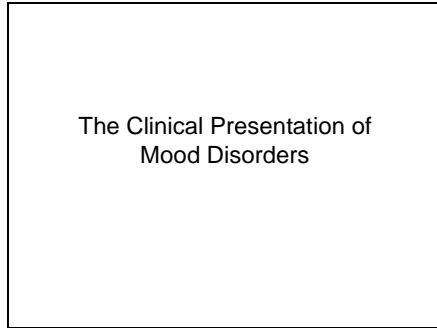


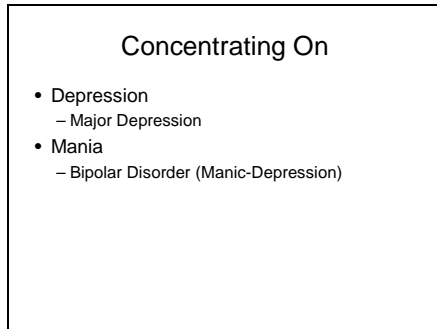
The Clinical Presentation of Mood Disorders.

Bob Boland MD

Slide 1

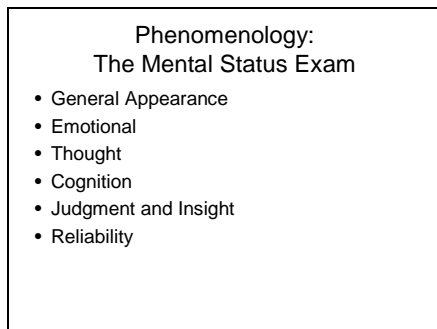


Slide 2



For the mood disorders, we're going to have to cover both depression AND mania.

Slide 3



Once again, we'll use the mental status exam to consider the phenomenology of the mood disorders.

Slide 4

General Appearance

- Depression
- Mania

In both cases, people may look “normal” with mood disorders. However, as the disorder worsens, often appearance is affected. Though one can imagine a variety of appearances, typically we see depressed patients taking less care of their appearance, whereas manic patients may be more flamboyant.

Slide 5

Emotions: Depression

- Mood
 - Dysphoric
 - Irritable, angry
 - Apathetic
- Affect
 - Blunted, sad, constricted

I prefer the word “dysphoric” (i.e., “feeling bad”) to “depressed” in describing the typical sad mood of the depressed patient. However patients may not be simply sad. They may be more irritable, angry, or feel like they have no emotion at all. Their affect may be sad, but it could also be blunted, or show less emotion altogether.

Slide 6

Emotions: Mania

- Mood
 - Euphoric
 - Irritable
- Affect
 - Heightened, dramatic, labile

The typical manic mood is euphoria. However, again, patients may instead be irritable. Typically, manic patients are animated with exaggerated emotional styles.

Slide 7

Thought: Depression

- Process
 - Slowed processing
 - Thought blocking
- Content
 - Everything's awful
 - Guilty, self-deprecating
 - Delusional

Depressed people often describe problems with their thoughts—thinking more slowly, having trouble organizing their thoughts. In the extreme, they describe feeling as if they are demented. Typically, they see things as worse than it really is, and in the extreme, they may become delusional.

Slide 8

Thought: Mania

- Process
 - Rapid
 - Pressured speech
 - Loosening of Associations
- Content
 - Grandiose
 - Delusions

Manic people tend to think more quickly. In the right amounts, the combination of this quick thought, and the somewhat broader associations can make them seem quite clever, but as it worsens, their thinking becomes more incomprehensible. The speech is pressured—not only rapid, but continuous, in the sense that they seem as if they will continue talking incessantly unless interrupted.

The content of thought is typically grandiose—ex. Thinking one is more important than they are, richer, more attractive, etc. In the extreme they can be delusional.

Slide 9

Cognition

- Depression
 - Poor attention
 - Registration
 - Effort
 - “Pseudodementia”
- Mania
 - Distractible
 - Concentration
 - May seem brighter, more clever

As already noted, depression can affect thought, to the point where patients cannot concentrate as well. As a result, they may find it harder to learn or remember things. The term “pseudodementia” has been applied to this, but it is probably best not used, as depression can affect cognition in a variety of ways, both in terms of actual thought processing, and in the effort applied to answering questions.

In the right amount, a manic patient can be very clever and certainly some of the brighter people around have had bipolar disorder. However, with worsening of the disorder, this worsens as well.

