Psychiatry 5th year

Chapter 4: Mood Disorders

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- Concepts in Mood Disorders
- Mood Disorders versus Mood Episodes
- Mood Episodes
- Mood Disorders

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.

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 DISORDERS VS 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).

MOOD EPISODES

- Major Depressive Episode (MDE)
- Manic Episode
- Hypomanic Episode
- Differences between Manic and Hypomanic Episodes
- Mixed Features

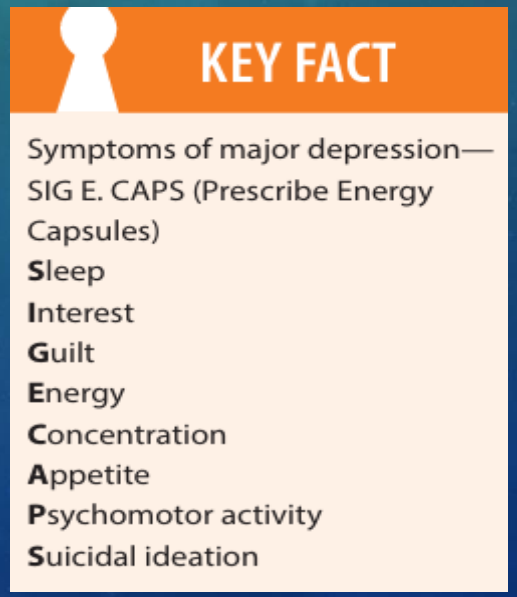
MAJOR DEPRESSIVE EPISODE (MDE)

Must have at least have 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.

- **WARDS TIP:** Major depressive episodes can be present in major depressive disorder, persistent depressive disorder (dysthymia), bipolar I/II disorder, and schizoaffective disorder.



MANIC EPISODE

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):**

1. Distractibility.
2. Inflated self-esteem or grandiosity.
3. ↑ in goal-directed activity (socially, at work, or sexually) or psychomotor agitation.
4. ↓ need for sleep.
5. Flight of ideas or racing thoughts.
6. More talkative than usual or pressured speech (rapid and uninterruptible).
7. 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.

- **WARDS TIP:** A manic episode is a psychiatric emergency; severely impaired judgment and impulsivity can make a patient dangerous to self and others.

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.

- **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

Differences between Manic and Hypomanic Episodes

Mania	Hypomania
Lasts at least 7 days	Lasts at least 4 days
Causes severe impairment in social or occupational functioning	No marked impairment in social or occupational functioning
May necessitate hospitalization to prevent harm to self or others	Does not require hospitalization
May have psychotic features	No 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.

MOOD DISORDERS

1. Differential Diagnosis of Mood Disorders Due to Other Medical Conditions
2. Substance/Medication-Induced Mood Disorders
3. Major Depressive Disorder (MDD)
4. Specifiers for Depressive Disorders
5. Bereavement
6. Bipolar I Disorder
7. Bipolar II Disorder
8. Specifiers for Bipolar Disorders
9. Persistent Depressive Disorder (Dysthymia)
10. Cyclothymic Disorder
11. Premenstrual Dysphoric Disorder
12. Disruptive Mood Dysregulation Disorder (DMDD)
13. Other Disorders of Mood in DSM-5

1) DIFFERENTIAL DIAGNOSIS OF MOOD DISORDERS DUE TO OTHER MEDICAL CONDITIONS

Medical Causes of a Depressive Episode	Medical Causes of a Manic Episode
• Cerebrovascular disease (stroke, myocardial infarction) • Endocrinopathies (diabetes mellitus, Cushing syndrome, Addison disease, hypoglycemia, hyper/hypothyroidism, hyper/hypocalcemia) • Parkinson disease Viral illnesses (e.g., mononucleosis) • Carcinoid syndrome • Cancer (especially lymphoma and pancreatic carcinoma) • Collagen vascular disease (e.g., systemic lupus erythematosus)	• Metabolic (hyperthyroidism) • Neurological disorders (temporal lobe seizures, multiple sclerosis) • Neoplasms HIV infection

2) SUBSTANCE/MEDICATION-INDUCED MOOD DISORDERS

Substance/Medication-Induced Depressive Disorder	Substance/Medication-Induced Bipolar Disorder
• EtOH • Antihypertensives • Barbiturates • Corticosteroids • Levodopa • Sedative-hypnotics • Anticonvulsants • Antipsychotics • Diuretics • Sulfonamides • Opiates • Withdrawal from stimulants (e.g., cocaine, amphetamines)	• 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.

KEY FACT

Depression is common in patients with pancreatic cancer.

3) 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.
- **WARDS TIP:** The two most common types of sleep disturbances associated with MDD are difficulty falling asleep and early morning awakenings.

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 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%.

Course and Prognosis

- 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.**
- Loss of a parent before age 11 is associated with the later development of major depression.
- Most adults with depression do not see a mental health professional, but they often first present to a primary care physician for other reasons.
- Unfortunately, only half of patients with MDD receive treatment.

MDD TREATMENT

1) **Hospitalization:** Indicated if the patient is at risk for suicide, homicide, or is unable to care for themselves.

2) **Pharmacotherapy** → Antidepressant medications -,,,- Adjunct medications.

