

07 - Chapter 4 Mood Disorders

- [01 - Chapter 4 Mood Disorders](#)

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Concepts in Mood Disorders.....	34
Mood Disorders versus Mood Episodes.....	34
Mood Episodes.....	34
Major Depressive Episode (MDE).....	34
Manic Episode.....	34
Hypomanic Episode.....	35
Differences between Manic and Hypomanic Episodes.....	35
Mixed Features.....	35
Mood Disorders.....	35
Differential Diagnosis of Mood Disorders Due to Other Medical Conditions.....	35
Substance/Medication-Induced Mood Disorders.....	36
Major Depressive Disorder (MDD).....	37
Specifiers for Depressive Disorders.....	40
Bereavement.....	40
Bipolar I Disorder.....	40
Bipolar II Disorder.....	42
Specifiers for Bipolar Disorders.....	42
Persistent Depressive Disorder (Dysthymia).....	43
Cyclothymic Disorder.....	44
Premenstrual Dysphoric Disorder.....	44
Disruptive Mood Dysregulation Disorder (DMDD).....	45
Other Disorders of Mood in DSM-5.....	46
MOOD DISORDERS CHAPTER 4	

34 MOOD DISORDERS WARDS TIP Major depressive episodes can be present in major depressive disorder, persistent depressive disorder (dysthymia), bipolar I/II disorder, and schizoaffective disorder. WARDS TIP When patients have delusions and hallucinations due to underlying mood disorders, they are usually mood congruent. For example, depression causes psychotic themes of paranoia and worthlessness, and mania causes psychotic themes of grandiosity and invincibility. Mood Episodes MAJOR DEPRESSIVE EPISODE (MDE) KEY FACT Symptoms of major depression— SIG E. CAPS (Prescribe Energy Capsules) Sleep Interest Guilt Energy Concentration Appetite Psychomotor activity Suicidal ideation MANIC EPISODE Concepts in Mood Disorders A mood is a description of one's internal emotional state. Both external and internal stimuli can trigger moods,

which may be labeled as sad, happy, angry, irritable, and so on. It is normal to have a wide range of moods and to have a sense of control over one's moods. Patients with mood disorders (also called affective disorders) experience an abnormal range of moods and lose some level of control over them. Distress may be caused by the severity of their moods and the resulting impairment in social and occupational functioning. Mood Disorders versus Mood Episodes ■ Mood episodes are distinct periods of time in which some abnormal mood is present. They include depression, mania, and hypomania. ■ Mood disorders are defined by their patterns of mood episodes. They include major depressive disorder (MDD), bipolar I disorder, bipolar II disorder, persistent depressive disorder, and cyclothymic disorder. Some may have psychotic features (delusions or hallucinations). Must have at least five of the following symptoms (must include either number 1 or 2) for at least a 2-week period:

1. Depressed mood most of the time.
 2. Anhedonia (loss of interest in pleasurable activities).
 3. Change in appetite or weight (↑ or ↓).
 4. Feelings of worthlessness or excessive guilt.
 5. Insomnia or hypersomnia.
 6. Diminished concentration.
 7. Psychomotor agitation or retardation (i.e., restlessness or slowness).
 8. Fatigue or loss of energy.
 9. Recurrent thoughts of death or suicide. Symptoms must not be attributable to the effects of a substance (drug or medication) or another medical condition, and they must cause clinically significant distress or social/occupational impairment. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week (or any duration if hospitalization is necessary), and including at least three of the following (four if the mood is only irritable):
 10. Distractibility.
 11. Inflated self-esteem or grandiosity.
 12. ↑ in goal-directed activity (socially, at work, or sexually) or psychomotor agitation.
 13. ↓ need for sleep.
 14. Flight of ideas or racing thoughts.
 15. More talkative than usual or pressured speech (rapid and uninterruptible).
 16. Excessive involvement in pleasurable activities that have a high risk of negative consequences (e.g., shopping sprees, sexual indiscretions). Symptoms must not be attributable to the effects of a substance (drug or medication) or another medical condition, and they must cause clinically significant distress or social/occupational impairment. Greater than 50% of patients with manic episodes have psychotic symptoms.
- HYPOMANIC EPISODE** A hypomanic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least 4 consecutive days, that includes at least three of the symptoms listed for the manic episode criteria (four if mood is only irritable). There are significant differences between mania and hypomania (see below).
- DIFFERENCES BETWEEN MANIC AND HYPOMANIC EPISODES**
- | | | | | |
|-----------|-----------------------|--|----------------------------------|-----------------------|
| Hypomania | Lasts at least 4 days | No marked impairment in social or occupational functioning | Does not require hospitalization | No psychotic features |
| Mania | Lasts at least 7 days | Causes severe | | |