Slide
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Insight and Judgment

- Depression
 - Unrealistically negative
- Mania
 - Unrealistically positive
 - Or just plain bad

One can imagine that as thought worsens, so does insight and judgment. For example, if one thinks they are hopeless and worthless, it will certainly affect their decisions about future plans. Similarly, a manic person can be unrealistically optimistic and make poor decisions: ex. Buying things they cannot really afford.

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Epidemiology

- Depression
 - 5-7%
 - 2:1 ♀:♂
 - \$53 billion/year in US
 - World: most costly (developed)

Depression is very common—5-7% lifetime risk in the Epidemiological Catchment Area (ECA) Study. Later follow ups suggest it may be even more common than that. It is more common in woman than men—this seems to be true worldwide, and most believe this reflects some biological predisposition, though social causes remain possible and plausible. It is one of the most costly diseases known to man, and certainly the most costly in developed countries. This is due to the fact that it often strikes persons during the most productive years of their lives. Though many famous people have suffered from it, this probably has more to do with the fact that this disorder is common, rather than any particular association with creativity.

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Epidemiology

- Bipolar Disorders
 - 1%
 - ~1:1 ♀:♂

Bipolar disorder is somewhat less common. The gender difference is closer to parity. Though many very productive and creative people have had the disorder, they usually have not been productive during highs and lows of the disorder.

Slide
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Diagnosis and Criteria

- Episodes Versus Disorders

In diagnosing the mood disorders, one should be aware that DSM describes first episodes, which are syndromes, or collections of symptoms, which then become the building blocks for the actual disorders.

Slide
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Episodes

- Major depressive
- Manic
- Mixed
- Hypomanic

There are the episodes. Once again, remember, these are not diagnoses, merely descriptions of syndromes.

Slide
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Major Depressive Episode

- Time
 - 2 weeks
- Change
 - From previous functioning
- Symptoms
 - 5 or more
 - 1 has to be depressed mood or anhedonia
- Global Criteria


All the episodes are described in terms of time course, a collection of symptoms with a minimum required number, and the “global criteria” (see the first lecture for more on that). In the case of a major episode, the criteria are listed here.

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Symptoms of Major Depressive Episode

- “Sig E Caps”
 - Sleep
 - Interest
 - Guilt
 - Energy
 - Concentration
 - Appetite
 - Psychomotor retardation
 - Suicide
- 5 or more

R:
**Sig:
E Caps**



These are the symptoms of a major depressive episode. In addition to these, one MUST have either dysphoria or anhedonia (taking no pleasure in anything). SIG E CAPS is a useful mnemonic (like a prescription for “energy capsules”) for remembering these symptoms.

Slide
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Manic Episode

- Time
 - 1 week
- Symptom list
 - 3 or more
- Global Criteria

Similarly, these are the criteria for a manic episode. The actual symptoms list is on the next slide.

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Symptoms of Manic Episode

- Grandiosity
- Decreased need for sleep
- Pressured Speech
- Flight of Ideas
- Distractibility
- Increased Activity/Agitation
- Risky Activities
- 3 or more

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Other Episodes

- Mixed
- Hypomanic

In addition to those (which I want to concentrate on) there are 2 other types of episodes: a mixed episode and a hypomanic episode. More on these later. Anyhow, the episodes become the building blocks for the actual disorders.

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The Disorders

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Major Depressive Disorder

- "Classic Depression"
- Major Depressive Episode
- Rule outs
 - Some other disorder
 - History of mania/hypomania

These are the criteria for the Major Depressive Disorder. Note that it doesn't list symptoms—these were covered by the episode criteria. Here, a patient has to have had a major depressive episode (and the accompanying symptoms of that), and, essentially nothing else.

Slide
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Bipolar Disorder I

- Classic "Manic-Depression"
- At least one
 - Manic or,
 - Mixed episode

Similarly, here are the bipolar criteria. A person has to have had at least 1 manic or mixed episode. In practice, most (@90%) patients usually have had a depressive episode as well (hence the synonym of manic-depression) however that is not required.

