MOOD DISORDERS (MD)

Mood is the subjective component of emotions.

Currently MD are restricted to disorders where changes of mood are the dominating feature.

Brief fluctuations of mood between sadness and happiness in response to events and circumstances is normal and require no treatment.

On the contrary, lack of emotions is abnormal.

Persistent mood changes downward (depression) and upward (mania) are abnormal, and with additional symptoms, constitute disorders or syndromes.

DEPRESSION:

The life time prevalence is 10-25% for women and 5-12% for men.

Symptoms of depressive disorders are grouped into psychological, biological, cognitive, social, and motor symptoms.

Psychological symptoms include low or irritable mood, lack of enjoyment (inability to respond to pleasurable events, anhedonia), loss of interest, and poor concentration.

Biological symptoms include sleep disturbance (insomnia), diurnal changes of mood (mood changes with time of day), and loss of appetite, weight, and libido, amenorrhea and constipation.

Cognition is characterised by slowing of thought process, negative thinking, preoccupation with self-blame and feeling of guilt and worthlessness.

The past is regretted, the present is resented, and the future appears hopeless.

The patient believes that nothing could be done to help him and there is no use in trying.

At this stage of depression, feelings of hopelessness and helplessness prevail and the risk of suicide is very high.

Social symptoms present as gradual withdrawal from work and social activities and reluctance to meet friends and relatives.

Motor symptoms include tiredness, feeling of lack of energy, sparse speech, and retardation of movements. In some patients, agitation and restlessness replace retardation.

Additional symptoms are obsessions, depersonalisation, and in mild cases, anxiety symptoms are common.

Psychotic symptoms in the form of auditory hallucinations and somatic and persecutory delusions may occur in severe depression.

The themes of depressive delusions and hallucinations confirms the patient's believe in his guilt and worthlessness (your are evil, it is your fault), and is accepted by the patient as a punishment for his wrongdoing (mood congruent).

In schizophrenia, auditory hallucinations and delusions may have the same themes, but the content is rejected and protested by the patient (it is not my fault, it is done to me, I do not know why).

The constellation and severity of the symptoms are related to the severity of depression.

Severe depression presents with more and severe symptoms.

Depressive stupor describes sever physical and mental retardation characterised by withdrawal from the surroundings, and lack of speech, response, and movements. Eating and drinking are reduced or stopped.

In masked or smiling depression there are depressive symptoms, but the mood appears not depressed, and it usually responds to treatment with antidepressants.

Atypical depression describes depression where the biological symptoms such as loss of appetite and insomnia are reversed (overeating and oversleeping); depressed mood is not persistent and responds to change in circumstances (reactive).

Mood may become irritable rather than depressed especially in young patients.

The underlying personality in atypical depression is sensitive and reacts in an exaggerated pattern. This depression responds better to monoamine

oxidase and selective serotonin re-uptake inhibitors than to tricyclic antidepressants.

In brief recurrent depression the symptoms are severe enough to cause distress and functional impairment, but the depressive episodes are brief (2-7 days) and recurrent (about once a month). Mild depressive disorder (neurotic depression) presents with some depressive symptoms as well as anxiety, obsessions, phobic, and dissociative symptoms. Sleep disturbance presents as difficulty in falling asleep, interrupted sleep with bad dreams, and the mood usually worsens later in the day.

In severe depressive disorder there is early wakening, and the mood usually improves later in the day (diurnal variation).

Mild depressive symptoms may accompany personal crises (financial loss, divorce) and resolve after the crises are over (minor depressive disorders). The person gradually makes adjustments and cope with the new situation.

However, some individuals are unable to adjust, and although symptoms are mild, functioning is impaired, may be for years (dysthymia, chronic depression). Underlying personality factors (constitutional factors) play a role in these cases. In depression, general appearance (personal care, grooming, facial expression, posture) and behaviour reflects how the patient feels.

MANIC DISORDERS: Symptoms of mania are opposite to symptoms of depression and varies in constellation and severity.

Mood is elated (elevated, euphoria, cheerful, high), but may become irritable and angry, especial young patients. The patient expects people around him to share his happiness (infectious mood); otherwise he becomes crossed and irritable.

The patient feels optimistic, overconfident, and powerful (grandiose) and behaves accordingly.

He overestimates his capabilities, wealth, and social status and may spend money recklessly.

Overctivity includes thought process, speech, and mobility. Thoughts and ideas are optimistic, crowded, and may be contradictory.

Speech is fast and plentiful, and the stream of thoughts may become disjointed and difficult to follow (flights of ideas).

Appetite is increased and the patient may eat without regard to table manners. The patient is restless, energetic, and physically active.

Physical activities may become aimless with neglect of personal hygiene and nutrition and leads to exhaustion.

This imposes stress on colleagues at work and on the family.

Overctivity is often counterproductive and jobs started but remain unfinished.

Patient may lose insight and becomes uninhibited with to disregard social standards.

Sexual desire is high and the patient may behave without restraint. Personal appearance (grooming, cloths, posture) and behaviour reflects patient's mood.