impairment in social or occupational functioning May necessitate hospitalization to prevent harm to self or others May have psychotic features MIXED FEATURES Criteria are met for a manic or hypomanic episode and at least three symptoms of a MDE are present for the majority of the time. These criteria must be present nearly every day for at least 1 week. Mood Disorders Mood disorders often have chronic courses that are marked by relapses with relatively normal functioning between episodes, which is a key factor in distinguishing a mood disorder from other chronic psychiatric disorders such as schizophrenia. Like most psychiatric diagnoses, mood episodes may be caused by another medical condition or drug (prescribed or illicit). Therefore, always investigate medical or substance-induced causes (see below) before diagnosing a primary mood disorder.

DIFFERENTIAL DIAGNOSIS OF MOOD DISORDERS DUE TO OTHER MEDICAL CONDITIONS

Medical Causes of a Depressive Episode Cerebrovascular disease (stroke, myocardial infarction) Endocrinopathies (diabetes mellitus, Cushing syndrome, Addison disease, hypoglycemia, hyper/hypothyroidism, hyper/hypocalcemia) MOOD DISORDERS WARDS TIP A suicide risk assessment should include evaluating current or recent suicidal ideation (including wishing to be dead, thinking of methods, planning, or having intent) and should assess frequency, duration, and intensity of these thoughts. Suicide Risk Factors: SAD PERSONS S: Male sex A: <19 or >45 years D: Depression P: Previous attempt E: Excess alcohol or substance use R: Rational thinking loss S: Social supports lacking O: Organized plan N: No spouse S: Sickness KEY FACT Symptoms of mania—DIG FAST Distractibility Insomnia/Impulsive behavior Grandiosity Flight of ideas/Racing thoughts Activity/Agitation Speech (pressured) Thoughtlessness WARDS TIP A manic episode is a psychiatric emergency; severely impaired judgment and impulsivity can make a patient dangerous to self and others. Medical Causes of a Manic Episode Metabolic (hyperthyroidism) Neurological disorders (temporal lobe seizures, multiple sclerosis)

36 MOOD DISORDERS Parkinson disease Viral illnesses (e.g., mononucleosis) Carcinoid syndrome Cancer (especially lymphoma and pancreatic carcinoma) Collagen vascular disease (e.g., systemic lupus erythematosus) WARDS TIP Irritability is often the predominant mood state in mood disorders with mixed features. Patients with mixed features have a poorer response to lithium. Anticonvulsants such as valproic acid may be more helpful. Substance/Medication-Induced Depressive Disorder EtOH Antihypertensives Barbiturates Corticosteroids Levodopa Sedative-hypnotics Anticonvulsants Antipsychotics Diuretics Sulfonamides Opiates Withdrawal from stimulants (e.g., cocaine, amphetamines) KEY FACT Patients with cardiovascular disease or strokes are at a significant risk for developing depression, and this is associated with a poorer outcome overall. KEY FACT Depression is common in patients with pancreatic cancer. Neoplasms HIV infection SUBSTANCE/MEDICATION-INDUCED MOOD DISORDERS Substance/Medication-Induced Bipolar Disorder Antidepressants Sympathomimetics Dopamine Corticosteroids Levodopa Bronchodilators Cocaine Amphetamines Ms. Cruz is a 28-year-old sales clerk who arrives at your outpatient clinic complaining of sadness after her boyfriend of 6 months ended their relationship 1 month ago. She describes a history of failed romantic relationships, and says, "I don't do well with breakups." Ms. Cruz reports that, although she has no prior psychiatric treatment, she was urged by her employer to seek therapy. Ms. Cruz has arrived late to work on several occasions because of oversleeping. She also has difficulty in getting out of bed stating, "It's difficult to walk; it's like my legs weigh a ton." She feels fatigued during the day despite spending over 12 hours in bed, and is concerned that she might be suffering from a serious medical condition. She denies any significant