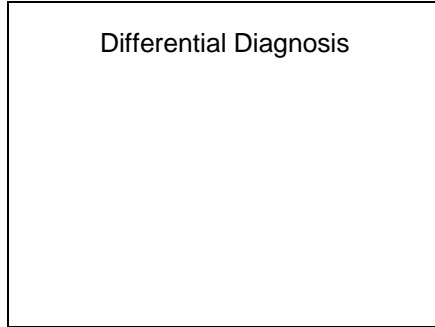
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Other Mood Disorders

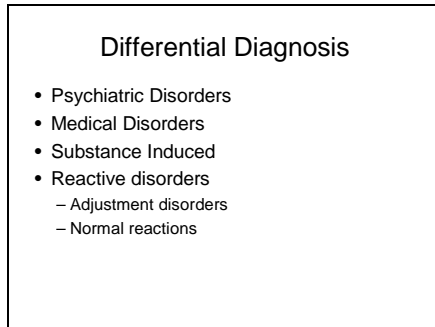
- Dysthymic Disorder
- Cyclothymic Disorder
- Bipolar II
- Due to a generalized medical condition
- Substance Induced
- NOS

See the syllabus for a description of these episodes. It will be primarily important to understand these as they differ from a major depressive disorder and bipolar I.

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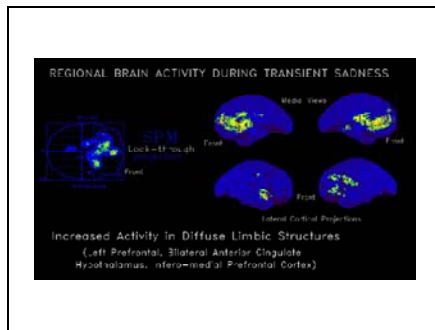
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There is a long list of other disorders that can cause depressive symptoms without actually causing major depression. Among the psychiatric disorders, some of the anxiety disorders can, for example, have overlapping symptoms.

Most difficult to judge are the reactive disorders: both normal reactions to severe stress (ex. Grief, loss) or abnormal reactions (ex. In the adjustment disorders). In practice, the differences are usually judged on the basis of how the disorder affects functioning, however in the acute setting, it can be difficult to judge.

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One should not become too keen on distinguishing between “physiological depression” and whatever the opposite of that might be. For example, the above scan demonstrates brain changes in the setting of normal transient sadness. No emotion, no thought is possible without some physiological effect or change.

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Comorbidity

- Anxiety disorders
- Substance abuse
- Psychotic disorders
- Personality disorders
- Depression in the medically ill.

A number of other disorders are commonly found in depressed persons; some of these are listed above.

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Comorbidity

That being said, major depression should never be thought of as a “normal” state, no matter how severe the setting. Even in the case of cancer, or a severe injury, depression, if present should be treated, and one should avoid the stance that “I’d feel depressed too if that happened to me” with the implication that, therefore, it is normal and not worthy of treatment or attention.

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Course and Prognosis of Mood Disorders

One important line of research in the last 2 decades has been the appreciation that the mood disorders are not merely acute illnesses, but often are part of a lifetime of impairment.

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Course and Prognosis of Mood Disorders

- Recovery
- Relapse
- Recurrence

One should become familiar with the above terms and their meaning. Definitions of there, and related terms are as follows:

(1) *Episode*, defined using by having a certain number of symptoms for a certain period of time,

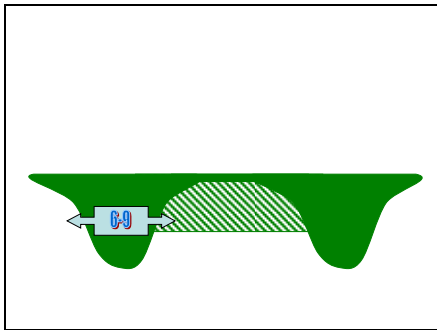
(2) *Remission*, defined by a period of time in which an individual no longer meets criteria for the disorder. In partial remission, an individual still has more than minimal symptoms. Full Remission is defined as the point at which an individual no longer meets criteria for the disorder and has no more than minimal symptoms.

(3) *Recovery*, defined as a full remission that lasts for a defined period of time. Conceptually, it implies the end of an episode of an illness, not the illness *per se*.

(4) *Relapse*, defined as a return of symptoms sufficient to satisfy full criteria for an episode. It occurs in an interval of time before what is defined as “recovery.” Conceptually, this refers to the return of an episode, not a new episode.

