

# MOOD DISORDERS

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- Mood disorders = Affective disorders.
- A group of disorders in which **disturbance in mood** is the predominant feature.
- DSM-IV:
  - Depressive disorders e.g. MDD
  - Bipolar disorders e.g. Bipolar I disorder
  - Mood disorder due to a general medical condition
  - Substance-induced mood disorder

# THE STORY OF DEBBIE

- Debbie is 36y-old, she lives with her husband of 12 years, and 2 sons aged 10 and 7. She wakes up at 6am everyday to prepare breakfast for her school going children and husband. When they left the house, she will start to clean the house, do the laundry and cook, in time for her children to come home for lunch. While her children do their school homework, she will go over to her neighbor's house for a light tea, while watching their favourite soap-opera. After an hour or two, Debbie will go home to prepare dinner for her family.

- She likes the evening best as it allows the whole family to get together before retiring about 10pm. She considers herself lucky to have a loving family.
- However, tragedy strikes when her husband is killed in a MVA on a business trip. Debbie is devastated, the whole event following her husband's demise is like a nightmare that she hopes will disappear when she 'wakes up'..... But it does not.
- Relatives and friends are encouraging, telling her to be strong for her children. They are supportive and says time will heal the pain.

- Days become weeks, and weeks become months. Before long, she realises it is the second anniversary of her husband's death. She still feels the pangs of sadness, a **persistent low mood** that lingers since that fateful day. She **cannot cheer up** and has stopped visiting her neighbours. She dislikes the TV and finds the slightest noise **irritates** her. She frequently loses her temper on her youngest son, something she has never done before. She will regret and feel guilty about her action. Each day is a drag and Debbie forces herself to care for the needs of her children. Although she still cooks and does other chores, she appears to take a much longer time to accomplish her work.

- By the time her children come back from school, she has just started cooking and it will be another hour or two before the meal is ready. She **moves so slowly** as if all the energy and zest in life have disappeared. She **tires easily** yet **sleep eludes her**. She tosses and turns in bed until 3 or 4 am before dozing off. She forces herself to wake up at 6 am for her children and will go back to bed until 10 or 11 am. She finds herself sleeping more and more in the afternoon.

- Concerned friends visit Debbie and remark how haggard and **thin** she looks. She finds it **difficult to focus** on conversation with her friends, and they have to repeat what they have just told her. She appears 'lost' in her own thoughts. Debbie cries almost every night when she thinks of her late husband. There are times she feels lonely and so **hopeless**, and wishes she can **sleep forever ...never to wake up.....**





# Depressive Disorders

- Major depressive disorder
- Dysthymic disorder
- Depressive disorder NOS

# What is a Major Depressive Episode?

- The primary disturbance is low mood or anhedonia causing subjective distress and functional impairment.

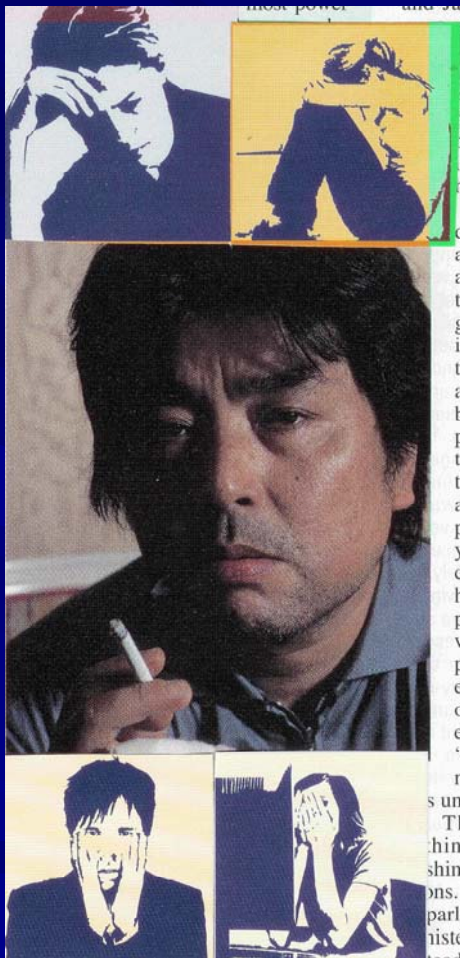
# Clinical Features

- More than 2 weeks of:
  - Depressed mood most of the day, nearly every day.
  - Markedly reduced interest/ pleasure in activities.
  - Appetite change or weight change (5% body weight in a month).
  - Insomnia or hypersomnia.