changes in appetite or weight since these symptoms began. Ms. Cruz reports that, although she has not missed workdays, she has difficulty concentrating and has become tearful in front of clients while worrying about not finding a significant other. She feels tremendous guilt over “not being good enough to get married,” and says that her close friends are concerned because she has been spending her weekends in bed and not answering their calls. Although during your evaluation Ms. Cruz appears tearful, she brightens up when talking about her newborn nephew and her plans to visit a college friend next summer. Ms. Cruz denies suicidal ideation. What is Ms. Cruz’s diagnosis? Ms. Cruz’s diagnosis is MDD with atypical features. She complains of sadness, fatigue, poor concentration, hypersomnia, feelings of guilt, anhedonia, and impairment in her social and occupational functioning. The atypical features specifier is given in this case as she exhibited mood reactivity (mood brightens in response to positive events) when talking about her nephew and visiting her friend, and complained of a heavy feeling in her legs (leaden paralysis) and hypersomnia. It is also important to explore Ms. Cruz’s history of “not doing well with breakups,” as this could be indicative of a long pattern

of interpersonal rejection sensitivity. Although it is common for patients who suffer from atypical depression to report an ↑ in appetite, Ms. Cruz exhibits enough symptoms to fulfill atypical features criteria. Adjustment disorder should also be considered in the differential diagnosis. What would be your pharmacological recommendation? Ms. Cruz should be treated with an antidepressant medication. While monoamine oxidase inhibitors (MAOIs) such as phenelzine had traditionally been superior to tricyclic antidepressants (TCAs) in the treatment of MDD with atypical features, selective serotonin reuptake inhibitors (SSRIs) would be the first-line treatment given more favorable safety and side-effect profile. The combination of pharmacotherapy and psychotherapy has been shown to be more effective for treating mild-to-moderate MDD than either treatment alone. MAJOR DEPRESSIVE DISORDER (MDD) MDD is marked by episodes of depressed mood associated with loss of interest in daily activities. Patients may not acknowledge their depressed mood or may express vague, somatic complaints (fatigue, headache, abdominal pain, muscle tension, etc.). Diagnosis and DSM-5 Criteria ■ At least one MDE (see above). ■ No history of manic or hypomanic episode. Epidemiology ■ Lifetime prevalence: 12% worldwide. ■ Onset at any age, but the age of onset peaks in the 20s. ■ 1.5-2 times as prevalent in women than men during reproductive years. ■ No ethnic or socioeconomic differences. ■ Lifetime prevalence in the elderly: <10%. ■ Depression can ↑ mortality for patients with other comorbidities such as diabetes, stroke, and cardiovascular disease. Sleep Problems Associated with MDD ■ Multiple awakenings. ■ Initial and terminal insomnia (hard to fall asleep and early morning awakenings). ■ Hypersomnia (excessive sleepiness) is less common. ■ Rapid eye movement (REM) sleep shifted earlier in the night and for a greater duration, with reduced stages 3 and 4 (slow wave) sleep. ■ Caution: Other medical conditions like obstructive sleep apnea (OSA) can cause sleep disturbances with associated changes in energy or mood that can mimic symptoms of depression. Etiology The precise cause of depression is unknown, but MDD is believed to be a heterogeneous disease, with biological, genetic, environmental, and psychosocial factors contributing. ■ MDD is likely caused by neurotransmitter abnormalities in the brain. Evidence for this is the following: antidepressants exert their therapeutic effect by increasing catecholamines; ↓ cerebrospinal fluid (CSF) levels of MOOD DISORDERS KEY FACT Anhedonia is the inability to experience pleasure, and apathy is the inability to feel interested or motivated; both are a common finding in depression. WARDS QUESTION Q: What are the most common psychiatric disorders among those who commit suicide? A: MDD and bipolar I disorder. WARDS TIP The two most common types of sleep disturbances

associated with MDD are difficulty falling asleep and early morning awakenings.

