Mood Disorders

Introduction

The term mood disorder refers to a range of conditions in which a disturbance of mood is the central feature. Most of us experience low moods as the natural consequences of loss or disappointment and a common response to success or achievement is an elevated mood. In a mood disorder the mood may be abnormally lowered as in depression or abnormally elevated as in mania. In psychiatry we need to distinguish between these natural "lows" and "highs" and pathological mood states. This can create confusion in both terminology and diagnosis.

Terminology

A number of terms are used interchangeably in describing mood disorders. This handout shall conform to ICD-10 usage, but in this section some alternative terminology is discussed so that if you come across these terms on your clinical attachment you will not be confused. It is important to note that some of these terms should not be used (particularly in exams!), when this is the case they will be highlighted.

Affect - Subjective experience of emotional state.
Mood - Pervasive and sustained emotion.
Affective disorder (syn. Mood disorder) - disorder in which the central feature is mood disturbance.
Depression - refers both to the *symptom* of low mood and an *episode* of a mood disorder.
Mania - an episode of a mood disorder characterised by elevated mood.
Hypomania - milder episode of mood disorder than mania, without hallucinations or delusions.
Bipolar affective disorder - recurrent mood disorder consisting of manic/hypomanic episodes with or without depressive episodes
Unipolar affective disorder - recurrent mood disorder consisting *solely* of episodes of depression.
Major depressive episode (DSM-IV) - a depressive episode with 5 or more biological features of depression.
Minor depressive episode (*(DO NOT USE THIS TERM*)- a depressive episode with less severe mood disturbance than in a major depressive episode and fewer, and less severe, features of depression. It is usually without suicidal ideation.
Endogenous depression *(DO NOT USE THIS TERM!)* - a depressive syndrome characterised by prominent biological symptoms with a strong genetic loading.
Reactive depression *(DO NOT USE THIS TERM!)* - a milder depressive syndrome with a presumed "psychological" origin.

Definitions

The word "depression" provides an example of terminological difficulty. Among lay users the word is generally used to refer to a normal state of dejection. In a clinical setting it is used both to describe a symptom (as in "her mood appeared consistently depressed") and to label a syndrome (as in "severe depressive disorder"). Depression is common, as an isolated symptom and is one of the most common complaints presented to doctors and as a result its management forms a large part of medical, as well as psychiatric, practice particularly as depressive symptoms or syndromes often accompany physical ailments.

There is little difficulty in distinguishing severe cases of mania or major depression from normal mood states. However, when a mood disorder is milder it can be difficult to distinguish from a "normal" emotional response to circumstances. In distinguishing a normal from a pathological mood state a clinician will make the following judgements:

> Whether the severity and duration exceed normal expectations.
> Whether the individuals ability to care for himself/herself has been impaired.
> Whether there are physical, psychomotor or cognitive changes that accompany the depressed or elevated mood.

Episodes of mood disorders may be of low mood (depressive episode), high mood (hypomanic or manic episode) or occasionally a mixture of high and low features (mixed affective state). In both ICD-10 and DSM-IV recurrent episodes of hypomania/mania with or without depression are termed bipolar disorder.

Diagnosis

There are no laboratory tests to assist in the diagnostic process, so instead we look for clusters of clinical symptoms that we associate together as a syndrome. The various affective syndromes are made up of symptoms involving mood, thought, perception, biological functioning and behaviour and are classified using systems of classification such as DSM-IV (Diagnostic and Statistical Manual IV) and ICD-10 (International Classification of Disease 10). Both provide specific diagnostic criteria for each disorder and these handout are based on the latter as it is the one used most widely by doctors in the UK.