3) **Psychotherapy**

4) **Electroconvulsive Therapy (ECT)**

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.

PHARMACOTHERAPY: ANTIDEPRESSANT

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 **@2-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 con version of tyrosine to norepinephrine); risk of serotonin syndrome when used in combination with SSRIs. **Most common side effect is orthostatic hypotension.**

WARDS TIP: MAOIs were considered particularly useful in the treatment of "atypical" depression; however, SSRIs remain first-line treatment for MDEs with atypical features.

Q: What are the hallmark symptoms of serotonin syndrome?

A: Autonomic instability, hyperthermia, hyperreflexia (including myoclonus), and seizures. Coma or death may result.

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

PHARMACOTHERAPY: ADJUNCT

- 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
- **WARDS TIP:** Adjunctive treatment is usually performed after multiple first-line treatment failures.

PSYCHOTHERAPY

- 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.
- May be used alone or in conjunction with pharmacotherapy.
- Early dropout is common (as with pharmacotherapy). It is important to track patient adherence over time.

ELECTROCONVULSIVE THERAPY (ECT)

- **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).
- **ECT is extremely safe** (primary risk is from anesthesia) and may be used alone or in combination with pharmacotherapy.
- 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.
- 6–12 treatments are administered over a 2- to 3-week period, but significant improvement is sometimes noted after the #rst several treatments. Somepatients require weekly or monthly maintenance ECT, though there is limited data on the efficacy of this.
- Retrograde and anterograde amnesia are common side effects, which usually resolve within 6 months.
- Other common but transient side effects: headache, nausea, muscle soreness

4) SPECIFIERS FOR DEPRESSIVE DISORDERS

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, fight 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.

- The postpartum period conveys an elevated risk of depression in women.

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).

- **Triad for seasonal affective disorder:** Irritability • Carbohydrate craving • Hypersomnia

5) BEREAVEMENT

- **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.
- 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.

6) BIPOLAR I DISORDER

Bipolar I disorder involves episodes of mania and of major depression; how ever, episodes of major depression are not required for the diagnosis. It is also known as manic-depression.

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.

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.
- Q: How is bipolar I disorder different from major depressive disorder? A: Bipolar I disorder requires a manic episode.

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

1) Pharmacotherapy:

- **Lithium remains the gold standard as a mood stabilizer**; 50–70% treated with lithium show partial reduction of mania. "e 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/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.

2) Psychotherapy: Supportive psychotherapy, family therapy, group therapy (may prolong remission once the acute manic episode has been controlled).

3) ECT:

- 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
- 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.

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:
Lithium: 0.8–1.2 mEq/L
Carbamazapine: 8–12 mcg/mL
Valproic acid: 80–120 mcg/mL

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

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.

7) BIPOLAR II DISORDER

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.)

Epidemiology

- Prevalence is unclear, with some studies showing greater and others less prevalence than bipolar I.
- May be slightly more common in women.
- Onset usually before age 30.
- No ethnic differences seen.
- Frequently misdiagnosed as unipolar depression and thereby inappropriately treated.

Etiology: Same as bipolar I disorder (see above).

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: Currently, treatment is the same as bipolar I disorder

8) SPECIFIERS FOR BIPOLAR DISORDERS

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, 43 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.

Rapid cycling is defined by the occurrence of four or more mood episodes (major depressive, hypo manic, or manic) in 1 year.

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.

9) 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

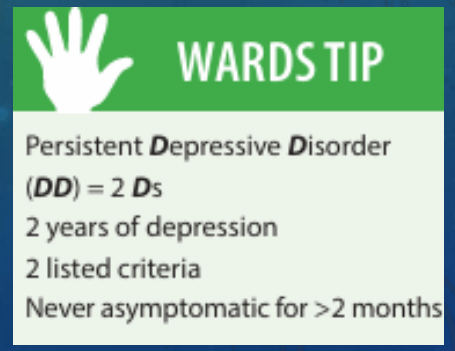
1. Depressed mood for the majority of time most days for at least 2 years (in children or adolescents for at least 1 year).

2. At least two of the following: CHASES

- Poor **c**oncentration or difficulty making decisions.
- Feelings of **h**opelessness.
- Poor **a**ppetite or overeating.
- In**s**omnia or hypersomnia.
- Low **e**nergy or fatigue.
- Low **s**elf-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.

Treatment

- 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.

10) CYCLOTHYMIC DISORDER

Alternating periods of hypomania and periods with mild-to-moderate depressive symptoms.

Diagnosis and DSM-5 Criteria

- 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.

Epidemiology

- Lifetime prevalence: <1%.
- May coexist with borderline personality disorder.
- Onset usually between ages 15 and 25.
- Occurs equally in males and females.

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

11) PREMENSTRUAL DYSPHORIC DISORDER

Mood lability, irritability, dysphoria, and anxiety that occur repeatedly during the premenstrual phase of the cycle.

Diagnosis and DSM-5 Criteria

- 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 post-menses (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.
- Rare, severe cases, bilateral oophorectomy with hysterectomy will resolve symptoms.

12) 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.

Course and Prognosis

- 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.

Treatment

- 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 #rst 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.

13) OTHER DISORDERS OF MOOD IN DSM-5

- 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)
- Unspecified depressive/bipolar disorder

Thank You