38 MOOD DISORDERS KEY FACT The Hamilton Depression Rating Scale (HAM-D) measures the severity of depression and is used in research to assess the effectiveness of therapies. PHQ-9 is a depression screening form often used in the primary care setting. KEY FACT Loss of a parent before age 11 is associated with the later development of major depression. Course and Prognosis KEY FACT Most adults with depression do not see a mental health professional, but they often first present to a primary care physician for other reasons. Treatment Hospitalization n Antidepressant medications: KEY FACT Unfortunately only half of patients with MDD receive treatment. 5-hydroxyindolacetic acid (5-HIAA), the main metabolite of serotonin, have been found in depressed patients with impulsive and suicidal behavior. ■ Increased sensitivity of beta-adrenergic receptors in the brain has also been postulated in the pathogenesis of MDD. ■ High cortisol: Hyperactivity of hypothalamic-pituitary-adrenal axis, as shown by failure to suppress cortisol levels in the dexamethasone suppression test. ■ Abnormal thyroid axis: Thyroid disorders are associated with depressive symptoms. ■ Gamma-aminobutyric acid (GABA), glutamate, and endogenous opiates may additionally have a role. ■ Psychosocial/Life events: Multiple adverse childhood experiences (ACEs) are a risk factor for later developing MDD. ■ Genetics: First-degree relatives are two to four times more likely to have MDD. Concordance rate for monozygotic twins is <40%, and for dizygotic twins is 10–20%. ■ Untreated, depressive episodes are self-limiting but last from 6 to 12 months. Generally, episodes occur more frequently as the disorder progresses. The risk of a subsequent MDE is 50–60% within the first 2 years after the first episode. Up to 15% of patients with MDD eventually commit suicide. ■ Approximately 60–70% of patients show a significant response to antidepressants. The gold standard for treatment of MDD is the combined use of both an antidepressant and psychotherapy, which produces a significantly ↑ response. n Indicated if the patient is at risk for suicide, homicide, or is unable to care for themselves. Pharmacotherapy • Selective serotonin reuptake inhibitors (SSRIs): Inhibit the reuptake of serotonin, thus increasing the amount of serotonin in the brain. Safer and better tolerated than other classes of antidepressants; side effects are mild but include headache, gastrointestinal disturbance, sexual dysfunction, and rebound anxiety. Examples are fluoxetine (Prozac®), escitalopram (Lexapro®), and sertraline (Zoloft®). • Serotonin-norepinephrine reuptake inhibitors (SNRIs): Inhibit the reuptake of both serotonin and norepinephrine, thus increasing the level of both neurotransmitters in the brain. Includes venlafaxine (Effexor®) and duloxetine (Cymbalta®). • Other antidepressants: Other agents commonly used to treat depression include the α2-adrenergic receptor antagonist mirtazapine (Remeron®), and the dopamine-norepinephrine reuptake inhibitor bupropion (Wellbutrin®). • Tricyclic antidepressants (TCAs): Most lethal in overdose due to cardiac arrhythmias; side effects include sedation, weight gain, orthostatic hypotension, and anticholinergic effects. Can aggravate prolonged QTc syndrome.

• Monoamine oxidase inhibitors (MAOIs): Older medications rarely used for refractory depression; risk of hypertensive crisis when used with sympathomimetics or ingestion of tyramine-rich foods, such as wine, beer, aged cheeses, liver, and smoked meats (tyramine is an intermediate in the conversion of tyrosine to norepinephrine); risk of serotonin syndrome when used in combination with SSRIs. Most common side effect is orthostatic hypotension. • Novel agents: Newer agents acting with unique mechanisms are available such as vilazodone (Viibryd) which has serotonin partial agonism, or vortioxetine (Trintilix) which interacts with additional serotonin receptors. Note: new medications can be prohibitively expensive until the generic form is available n Adjunct

medications: • Atypical (second-generation) antipsychotics along with antidepressants are first-line treatment in patients with MDD with psychotic features. In addition, they may also be prescribed in patients with treatment resistant/ refractory MDD without psychotic features. • Triiodothyronine (T3), levothyroxine (T4), and lithium have demonstrated some benefit when augmenting antidepressants in treatment refractory MDD. • While stimulants (such as methylphenidate) may be used in certain patients (e.g., geriatric and terminally ill patients), the efficacy is limited and trials are small. Psychotherapy n Cognitive-behavioral therapy (CBT), interpersonal psychotherapy, supportive therapy, psychodynamic psychotherapy, problem-solving therapy, and family/couples therapy have all demonstrated benefit in treating MDD. • Among the major kinds of psychotherapy, there is no compelling evidence that one is superior to the rest. The choice is usually based on availability and patient preference. • CBT and interpersonal psychotherapy are often selected as initial treatment because they have been the most widely studied. n May be used alone or in conjunction with pharmacotherapy. n Early dropout is common (as with pharmacotherapy). It is important to track patient adherence over time. Electroconvulsive Therapy (ECT) n Indicated if the patient is unresponsive to pharmacotherapy, if patient cannot tolerate pharmacotherapy (pregnancy, etc.), or if rapid reduction of symptoms is desired (e.g., immediate suicide risk, refusal to eat/drink, catatonia). n ECT is extremely safe (primary risk is from anesthesia) and may be used alone or in combination with pharmacotherapy. n ECT is often performed by premedication with atropine, followed by general anesthesia (e.g., methohexital) and administration of a muscle relaxant (typically succinylcholine). A generalized seizure is then induced by passing a current of electricity across the brain (either bilateral or unilateral); the seizure should last between 30 and 60 seconds, and no longer than 90 seconds. n 6–12 treatments are administered over a 2- to 3-week period, but significant improvement is sometimes noted after the first several treatments. Some MOOD DISORDERS WARDS TIP MAOIs were considered particularly useful in the treatment of “atypical” depression; however, SSRIs remain first-line treatment for MDEs with atypical features. WARDS QUESTION Q: What is the most effective antidepressant medication and how quickly does it work? A: All antidepressant medications are equally effective but differ in side-effect profiles. Medications take 4–6 weeks to reach peak efficacy. WARDS QUESTION Q: What are the hallmark symptoms of serotonin syndrome? A: Autonomic instability, hyperthermia, hyperreflexia (including myoclonus), and seizures. Coma or death may result.