For clinical purposes we suggest a systematic description of the disorder based on ICD-10:

1 The Episode
   a. Type
   b. Special Features
   c. Severity
2 The Course
3 Preceding Stressors
4 Other Diagnostic Categories

The Episode

Type:

	Manic Episode	**Depressive Episode**
Mood	elation irritability	mood low most of the time anhedonia anxiety (common)
Speech & Thought	over talkative pressure of speech flight of ideas full of plans(usually unfulfilled) grandiose ideas may develop delusions (mood congruent)	slow speech poverty of thought pessimistic, hopeless suicidal ideas and/or intent may develop delusions (mood congruent)
Biological functions	diminished sleep reduced or increased appetite increased libido	disturbed sleep (often early morning wakening) anergia decreased appetite/weight loss reduced libido
Perception	may develop hallucinations if severe	may develop hallucinations if severe
Behaviour	overactive unrealistic plans impulsive overspending aggressive disinhibited (inc. sexually)	avoids social interaction self neglect may show psychomotor retardation or agitation actions in preparation for suicide
Minimum duration	1 week	2 weeks

Special Features:

Psychotic symptoms - Hallucinations and delusions can occur in severe depression and mania. Delusions are usually mood congruent e.g. delusions of grandeur in mania. Delusions of poverty or guilt in depression. Hallucinations are usually auditory and in the second person.

"Neurotic" Symptoms - Most commonly anxiety symptoms but prominent obsessive compulsive or hypochondriacal symptoms may occur, particularly in the elderly.

Melancholia -This refers to a severe depression where biological symptoms are prominent i.e. weight loss or marked anorexia, early morning wakening, diurnal variation (with mood worse in the morning), psychomotor retardation or agitation.

Severity:

The severity of a depressive episode depends upon the number of individual key symptoms, which are present, the intensity of these symptoms and the effect upon the person's level of functioning.

	Symptoms	Duration
Mild	At least 2 typical symptoms (depressed mood, anhedonia, fatiguability) and at least 2 other symptoms (biological symptoms and/or suicidal ideation). No symptoms are present to an intense degree.	At least 2 weeks
Moderate	At least 2 typical symptoms (see above) plus at least 3 (and preferably 4) other symptoms. Several symptoms are liable to be present to a marked degree but this is not essential if a particularly wide range of symptoms are present.	At least 2 weeks
Severe	All 3 typical symptoms plus at least 4 other symptoms, some of which should be of severe intensity, should be present. Note that marked agitation or retardation may make the patient unable to describe their symptoms fully. Mood congruent delusions and/or hallucinations may be present.	Usually 2 weeks but if particularly severe may be made sooner.

The Course

There are four common patterns :

Single episode

Recurrent depressive disorder

(a.k.a. unipolar affective disorder) - There should have been at least 2 episodes reaching the criteria for mild, moderate or severe depression, lasting at least 2 weeks and they should have been separated by several months without significant mood disturbance.

Bipolar affective disorder

(a.k.a. manic depression) - There should have been at least 2 episodes reaching the criteria for a mood disorder, one of which must have been mania/hypomania, lasting at least 2 weeks and they should have been separated by several months without significant mood disturbance.

Chronic depression

Meets the criteria for mild, moderate or severe depression, lasting at least 2 years.

Mixed affective episode

Lasts for at least 2 weeks and is characterised by either a mixture or a rapid alteration (usually within a few hours) of hypomanic/manic, and depressive symptoms.

Preceding Stressors

Stressful life events or experiences of varying severity frequently precede affective disorders.

Other diagnostic categories:

Dysthymia is a form of mild depression which has a chronic course and does not meet the criteria for a recurrent depressive disorder (DSM-IV requires that the symptoms should be present for at least two years).

Cyclothymia is a milder form of bipolar disorder with persistent instability of mood, involving numerous periods of mild depression and elation.
It may be a personality variant.

Schizoaffective disorder – This diagnosis should be limited to cases where diagnostic criteria for both schizophrenia and a mood disorder occur during the same episode. Otherwise the diagnosis is of the predominant syndrome.

Epidemiology

The epidemiology of recurrent depressive and bipolar affective disorders are summarised in the table below.

