

Mood Disorders

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Overview

- What is a mood disorder?
- Criteria for specific mood episodes and disorders
- Differential diagnosis
- Case examples
- Questions

What is a mood disorder?

- Mood is a person's subjective emotional state
- Affect is the objective appearance of mood
- Mood disorders (according to DSM-IV) involve a depression or elevation of mood as the primary disturbance
- Can have other abnormalities (psychosis, anxiety, etc.)
- Disclaimer: all criteria and statistics taken from the DSM-IV-TR

Major Depressive Episode

- | | |
|---|--|
| ■ Depressed mood | ■ Fatigue or low energy |
| ■ Anhedonia | ■ Feelings of worthlessness or inappropriate guilt |
| ■ Decrease or increase in appetite OR significant weight loss or gain | ■ Decreased concentration or indecisiveness |
| ■ Persistently increased or decreased sleep | ■ Recurrent thoughts of death, suicidal ideation, or suicide attempt |
| ■ Psychomotor agitation or retardation | |

Five or more symptoms present for \geq 2 weeks

Major Depressive Disorder

- Presence of a major depressive episode
- Episode not better explained by another diagnosis
- NO HISTORY of mania, hypomania, or mixed episode (unless substance or medical illness related)

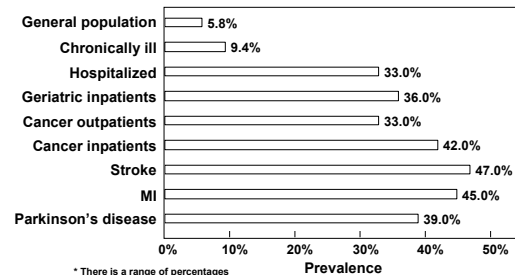
MDE specifiers

- Psychotic features
- Melancholic features
- Catatonic features
- Postpartum onset
- Chronic (>2 years duration)
- Seasonal pattern (Seasonal Affective Disorder [SAD] or winter depression)

Major Depressive Disorder

- Lifetime risk:
 - 10%-25% for women
 - 5%-12% for men
- Point prevalence:
 - 5%-9% for women
 - 2%-3% for men
- Family history of MDD increases risk 1.5-3 times
- Up to 20%-25% of patients with major medical comorbidity (CVA, diabetes, cancer) will develop MDD
- Average age of onset in mid-20's
- Often comorbid with one or more anxiety disorders

Prevalence of Depressive Disorders in Various Patient Populations*



Adapted from WPA/PTD Educational Program on Depressive Disorders

Major Depressive Disorder: Treatment basics

- Medications:
 - Selective serotonin reuptake inhibitors (SSRIs)
 - Tricyclic antidepressants (TCAs)
 - Monoamine oxidase inhibitors (MAOIs)
 - Other: venlafaxine, mirtazapine, nefazodone, bupropion
- Psychotherapy:
 - Cognitive-behavioral therapy (CBT)
 - Interpersonal therapy (IPT)
 - Psychodynamic psychotherapy (e.g., psychoanalysis)
- Other
 - Electroconvulsive therapy (ECT)
 - Light therapy – primarily for SAD
 - rTMS – currently being investigated

Major Depressive Disorder: Medications

- Treatment choice based on:
 - Severity
 - Side effect profile
 - Risk of overdose
 - Other diagnoses (e.g., anxiety)
 - ?Family history of treatment response
- If psychosis is present, this must be treated
- Medications may take up to 6 (8? 12?) weeks to be maximally effective
- Efficacy 60%-80% overall (50%-60% for each)

Major Depressive Disorder: Psychotherapy

- Good evidence for efficacy of CBT and IPT; less for psychodynamic
- Psychotherapy may be just as effective as medications in mild-moderate illness
- Combination of medications and psychotherapy may be better than either alone

Major Depressive Disorder: Electroconvulsive therapy (ECT)

- Up to 80%-90% remission rate with 8-12 treatments; less in tx-resistant depression
- Up to 50%-80% relapse within 6 months
- Side effects: transient cognitive problems, headaches, fatigue
- Also effective for mania, catatonia
- May be first line for certain populations (e.g., medically ill, intensely suicidal, catatonic, pregnancy)

Major Depressive Disorder: Course and prognosis

- Major cause of morbidity and disability
- Untreated episodes can last \geq 4 months
- Risk of having another episode:
 - \geq 60% if one previous episode
 - \geq 70% if two previous episodes
 - \geq 90% if three previous episodes
- 5%-10% will go on to develop Bipolar Disorder
- Up to 15% of patients with severe MDD will kill themselves

Bipolar I Disorder

- At least one manic or mixed episode
- No need for a prior depressive episode
- More severe illness than Bipolar II and easier to diagnose

Bipolar II Disorder

- At least one previous major depressive episode
- At least one hypomanic episode
- Less severe than Bipolar I and more difficult to diagnose

General Comments

- Symptoms cause significant impairment in social and/or occupational functioning (except hypomania)
- Symptoms do not result from a drug of abuse, medication, other treatment, or general medical condition
- Psychosis can be present (except in hypomania)
 - If present, needs specific treatment
 - Usually mood congruent