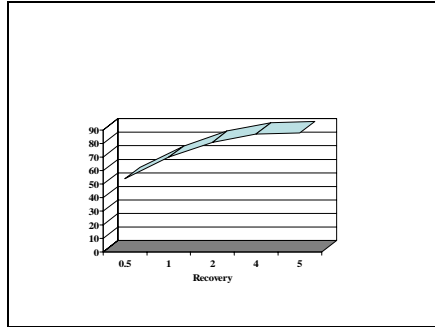
(5). *Recurrence*, defined as a return of full symptomatology occurring after the beginning of the recovery period. Conceptually, this represents the beginning of a new episode of an illness.

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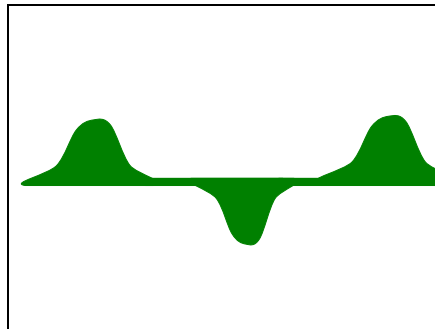
A typical episode of depression. Note that some patients never truly recover, though the episode may become less severe (chronic depression) and, in some cases, it becomes clear that, until they were treated, some patients always had some at least minor symptoms, interrupted by episodes of more severe major depression (“double depression”).

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Natural studies suggests that most patient recover from an episode of depression, but some (@10%) do not. Most recover in the first ½ year, and the longer one goes after that without recovery, the higher the risk of chronicity. Hence the need for aggressive treatment.

Slide 33



Bipolar disorder typically has episodes of mania and depression (they need not alternate as above) with inter episode periods of euthymia. However, longitudinal data suggests that, the more episodes one has, the shorter the periods of inter episode normalcy. Hence the need to intervene early.

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Predictors

- # Episodes
- Length of episodes
- Symptoms
 - # and type
- Comorbidity

Certain features predict the outcome of mood disorders. In both depression and bipolar disorder, more episodes, longer episodes, more severe symptoms, psychotic symptoms, and comorbid disorders (esp. substance abuse and psychosis) are bad predictors.

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Risk of Suicide

- Depression
 - 10-15% severe (hosp) pts

Suicide is common. It has been reported that 10-15% of severely depressed patient (severe enough to be hospitalized) will eventually take their own lives.

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Choice of treatment

- Best?
- Fastest?
- Predictors of response
- Major difference

Treatment will be covered in another lecture. As one thing about antidepressants, one should try to answer the following questions:

What is the best treatment for depression?
What works the fastest?
Are there predictors of response?
What's the major difference between treatments.

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Psychotherapies

- Good Evidence most brands of therapy in the treatment of a major depressive episode
- Best Evidence for:
 - Cognitive Behavioral Therapy
 - Interpersonal Therapy
- Meds Versus Therapy
 - And combinations thereof
- Protective?

Psychotherapies will also be covered in another lecture. It is important to know, however, that much of the work, and success of psychotherapies has been in the treatment of depression.

Psychotherapy is another important treatment for depression. Most of the available psychotherapies have at least some data attesting to their efficacy in treating depressive episodes. Some also have data for preventing future episodes.

The best evidence is for Cognitive Behavioral Therapy and Interpersonal Therapy. This is not necessarily proof that they are the best—more likely they are the easiest to study, as they are very structured therapies that can be done in relatively consistent ways.

Cognitive-Behavioral Therapy (CBT) is based on learning theory. Learning theory suggests that behaviors are learned (i.e., made more likely to occur), usually through some sort of reinforcement. CBT applies

Clinical Presentation of Mood Disorders

learning theory to depression by suggesting that thoughts can also be learned, and that we learn to think a certain way and develop automatic thoughts and responses to situations. Depressive ways of thinking can become habitual. However, what we learn can be unlearned through practice, hence the rationale for CBT. CBT is an active therapy with lots of homework and assignments.

Interpersonal Therapy (IPT) is based on the notion that depression is a response to loss or perceived loss in social network. It is also very active and practice based.

Most other types of psychotherapy have at least some evidence showing effectiveness in treating depression. Other psychotherapies shown to be effective include Psychodynamic Therapy and Marital/Family Therapy.

When To Choose Meds Versus Psychotherapy?

The weight of data supports the following conclusions: Medication is superior to therapy for severe depression. Medication and therapy are probably equal for mild to moderate depression.

Combination of medication and therapy likely confer an advantage over either alone, perhaps a strong advantage. Psychotherapy may confer some protection against episodes, even after the therapy is over.