	Recurrent Depressive Disorder	**Bipolar Affective Disorder**
Sex ratio (M:F)	1:2	equal
Social class	greater in lower socio-economic class	no social class differences
Prevalence	male = 2-3%; female = 2-9%	less than 0.3%
Lifetime risk	male = 10%; female = 20%	1%
Age	onset - 50% before the age of 40 years peak age - 25-40 (50-70 when psychotic features)	both onset and peak age is in the late 20's to early 30's
Other factors	urban population > rural	more episodes than for recurrent depression but they tend to be shorter in the majority first episode is depressive 10-20% experience only manic episodes

It is probably worth while at this point to consider the epidemiology of suicide.

There are between 4000-8000 deaths in the England and Wales per year (as compared to around 5000 road deaths).

There are in excess of (probably greatly) 150 000 attempted suicides per year.

15% of those with depression die by suicide.

Aetiology

The aetiology of mood disorders is not fully understood but is clearly multi-factorial. It is probable that biological and genetic factors play an important role particularly in the aetiology of bipolar affective disorders and melancholic depression. The biological systems that are likely to be involved include monoamine systems, particularly 5-HT (5-hydroxytryptamine), and the hypothalamic-pituitary-adrenal axis.

Personality and psychosocial factors are probably more significant in dysthymic disorders.

Theoretical models often suggest an interaction between vulnerability, which is usually biological/genetic and precipitating factors, which may be a life event or biological (e.g. secondary to a viral illness, medication, hypothyroidism). The impact of the resulting stress will depend on social supports and the psychological capacity to cope.

Aetiological factors are summarised below under the headings:

- Biological
  Genetic; Endocrine; Neurotransmitters
- Psychological
  Psychodynamic; Cognitive; Behavioural
- Social
  Predisposing; Precipitating

Biological.

Genetic:

In bipolar disorder twin studies show monozygotic concordance rates of ~70%; dizygotic rates of ~20%; monozygotic reared apart rates of ~66%.

Family studies in recurrent depressive disorder show an overall risk of ~7% for first degree relatives as compared to ~20% for first degree relatives of bipolars.

Endocrine:

Hypothalamic-pituitary adrenal axis - Many depressives have elevated plasma, CSF and urine cortisol. The diurnal variation of cortisol may be varied.

Thyroid function - The TSH response to TRH is impaired in some patients and in some with treatment resistant depression the addition of thyroxine may be beneficial. Hypo- and hyperthyroidism are recognised to cause alteration in mood.

Neurotransmitters:

In those individuals who develop an affective disorder a dysregulation of neurotransmitter systems is initiated with serotonin (5-HT) and noradrenaline the neurotransmitters most commonly implicated.

The disorders are not simply due to low levels of transmitters, but may be connected with alterations in the functioning of specific receptors.

Psychological.

Psychodynamic:

This emphasises the importance of loss, as in bereavement or separation, and also self-esteem and self-image. Psychoanalytic theory also views depression as a turning inward of aggression and hostility.

Cognitive:

This stresses the importance of cognitive distortions and errors that occur in depression. The cognitive theory of depression suggests that these are not just s result of the lowered mood but are instrumental in the origin and persistence of the disorder.

Behavioural:

Based on animal models where it has been noted that chronic stress can result in loss of ability to act and avoid the stress. These animals show behavioural and neurotransmitter system changes similar to that seen in depressed humans.

Social.

Predisposing:

Brown and Harris identified a number of factors that predisposed an individual to depression:

lack of a confiding relationship;
unemployment;
3 or more children under the age of 14 years at home;
loss of mother before the age of 11 years

Precipitating:

In the 6 months after a life event (*exit events* - bereavement or separation; *undesirable events* - assault, redundancy etc.) the chance of an episode of depression is increased 5 to 6 times.

Prognosis

Regardless of treatment most patients (90%) suffering from mood disorders recover. They are, however, likely to relapse and in both recurrent depressive disorder and bipolar disorder a percentage will develop chronic symptoms (around 10-15%).