Manic Episode

- Elevated (or irritable) mood for >1 week
- Three or more of following (four if mood irritable):
 - Grandiosity
 - Distractibility
 - Decreased need for sleep
 - Increased goal-directed activity
 - Pressured speech
 - Flight of ideas, racing thoughts
 - Excessive involvement in pleasurable activities with high risk

Hypomanic Episode

- Elevated, expansive, or irritable mood lasting > 4 days – clearly different from baseline
- Three or more of the following (four if mood irritable):
 - Grandiosity
 - Decreased need for sleep
 - Pressured speech
 - Flight of ideas, racing thoughts
 - Distractibility
 - Increased goal-directed activity
 - Excessive involvement in pleasurable activities with high risk
- Clear change in functioning but no marked impairment in social or occupational functioning

Mixed Episode

- Patient meets criteria for a major depressive episode AND a manic episode at the same time
- Symptoms persist for at least 1 week

Rapid cycling

- Qualifier for either Bipolar I or Bipolar II disorder
- Four or more mood episodes (any type) within any 1 year period
- Occurs in 10%-20% of patients with bipolar disorder
- 70%-90% of rapid-cyclers are women
- Can be very difficult to treat

Bipolar Disorders

- Lifetime risk:
 - Bipolar I Disorder: 1% (men = women)
 - Bipolar II Disorder: 0.5% (women > men)
- Age of onset late teens to early 20's
- Family history (1st degree relative with bipolar I):
 - 10%-20% risk of bipolar I
 - 1%-5% risk of bipolar II
 - 10%-20% risk of MDD

Bipolar Disorders: Treatment basics

- Established mood stabilizers are first-line treatment throughout illness:
 - Lithium
 - Valproate
 - Carbamazepine??
 - Olanzapine??
 - Lamotrigine??
- Combination therapy often required
- Treatment should continue to prevent future episodes

Bipolar Disorders: Treatment of manic or mixed episode

- Most common choices include:
 - Lithium (may be preferable in euphoric episode)
 - Valproate (may be preferable in mixed episode)
 - Olanzapine
- If psychosis is present, mood stabilizer often combined with antipsychotic
- Use adjunctive treatments as necessary:
 - Benzodiazepines, seclusion and restraint, sleep aids
- ECT can be effective

Bipolar Disorders: Treatment of depression

- **DIFFICULT TO TREAT**
- Optimize mood stabilizer therapy first
- Lamotrigine has specific efficacy for bipolar depression
- May combine mood stabilizers or add antidepressants, BUT
- Antidepressants may cause switch into mania
 - TCAs have highest switch rate
 - Largely unknown risk with other antidepressants

Bipolar Disorders: Course and prognosis

- Chronic illness, typically with multiple episodes over lifetime
- Major cause of distress and disability (depressive episodes >> manic or hypomanic episodes)
- Chronic mood stabilizer therapy can reduce number and severity of episodes over time
BUT
- Up to 15% of patients will kill themselves

Dysthymic Disorder

- Depressed mood nearly every day for > 2 years
- Associated with ≥ 2 of the following:
 - decreased or increased appetite
 - decreased or increased sleep
 - low energy or fatigue
 - low self-esteem
 - poor concentration or indecisiveness
 - hopelessness
- No more than 2 months symptom free

Dysthymic Disorder

- Lifetime risk = 6%; point prevalence = 3%
- Equal male/female prevalence
- Age on onset similar to MDD
- Family history of MDD or dysthymia increases risk
- Often comorbid with personality disorders (mainly Clusters B and C)
- Chronic course; <10% remission per year
- Can respond to treatment – may need higher doses, longer duration of treatment
- **Risk of suicide and disability is \geq MDD**

Cyclothymic Disorder

- Several hypomanic episodes
- Several distinct periods of depressive symptoms that do not meet criteria for a major depressive episode
- Hypomanic episodes and depressive symptoms alternate over at least 2 years
- Symptom-free periods are < 2 months duration
- Prevalence 0.4%-1% (??)
- Treatment??

Atypical Depression

- Mood reactivity (responsive to events)
- Two or more of following:
 - Weight gain or increased appetite
 - Hypersomnia
 - Leaden paralysis (heavy, “leaden” feeling in arms or legs)
 - Long-standing pattern of interpersonal rejection sensitivity (not limited to mood episode)
- May respond better to certain treatments (SSRIs and MAOIs rather than TCAs)

Differential Diagnosis for Mood Disorders

- Other mood and anxiety disorders
- Mood disorder due to a general medical condition
- Substance-induced mood disorder
- Bereavement
- Adjustment disorder with depressed mood
- Psychotic disorders
- Premenstrual dysphoric disorder (??)
- Depression NOS and Mood Disorder NOS

Differential Diagnosis: Other mood and anxiety disorders

- Symptoms of mood disorders may overlap (e.g., dysthymia and MDD)
- Anxiety is common in MDD and bipolar disorder; however, may be a separate diagnosis (e.g., PTSD)
- Diagnosis is often based on history – and patient’s memory of past symptoms may be unreliable

Medical conditions

- Thyroid abnormalities
- Cortisol abnormalities
- Parkinson's disease
- Multiple sclerosis
- Epilepsy
- Brain tumor
- Cancer (e.g., pancreatic)
- Dementia
- Traumatic brain injury
- Autoimmune disorders
- Stroke
- Huntington's disease
- Chronic infections
- Certain medications:
 - Steroids
 - Interferon
 - Beta-blockers
 - Isotretinoin (Accutane)
 - Oral contraceptives
 - Antidepressants (!)
 - Everything else!?