- Psychomotor retardation/ agitation as observed by others.
- Loss of energy, fatigue.
- Decreased concentration or indecisive.
- Feelings of being worthless, hopeless, excessive or inappropriate guilt.
- Recurrent thoughts of death, suicidal ideation or suicide attempt.

# Everybody feels sad before, but when does it become a Disorder?

- Psychopathology persists almost every day for 2 weeks or more.
- Causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - Not due to direct physiological effect of a Substance or general Medical condition.
  - Not due to Bereavement.

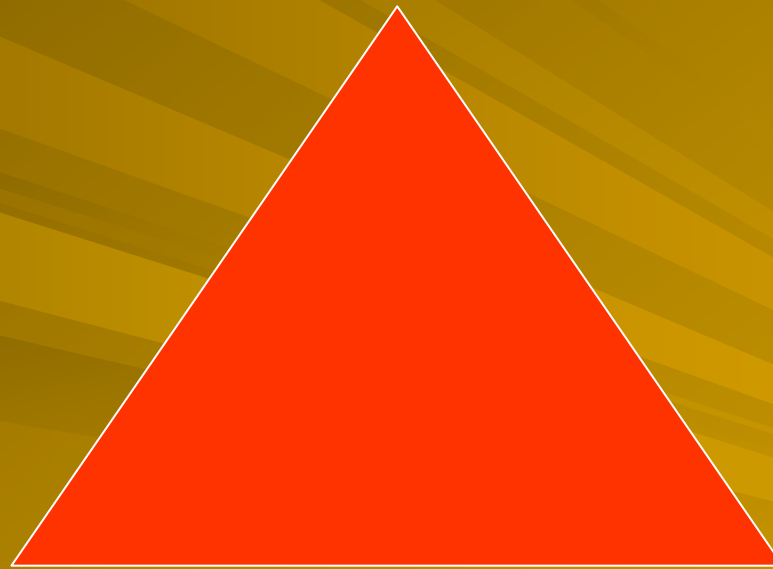


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# ETIOLOGY

Biological



Psychological

Social

# ETIOLOGY

- **Biological etiology:**
  - Changes in neurotransmitter activity e.g. serotonin, noradrenaline.
  - Abnormality in the limbic-hypothalamic-pituitary-adrenal axis.





## ■ Psychological etiology:

- Losses in life e.g. first decade of life.
- Misinterpretation of life events:
  - “I am worthless”
  - “The world is against me”
  - “The future is hopeless”

## ■ Social etiology:

- Observational learning and imitation
- Learned Helplessness
- Poor social and problem-solving skills

# MANAGEMENT

- INVESTIGATE to rule out possible associated medical conditions:
  - Cancers (pancreas)
  - Cardiopulmonary and Renal diseases
  - Infectious diseases (pneumonia, HIV)
  - Neurological diseases (Parkinson's, stroke)
  - Endocrine dysfunction (hypothyroidism)
  - Iatrogenic (drugs: propranolol, steroids, reserpine, methyldopa)

# Treatment:

- Pharmacotherapy: antidepressants
- Physical treatment: ECT
- Psychotherapy

# PHARMACOTHERAPY (medication)

- All antidepressants have almost similar efficacy.
- Mainly differ in their side-effect profiles.
- Mechanism of action:
  - Regulating the amount of neurotransmitter especially serotonin (and noradrenaline).

# Antidepressants

<b>TRICYCLICS</b>	Amitriptylline Clomipramine Dothiepin
<b>SSRIs</b>	Fluoxetine Fluvoxamine Sertraline Citalopram
<b>SNRIs</b>	Venlafaxine
<b>Others</b>	Tianeptine Nefazodone

- Advisable to start at a low dose and titrate in 1-2 weeks. Maintain at (lowest) effective dose.
- Certain drugs may be more rapid in onset.
- It takes 2-4 weeks for clinical improvement.
- **Common side effects:**
  - Sedation
  - GIT symptoms
  - Orthostatic hypotension
  - Weight gain

# Electro-convulsive therapy (ECT)

- A safe procedure where a low frequency electrical stimulus is applied on the scalp to induce seizures for therapeutic purposes.
- Mainly for:
  - Depressive disorders
  - Mania
  - Catatonic schizophrenia
  - NMS where medication is associated with substantial risk of aggravating the condition.



