

F. No organic factor initiated and maintained the disturbance .

Classification of Bipolar disorder

Bipolar disorder

1. Bipolar manic: Currently manic.

2. Bipolar depressed:

a. Has had one or more manic episode.

b. Currently major depressive episode.

3. Bipolar mixed:

Current episode involves the full symptomatic picture of both manic, and major depressive episodes intermixed or rapidly alternating every few days.

Diagnosis of manic episode

Mild, moderate, severe mood congruent, and mood incongruent.

Mania In Adolescents

It may be misdiagnosed as sociopathy or schizophrenia, symptoms of mania in adolescents may include psychosis, alcohol or drug abuse, suicide attempts ,academic problem, multiple somatic complaints ,marked irritability resulting in fights and other antisocial behavior.

Differential diagnosis of Manic episode

2) Manic episode

A. Medical:

Drugs, neurological causes.

Course and prognosis of Bipolar mood disorder(Mania)

1- Course:

No premorbid personality traits is present.

Bipolar disorder most often starts with depression (75% of the time in females, 67% in males).

Bipolar disorder is a recurring illness.

10-20% experience only manic episode.

The manic episodes typically have a very rapid onset.

May be associated with precipitating events .

Untreated episode lasts for 3 months .

After 5 episodes the inter episode interval stabilizes to about 6-9 months.

2- Prognosis:

(Mania)Bipolar disorder has a worse prognosis than major depressive disorder.

7% of patients do not have a recurrence of symptoms.

45% have more than one episode.

40% Develops chronic episode.

Patients may have 9 episodes

15% of patients are well.

45% well but had multiple relapses

30% In partial remission.

10% chronically ill.

Management of Mania

Lithium, antipsychotic or lorazepam ,the lithium level should be 0.8-1.2 Meq/L , if failed after 4 weeks we add L-Tryptophan for two weeks, if fails carbamazepine is tried, if not affective in 4 weeks, lithium should be added.

ECT is effective.

Clinical trials with Valporic acid ,Verapamil , Clonidine, and Clonazepam can be tried.

The period of treatment is 4 months, the maintenance dose is 0.4-0.8mEq/L.

Rapid cycling 3-4 episode /year:

Levothyroxine sodium, T4, Carbamazepine, Lithium, Clogyline (Selective MAOI) can be given