40 MOOD DISORDERS WARDS TIP Adjunctive treatment is usually performed after multiple first-line treatment failures. SPECIFIERS FOR DEPRESSIVE DISORDERS KEY FACT The postpartum period conveys an elevated risk of depression in women. WARDS TIP Triad for seasonal affective disorder: • Irritability • Carbohydrate craving • Hypersomnia BEREAVEMENT KEY FACT Bereavement is NOT a DSM-5 diagnosis—if a patient meets criteria for MDD following the loss of a loved one, the diagnosis would be major depressive disorder. BIPOLAR I DISORDER patients require weekly or monthly maintenance ECT, though there is limited data on the efficacy of this. n Retrograde and anterograde amnesia are common side effects, which usually resolve within 6 months. n Other common but transient side effects: headache, nausea, muscle soreness. ■ Melancholic features: Present in approximately 25–30% of patients with a MDE and more likely in severely ill inpatients, including those with psychotic features. Characterized by anhedonia, early morning awakenings, depression worse in the morning, psychomotor disturbance, excessive guilt, and anorexia. For example, you would list the diagnosis as MDD with melancholic features. ■ Atypical features: Characterized by hypersomnia, hyperphagia, reactive mood, leaden paralysis, and hypersensitivity to interpersonal rejection. ■ Mixed features: Manic/hypomanic symptoms present during the

majority of days during a MDE: elevated mood, grandiosity, talkativeness/pressured speech, flight of ideas/racing thoughts, increased energy/goal-directed activity, excessive involvement in dangerous activities, and decreased need for sleep. ■ Catatonia: Features include catalepsy (immobility), purposeless motor activity, extreme negativism (resistance to instructions), staring, mutism, bizarre postures, and echolalia. Treatment is lorazepam (Ativan) though catatonia is especially responsive to ECT. (May also be applied to bipolar disorder.) ■ Psychotic features: Characterized by the presence of delusions and/or hallucinations. Present in 24–53% of older, hospitalized patients with MDD. ■ Anxious distress: Defined by feeling keyed up/tense, restless, difficulty concentrating, fears of something bad happening, and feelings of loss of control. ■ Peripartum onset: Onset of MDD symptoms occurs during pregnancy or 4 weeks following delivery. ■ Seasonal pattern: Temporal relationship between the onset of a MDE and particular time of the year (most commonly the winter but may occur in any season). Patients with fall-onset SAD (seasonal affective disorder or “winter depression”) often respond to light therapy (a 10,000 lux white light for 30 minutes in the early morning). Bereavement, also known as simple grief, is a normal reaction to a major loss, usually of a loved one, and it is not a mental illness. While symptoms are usually self-limited and only last for several months, if an individual meets criteria for a depressive episode, they would be diagnosed with MDD. Normal bereavement should not include gross psychotic symptoms, disorganization, or active suicidality. Bipolar I disorder involves episodes of mania and of major depression; however, episodes of major depression are not required for the diagnosis. It is also known as manic-depression.

Diagnosis and DSM-5 Criteria The only requirement for this diagnosis is the occurrence of a manic episode (5% of patients experience only manic episodes). Between manic episodes, there may be interspersed euthymia, MDEs, or hypomanic episodes, but none of these are required for the diagnosis. There is usually a return to baseline functioning in between mood episodes.