Severe cases of mania may show psychotic symptoms in the form of delusions of reference, grandiose and persecutory delusions, and hallucinations.

The theme of these psychotic symptoms reflects the elated mood, sense of power, and self-importance.

Patient may believe he is a profit, a king, or an international personality (grandiose delusions).

He may believe that because of his high social status there is a conspiracy against him, (persecutory delusions) and the media print and broadcast material about him (delusion of reference). Voices talk about the patient's special power and importance (you are a profit, you're a saviour) and visions may have religious tone (seeing God, surrounded by angels). Schneider first rank symptoms (thought insertion, withdrawal, and broadcasting, third person and commentary hallucinations) may occur in mania.

Similar to depressive disorders, severity and constellation of symptoms varies with the severity of mania. Less severe cases of mania are hypomania.

When depressive and manic episodes occur in the same patient, alternating or merging into each other without remission, the disorder is called bipolar affective disorder. Recurrent depression without mania is called unipolar disorder.

Symptoms of depression and mania may be present at the same time (mixed affective states).

Elated mood may be associated with depressive thoughts or crying.

Mild symptoms of depression may alternate with mild symptoms of mania i.e hypomania….this called (cyclothymia).

The term manic stupor describes a disorder where the patients is mute or speak with low voice, lay in bed with no interest in the surroundings, and looks happy and may smile without apparent cause.

After recovery, the patient recalls events that occurred during the period of stupor and acknowledges that he had crowded thoughts.

Manic stupor may evolve from manic excitement or from depressive stupor.

Rapid cycling manic depressive disorder refers to cases in which episodes of mania, depression, or mixed affective states recur at intervals of weeks or months (circular insanity, periodic psychosis).

Four episodes a year is required for the diagnosis and episodes may be separated by remission or merge into each other.

The disorder is more common in females, some of whom have abnormal thyroid function.

It may be triggered by tricyclic antidepressants and response to lithium is poor, but it responds better to valproate or carbamazepine.

Seasonal affective disorder refers to depressive or manic episodes that occur during a particular season in the year

. It is suggested that this disorder be related to the length of daylight.

In seasonal depression there is hypersomnia and increased appetite (similar to atypical depression) and craving for carbohydrate.

Depression usually occurs in autumn or winter and mania in summer. Depressive episodes respond to exposure to artificial bright light during dark hours and sometimes during the day.

Exposure to bright light at night reduces the amount of sleep and it is known that sleep deprivation temporarily improve depression.

The beneficial effect of light in seasonal affective disorder is more likely

due to light than to sleep deprivation.

Extra light at night suppresses the secretion of melatonin, which may have some effect.

The terms involutional and senile depression have been discarded because they are not separate entities.

DSM1V classifies repeated depressive episodes with at least one manic episode as bipolar-1 affective disorder, and repeated depressive episodes with hypomania as bipolar-11 affective disorder.

ICD 10 does not use the term bipolar 1 and bipolar 11, only bipolar. Severe depressive and manic disorders are not difficult to diagnose because of the severity and constellation of symptoms. Mild depression may present with additional symptoms of anxiety, phobia, and obsessions and has to be differentiated from these disorders. History helps to show which symptoms of these disorders appeared first.

Comorbidity of depression and anxiety disorders is to be considered. Psychotic symptoms in severe depression and mania may confuse these disorders with schizophrenia.

The contents and themes of the delusions and hallucinations differentiate these disorders from each other. In elderly patients, dementia and organic diseases are to be excluded.

The lifetime risk for bipolar mood disorder ranges between 0.5 to 1.5 percent and is equal for men and women.

The prevalence of mania is probably higher in upper social class and in artists and intellectuals. Genetics plays a major role in the aetiology of affective disorders, especially in moderate and severe cases. Morbidity risk in parents, siblings, and children is 20 percent in sever depression (7 percent in control), and 69 percent in monozygotic twins and 13 percent in dizygotic twins.

Adoption studies confirmed that morbidity risk in adopted children is related to that of their biological parents and not to the adopting families. The role of genetics is higher in bipolar than in unipolar mood disorders. The mode of genetic transmission is not clearly known.

The role of body build (physique); personality traits; parental deprivation; and relationship with parents remain ambiguous.

The mean age of onset of bipolar disorders is about 21 years and more

cases occur in teens than in late life.

The natural course of an episode is months and sometimes several years. Recurrence is a characteristic of bipolar disorders.

In an individual patient, the length of each episode may remain the same, but periods of remissions become shorter with recurrences.

Men have about equal number of manic and depressive episodes, whereas women have more depression.

The number of episodes in bipolar disorders is higher than in unipolar disorders.

Family history of mania increases the risk of recurrence in bipolar patients.

Unipolar depressive disorders have later age of onset; episodes may last longer; and are more likely to have chronic residual symptoms. Recurrence is higher in women and in patients with early age of onset.

In general, unipolar depression has poor outcome.

Mood disorders carries higher risk for suicide than other psychiatric disorders.

Bipolar and unipolar disorders have similar rate of suicide.

Sever depression is associated with 11 to 17 percent rate of suicide.