Substance-induced mood disorder

- Alcohol: depression
- Cocaine: hypomania, mania
- Amphetamines: hypomania, mania
- PCP, ketamine: hypomania, mania
- Heroin: depression?
- Marijuana: depression?
- Mood symptoms with intoxication or withdrawal
- May take weeks-months to normalize mood
- Substance use highly comorbid in mood disorders (bipolar I > bipolar II > MDD)

Bereavement (mourning)

- "Normal" reaction to the loss of a loved one
- May have several depressive symptoms
- Consider diagnosis of major depressive episode if:
 - Symptoms persist ≥ 2 months after loss
 - Presence of any of the following:
 - Guilt (except for actions taken or not taken at time of death)
 - Profound and persistent anhedonia
 - Marked psychomotor retardation
 - Decreased self-esteem
 - Suicidal ideation
 - Hallucinations other than hearing voice or seeing image of deceased person

Adjustment disorder with depressed mood

- Depressive symptoms that develop within 3 months of a stressor
- Symptoms do not meet criteria for another mood episode
- Symptoms are clinically significant because of:
 - Marked distress in excess of what would be expected
- OR
- Significant social or occupational impairment
- Treatment?

Suggested history/workup

- Review of current and past psych sx/dx
 - Get collateral history
- Review prior treatments and response
- Family history
- Medical history
- Current medications
- Substance use history
- Social history
- Review of systems
- Workup
 - CBC
 - Electrolytes
 - Renal function
 - Liver Function
 - TSH
 - RPR?
 - HIV?
 - Imaging?

Treatment/management

- ALWAYS ASSESS FOR SUICIDE!!!
 - Ideation, plan, intent, means, risk factors
- Choose medications carefully and thoughtfully
- Don't give up too soon
- Can always incorporate some behavioral and CBT techniques (e.g., behavioral activation)
- Address perpetuating factors (medical problems, psychosocial stressors)
- Treat the acute AND chronic aspects of the illness (i.e., preventive management)

Case #1a

- Mr. M is a 34 y/o man who presents with 1-month history of sad mood and decreased motivation to go to work. He reports difficulty falling asleep at night and multiple mid-cycle awakenings. His appetite and energy are normal.
- What other questions do you have?
- What is your working diagnosis?
- What is your initial treatment plan?

Case #1b

- Mr. M returns one month later. He continues to have sad mood, decreased motivation, and feels that things are getting worse.
- What other questions do you have?
- What is your working diagnosis?
- What is your treatment plan?

Case #2a

- Ms. T is a 19 y/o female college student who presents to the emergency room with a several day history of bizarre behavior at school. Her friends say she hasn't slept for 4-5 days, is talking "a mile a minute," and is trying to help everybody do their homework stating, "you'll never find a better tutor than me!"
- What other questions do you have?
- What is your working diagnosis?
- What is your treatment plan?

Case #2b

- Ms. T does well during the hospitalization and is discharged in about 8 days. She returns to clinic in 4 weeks and says she thinks she's ready to come off the medication.
- What other questions do you have?
- What do you tell her?

Case #2c

- Ms. T stops her medications. She returns to see you in another 4 weeks and tells you she feels great – especially since she's "off of those mind-dulling drugs." She feels *much* more alert and is able to accomplish "more than ever before." She says she is doing well with just 5 hours sleep per night and feels that she's finally "found" herself.
- What other questions do you have?
- What is your working diagnosis (has it changed)?
- What is your treatment plan?

Case #2d

- Ms. T refuses to re-start medications. Eight weeks later, she is brought into the emergency room after an acetaminophen OD. You evaluate her during the medical hospitalization. She reports 4-5 weeks of worsening "emptiness," difficulty falling asleep, racing thoughts, and feeling "revved up." She has had increasing SI over the past week.
- What other questions do you have?
- What is your working diagnosis (has it changed)?
- What is your treatment plan?

Case #3a

- Patient is a 6-7 y/o gray male donkey who complains that “no one really cares about me.” He states that he generally feels down and never has enough energy.
 - What other questions do you have?
 - What is your working diagnosis?
 - What is your treatment plan?

Case #3b

- He returns 4 weeks later and tells you he doesn't really feel any better.
 - What other questions do you have?
 - What is your working diagnosis?
 - What is your treatment plan?