# Psychotherapy

- Studies showed a combination of medication and psychotherapy has better outcome compared with either one alone.
- **Supportive psychotherapy:**
  - Social skill
  - Problem-solving skill etc.
- **Cognitive behavioral therapy.**
- **Psychodynamic psychotherapy**

# When to admit a patient?

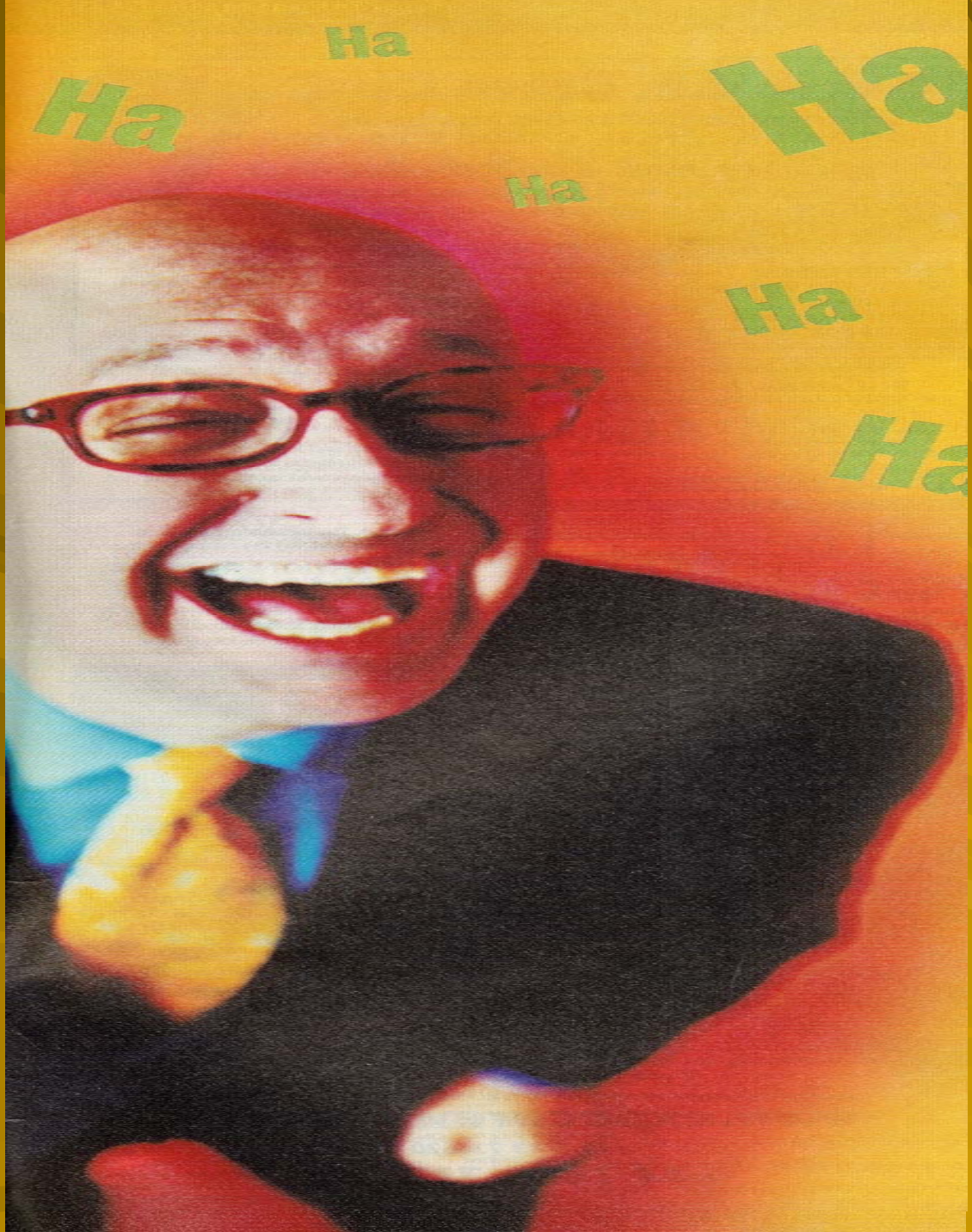
- Patient is severely depressed and has **suicide** thoughts.
- Patient is severely depressed and **neglect** self care (feeding).
- Showing **psychotic** symptoms.
- Sometimes, for respite.