Epidemiology ■ Lifetime prevalence: 1–2%. ■ Women and men are equally affected. ■ No ethnic differences seen; however, high-income countries have twice the rate of low-income countries (1.4% versus 0.7%). ■ Onset usually before age 30, mean age of first mood episode is 18. ■ Frequently misdiagnosed as unipolar depression and thereby inappropriately or inadequately treated. **Etiology** ■ Biological, environmental, psychosocial, and genetic factors are all important. ■ First-degree relatives of patients with bipolar disorder are 10 times more likely to develop the illness. ■ Concordance rates for monozygotic twins are 40–70%, and rates for dizygotic twins range from 5% to 25%. ■ Bipolar I has the highest genetic link of all major psychiatric disorders. **Course and Prognosis** ■ Untreated manic episodes generally last several months. ■ The course is usually chronic with relapses; as the disease progresses, episodes may occur more frequently. ■ Ninety percent of individuals after one manic episode will have a repeat mood episode within 5 years. ■ Bipolar disorder has a poorer prognosis than MDD: treatment refusal frequently occurs in patients with mania who enjoy their increased creativity and energy, and lack insight into the dangerousness of the illness. ■ Maintenance treatment with mood stabilizing medications between episodes helps to ↓ the risk of relapse. ■ 25–50% of people with bipolar disorder attempt suicide, and 10–15% die by suicide. **Treatment** ■ Pharmacotherapy: ●Lithium remains the gold standard as a mood stabilizer; 50–70% treated with lithium show partial reduction of mania. The mechanism is unclear, but long-term use reduces suicide risk. Acute overdose can be fatal due to its narrow therapeutic index. ●The anticonvulsants carbamazepine and valproic acid are also mood stabilizers. They are particularly useful for rapid cycling bipolar disorder and those with mixed features. ●Atypical antipsychotics (e.g., risperidone, olanzapine, quetiapine, ziprasidone) are

effective as both monotherapy and adjunct therapy for acute mania. In fact, many patients (especially with severe mania and/ MOOD DISORDERS WARDS QUESTION Q: What is the most effective treatment for major depression with psychotic features? A: Combination of an antidepressant and antipsychotic, or ECT. WARDS QUESTION Q: How is bipolar I disorder different from major depressive disorder? A: Bipolar I disorder requires a manic episode. WARDS QUESTION Q: What is the first-line treatment for bipolar disorder? A: Lithium, valproic acid, and - carbamazepine, or second-generation antipsychotics. KEY FACT Side effects of lithium include: • Weight gain • Tremor • Gastrointestinal disturbances • Fatigue • Cardiac arrhythmias • Seizures • Goiter/Hypothyroidism • Leukocytosis (benign) • Coma (in toxic doses) • Polyuria (nephrogenic diabetes insipidus) • Polydipsia • Alopecia • Metallic taste Note: Lithium's toxidrome has a similar presentation though it is more severe.

42 MOOD DISORDERS WARDS TIP The following mood stabilizers require monitoring of blood concentrations to guide dose adjustments. The therapeutic range is simple to remember with the 8 and 12 rule: ■ ECT: Lithium: 0.8-1.2 mEq/L Carbamazepine: 8-12 mcg/mL Valproic acid: 80-120 mcg/mL BIPOLAR II DISORDER KEY FACT ECT is the best treatment for a pregnant woman who is having a manic episode. It provides a good alternative to antipsychotics and can be used with relative safety in all trimesters. Epidemiology ■ May be slightly more common in women. ■ Onset usually before age 30. KEY FACT ■ No ethnic differences seen. A patient with a history of postpartum mania has a high risk of relapse with future deliveries and should be treated with mood stabilizing agents as prophylaxis. However, some of these medications may be contraindicated in breastfeeding. Etiology Same as bipolar I disorder (see above). KEY FACT SPECIFIERS FOR BIPOLAR DISORDERS Rapid cycling is defined by the occurrence of four or more mood episodes (major depressive, hypomanic, or manic) in 1 year. or with psychotic features) are treated with a combination of a mood stabilizer and antipsychotic; studies have shown a greater and faster response with combination therapy. ● Antidepressants are discouraged as monotherapy due to concerns of activating mania or hypomania. They are occasionally used to treat depressive episodes when patients concurrently take mood stabilizers. ■ Psychotherapy: Supportive psychotherapy, family therapy, group therapy (may prolong remission once the acute manic episode has been controlled). ● Works quickly in treatment of manic episodes. ● Some patients require more treatments (up to 20) than for depression. ● Especially effective for refractory or life-threatening acute mania or depression. ● Like lithium, ECT reduces suicide risk. Alternatively thought of as recurrent MDEs with hypomania. Diagnosis and DSM-5 Criteria History of one or more MDEs and at least one hypomanic episode. Remember: If there has been a full manic episode, even in the past, or if the patient ever has a history of psychosis, then the diagnosis is bipolar I, not bipolar II disorder. ■ Prevalence is unclear, with some studies showing greater and others less prevalence than bipolar I. ■ Frequently misdiagnosed as unipolar depression and thereby inappropriately treated. Course and Prognosis Tends to be chronic, requiring long-term treatment. Likely better prognosis than bipolar I given the lack of overt manic episodes. Treatment Fewer studies focus on the treatment for bipolar II. Currently, treatment is the same as bipolar I disorder (see above). ■ Anxious distress: Defined by feeling keyed up/tense, restless, difficulty concentrating, fears of something bad happening, and feelings of loss of control. ■ Mixed features: Depressive symptoms present during the majority of days during mania/hypomania: dysphoria/depressed mood, anhedonia,