	Recurrent Depressive Disorder	**Bipolar Disorder**
Duration	without treatment ~6 to 13 months with treatment ~3 to 6 months	~3 months
Repeated episodes	over a 20 year period the mean number of relapses is around 5 or 6	in a lifetime a patient can have between 2 and 30 episodes, with a mean of 9
Other variables	15% will die by suicide	manic episodes may be followed by a depressive phase with a 25% risk of an episode of depression following on immediately afterwards

Management

In common with the management of all psychiatric disorders management is divided into managing the acute and chronic phases, and also consists of using management strategies which may include physical, psychological and social. This section will first consider treatment strategies for manic and depressive episodes, then will look at specific issues in the use of antidepressants and electroconvulsive therapy (E.C.T.). Pharmacotherapy and psychotherapies are covered more generally in their specific sections.

Manic episode.

	Short term	**Long term**
Physical	neuroleptic medication consider lithium	consider lithium, carbamazepine or sodium valproate as prophylaxis
Psychological	support for patient and family	support may need to continue specific psychotherapies not currently proven
Social	admission to hospital should be considered to minimise risk to patient and others	a minority need rehabilitation and supervised care most need advice regarding return to normal life and spotting future relapses

Depressive episode

	Short term	Long term
Physical	antidepressant medication E.C.T. neuroleptics in cases where there are psychotic features	if treatment resistance consider; second or an alternative antidepressant, lithium, anti-epileptic medication continue antidepressants for at least 6 months after recovery to decrease risk of relapse
Psychological	support specific psychotherapies; e.g. cognitive-behavioural (C.B.T.), bereavement counselling	more emphasis on specific psychotherapies such as C.B.T., dynamic, family therapy etc.
Social	support for carers admission if risk to patient or others specific social interventions	specific social interventions e.g. housing, finance in some cases social and/or occupational rehabilitation

Antidepressants.

Tricyclic antidepressants (TCAs) are the longest established pharmacological treatment for depressive disorders, but are associated with a higher rate of adverse effects (including toxicity in overdose) compared with the newer serotonin selective reuptake inhibitors (SSRIs).

Patients may not persevere with treatment if they are not warned to expect unwanted effects and a delay before improvement. Anticholinergic side effects can be minimised by starting at a low dose e.g. amitriptyline 25 mg, increasing to a "treatment" dose of 150 mg.

75 mg of TCAs are often used in general practice. This is sometimes reported as being effective, perhaps because a milder form of depression is often seen in the community. However, most studies have strongly suggested that generally, and particularly in hospital practice, a dose of 75 mg is sub-therapeutic and 150 mg or greater is usually required.

There is dispute about whether TCAs or SSRIs should be the first line treatment for depression. SSRIs should probably be first choice in the elderly, those with cardiac problems or epilepsy, those with high suicidal intent, and those who have been over sedated or put on weight when on TCA's.

Monoamine oxidase inhibitors (MAOIs) are very much second line treatments, though the new reversible MAOI, moclobamide, does not need the same dietary restrictions, and therefore may gain favour. Newer antidepressants such as venlafaxine, a serotonin and noradrenaline reuptake inhibitor (SNRI), and reboxetine, a noradrenaline reuptake inhibitor (NARI), are now being used in clinical practice.

Electroconvulsive therapy (E.C.T.).

Despite its adverse image modern E.C.T. is a relatively safe procedure, particularly when compared to TCA use. The main side effects are headache, myalgia (probably related to the muscle relaxant used in the anaesthetic) and mild memory problems (retrograde and anterograde) that settle over the 6 weeks after treatment finishes.

E.C.T. is particularly useful in severe depression i.e. where there are marked melancholic or psychotic features. It is also strongly indicated where a delay in the treatment is unacceptable such as in cases where there is a serious risk of suicide or the patient is not eating or drinking.

E.C.T. use may also be indicated in resistant mania and in the elderly (due to its comparative safety and rapid onset of action).