# Course & Prognosis

- Depression may be self-limiting and resolves in 6-12 months.
- However, up to 15% of them may commit suicide.
- Around the world, **SUICIDE** results in more death than accidents and war every year.

# How long to maintain on medication?

- For first episode of major depression, medication should be continued at least **6-9 months after complete symptoms remission**.
- If stopped too early, there is high risk of relapse.
- Nevertheless, studies have shown a number of patients do relapse within 5 years.
- Hence, analysis of **risk-benefit** is advisable before stopping antidepressant.



# The story of Magendran

- Mr. Magendran is the most popular man in his office. He is young, in his mid-20s. Always well-dressed and groomed. He is charismatic and sociable, and all the staff like him very much even though he is a new comer. His work brings him to the East Coast, where he markets 'industrial dye' used in textile. He will lavish the girls in his office with yards and yards of batik scarf and clothes each time he returns from his business trips.

■ Magendran is performing fairly well in his new job until a rival company penetrates his market in the East Coast. He loses his clients who shun his more expensive product. His sales fall and the manager puts pressure on him to meet the sales target. Even though he tries very hard, he still loses his clients and after 6 months he only has 3 left, when it used to be 30. Nevertheless, he remains cheerful and 'care free'. He even starts to sing loudly and clown around in the office to the amusement of others.

■ Magendran appears to be elated and ‘on-top of his world’. One morning, he bursts into the office in an assortment of colorful but mismatched attire, proclaiming, “Maha! Maha! Maharaja”. He points to the nearest girl and shouts, “You! Bow before me, your Raja! Son of Ganesha, son of Shiva”. Then he jumps onto the table, puts on his sunglasses and begins to belt out Hindi songs while doing the ‘bhangra’ dance! He throws his rainbow-colored necktie at the secretary and proceeds to strip his shirt to



■ the horror of the female staff. By then, the commotion has attracted the manager who demanded Magendran to step down. He merely sneers and sings on top of his lungs while jumping from table to table, kicking away the computers and other stationary. The manager phoned for the security guards. Magendran becomes agitated when he sees them and starts to abuse them with vulgar words. He resisted capture by the 2 guards who have no choice but to call for back-up. He is subdued when pin-downed

- by a total of 6 security guards who handed him over to the police. He is later admitted to a psychiatric ward under Form A for suspected 'mental illness'.

# Clinical Features

- Over the next few days, the ward doctor interviewed the patient and found him to have:
  - A period of abnormally and persistently elevated mood of more than 1 week. He is also very irritable.
  - Inflated self-esteem/ grandiosity.
  - Decreased need for sleep.
  - More talkative than usual/ pressured speech.
  - Flight of ideas.

- Distractable.
  - Psychomotor agitation/ increase in goal-directed activity (sexually, socially etc).
  - Excessive involvement in pleasurable activities that have high potential for painful consequences (buying spree, sexual indiscretion etc).
- 
- The symptoms are severe enough to cause impairment in functioning/ hospitalisation/ psychosis.
  - Not due to substance/ general medical condition.

■ The doctor thinks the patient is having a **MANIC EPISODE:**

- A period of abnormally and persistently elevated mood of more than 1 week. He is also very irritable.
- Inflated self-esteem/ grandiosity.
- Decreased need for sleep.
- More talkative than usual/ pressured speech.
- Flight of ideas.
- Distractable.
- Psychomotor agitation/ increase in goal-directed activity (sexually, socially etc).
- Excessive involvement in pleasurable activities that have high potential for painful consequences (buying spree, sexual indiscretion etc).