psychomotor retardation, fatigue/loss of energy, feelings of worthlessness or inappropriate guilt, thoughts of death or suicidal ideation. ■ Rapid cycling: At least four mood episodes (manic, hypomanic, depressed) within 12 months. ■ Melancholic features (during depressed episode): Characterized by anhedonia, early morning awakenings, depression worse in the morning, psychomotor disturbance, excessive guilt, and anorexia. ■ Atypical features (during depressed episode): Characterized by hypersomnia, hyperphagia, reactive mood, leaden paralysis, and hypersensitivity to interpersonal rejection. ■ Psychotic features: Characterized by the presence of delusions and/or hallucinations. ■ Catatonia: Catalepsy, purposeless motor activity, extreme negativism or mutism, bizarre postures, and echolalia. Especially responsive to ECT. ■ Peripartum onset: Onset of manic or hypomanic symptoms occurs during pregnancy or 4 weeks following delivery. ■ Seasonal pattern: Temporal relationship between onset of mania/ hypomania and particular time of the year. PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA) Patients with persistent depressive disorder (dysthymia) have chronic depression most of the time, and they may have discrete MDEs. Diagnosis and DSM-5 Criteria

1. Depressed mood for the majority of time most days for at least 2 years (in children or adolescents for at least 1 year).
2. At least two of the following: ●Poor concentration or difficulty making decisions. ●Feelings of hopelessness. ●Poor appetite or overeating. ●Insomnia or hypersomnia. | Low energy or fatigue. | Low self-esteem.
3. During the 2-year period: ●The person has not been without the above symptoms for >2 months at a time. ●May have MDE(s) or meet criteria for major depression continuously. ●The patient must never have had a manic or hypomanic episode (this would make the diagnosis bipolar disorder or cyclothymic disorder, respectively). Epidemiology ■ Twelve-month prevalence: 2%. ■ More common in women. ■ Onset often in childhood, adolescence, and early adulthood. Course and Prognosis Early and insidious onset, with a chronic course. Depressive symptoms much less likely to resolve than in MDD. MOOD DISORDERS WARDS TIP Bipolar I disorder may have psychotic features (delusions or hallucinations); these can occur during major depressive or manic episodes, but not in between. Remember to always include bipolar disorder in the differential diagnoses of a psychotic patient. WARDS TIP Schizoaffective disorder is characterized by psychosis with mood symptoms that are only present during psychotic episodes, while major depression with psychotic features is characterized by depression with psychosis only during depressive episodes. Remember this by looking at the word order: schizoaffective is psychosis as the main symptom, and depression with psychotic features has depression as the main symptom. WARDS TIP Persistent Depressive Disorder (DD) = 2 Ds 2 years of depression 2 listed criteria Never asymptomatic for >2 months

44 MOOD DISORDERS Treatment WARDS TIP Symptoms of persistent depressive disorder (dysthymia)—two or more of: CHASES Poor Concentration or difficulty making decisions Feelings of Hopelessness Poor Appetite or overeating InSomnia or hypersomnia Low Energy or fatigue Low Self-esteem CYCLOTHYMIC DISORDER Diagnosis and DSM-5 Criteria WARDS QUESTION Q: What is the difference between bipolar I and bipolar II disorder? A: Bipolar I disorder requires at least one manic episode but not necessarily a MDE, whereas bipolar II disorder requires both a hypomanic episode plus at least one MDE. Epidemiology ■ Lifetime prevalence: <1%. ■ Onset usually between ages 15 and 25. ■ Occurs equally in males and females. PREMENSTRUAL DYSPHORIC

DISORDER Diagnosis and DSM-5 Criteria ■ Combination treatment with psychotherapy and pharmacotherapy is more efficacious than either alone. ■ Cognitive therapy, interpersonal therapy, and insight-oriented psychotherapy are the most effective. ■ Antidepressants found to be beneficial include SSRIs, SNRIs, novel antidepressants (e.g., bupropion, mirtazapine), TCAs, and MAOIs. Alternating periods of hypomania and periods with mild-to-moderate depressive symptoms. ■ Numerous periods with hypomanic symptoms (but not a full hypomanic episode) and periods with depressive symptoms (but not full MDE) for at least 2 years. ■ The person must never have been symptom free for >2 months during those 2 years. ■ No history of MDE, hypomania, or manic episode. ■ May coexist with borderline personality disorder. Course and Prognosis Chronic course; approximately one-third of patients eventually develop bipolar I/II disorder. Treatment Antimanic agents (mood stabilizers or second-generation antipsychotics) are used to treat bipolar disorder (see above). Mood lability, irritability, dysphoria, and anxiety that occur repeatedly during the premenstrual phase of the cycle. ■ In most menstrual cycles, at least five symptoms (below) are present in the final week before menses, improve within a few days after menses, and are minimal/absent in the week postmenses (should be confirmed by daily ratings for at least two menstrual cycles). ■ At least one of the following symptoms is present: affective lability, irritability/anger, depressed mood, anxiety/tension. ■ At least one of the following symptoms is present (for total of at least five symptoms when combined with above): anhedonia, problems concentrating, anergia, appetite changes/food cravings, hypersomnia/insomnia, feeling overwhelmed/out of control, physical symptoms (e.g., breast tenderness/ swelling, joint/muscle pain, bloating, weight gain).

■ Symptoms cause clinically significant distress or impairment in functioning. ■ Symptoms are not only exacerbation of another disorder (e.g., MDD, panic disorder, persistent depressive disorder). ■ Symptoms are not due to a substance (medication or drug) or another medical condition.

Epidemiology/Etiology ■ Prevalence: 1.8%. ■ Onset can occur at any time after menarche. ■ Has been observed worldwide. ■ Environmental and genetic factors contribute. Course and Prognosis Symptoms may worsen prior to menopause but cease after menopause. Treatment SSRIs are first-line treatment, either as daily therapy or luteal phase-only treatment (starting on cycle day 14 and stopping upon menses or shortly thereafter). Oral contraceptives may reduce symptoms.

Gonadotropin-releasing hormone (GnRH) agonists have also been used, and, in rare, severe cases, bilateral oophorectomy with hysterectomy will resolve symptoms. DISRUPTIVE MOOD

DYSREGULATION DISORDER (DMDD) Chronic, severe, persistent irritability occurring in childhood and adolescence. Diagnosis and DSM-5 Criteria ■ Severe recurrent verbal and/or physical outbursts out of proportion to situation. ■ Outbursts ≥ 3 per week and inconsistent with developmental level. ■ Mood between outbursts is persistently angry/irritable most of the day nearly every day, and is observed by others. ■ Symptoms for at least 1 year, and no more than 3 months without symptoms. ■ Symptoms in at least two settings (e.g., home, school, peers). ■ Symptoms must have started before age 10, but diagnosis can be made from ages 6 to 18. ■ No episodes meeting full criteria for manic/hypomanic episode lasting longer than 1 day. ■ Behaviors do not occur during MDD and not better explained by another mental disorder (this disorder cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder). ■ Symptoms not due to a substance (medication or drug) or another medical condition.

Epidemiology/Etiology ■ Prevalence is unclear as this is a newer diagnosis. ■ 6-12-month prevalence rates of chronic/severe persistent irritability in children: 2-5%. ■ Rates likely greater in males than females. MOOD DISORDERS

46 MOOD DISORDERS Course and Prognosis Treatment OTHER DISORDERS OF MOOD IN DSM-5 ■
Unspecified depressive/bipolar disorder. ■ By definition, DMDD must occur prior to 10 years of age.
■ Approximately 50% of those with DMDD continue to meet criteria after 1 year. ■ Rates of
conversion to bipolar disorder are very low. ■ Very high rates of comorbidity, especially with
ADHD, MDD, and substance use disorders. ■ Given the newer nature of this diagnosis, there are no
consensus evidenced-based treatments. Psychotherapy (such as parent management training) for
the patient and family is generally first line. ■ Medications should be used to treat comorbid
disorders. ■ Stimulants, SSRIs, mood stabilizers, and second-generation antipsychotics have all
been used to treat the primary symptoms of DMDD. ■ Mood disorder due to another medical
condition. ■ Substance/Medication-induced mood disorder. ■ Specified depressive/bipolar disorder
(meets criteria for MDE or bipolar except shorter duration or too few symptoms)