■ He makes the diagnosis of **BIPOLAR DISORDER.**

# BIPOLAR DISORDERS

## ■ BIPOLAR I DISORDER

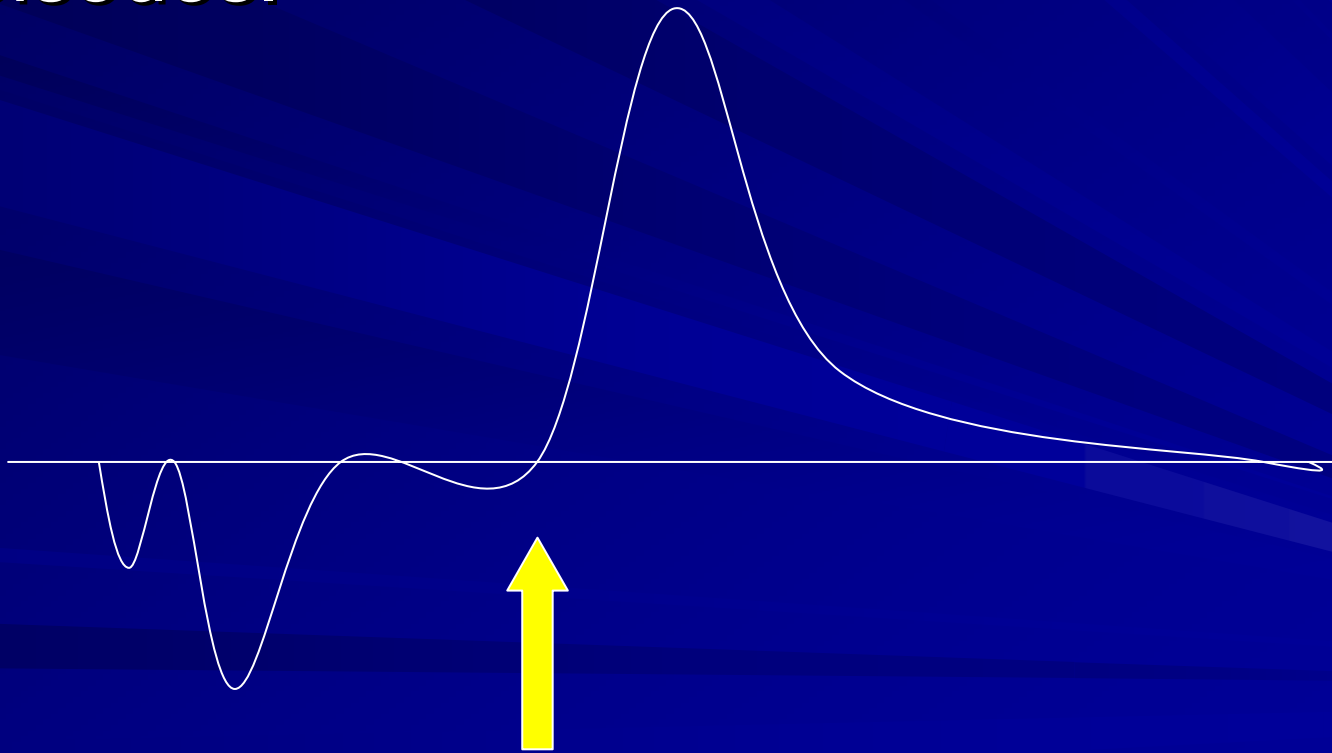
■ Bipolar II Disorder

■ Cyclothymia

■ Bipolar Disorder NOS

# Bipolar I Disorder

- **Manic episodes** + Major depressive episodes.



# Etiology

## ■ Biological etiology:

- Altered neurotransmitter activity in the brain.
- Abnormalities of the limbic-hypothalamic-pituitary-adrenal axis.

## ■ Psycho-social etiology:

- Mania: a defence mechanism against depression.



- In a bipolar disorder, the depressed phase usually comes first, before the manic phase.
- The first manic phase usually occurs before 30 years old.
- Manic episode lasts about 3 months if untreated.
- Important differential diagnosis in practice:
  - Schizophrenia
  - Substance-related disorder
  - Delirium

# Treatment of Bipolar Disorder (manic phase)

## ■ Main pharmacotherapy:

- Lithium

- Mood stabiliser

  - Carbamazepine

  - Sodium valproate

  - Lamotrigine

- If patient is showing prominent psychotic symptoms or too aggressive; addition of ANTIPSYCHOTIC is useful.

## ■ Note of caution:

– When using lithium (and other mood stabiliser);

- Monitor the drug level.
- Assess compliance to treatment.
- Check for over-dose.

## ■ Lithium toxicity $>1.5\text{mmol/L}$

- Nausea, vomiting, tremors, renal failure, ataxia, confusion, coma, death.

THANK

YOU

