Mood disorders include depressive episodes, bipolar and mood disorder and persistent mood disorders. In these disorders the main characterising feature is disturbance of mood that is not secondary to any organic cause, psychoactive substance use or any other psychiatric disorder such as schizophrenia or schizoaffective disorder. Depressive disorders alone are reported to have a prevalence of 5-10% in primary care settings. Although effective treatments are available, depression often goes undiagnosed and untreated. This chapter provides an overview of depression and other mood disorders to enable practitioners in the primary care settings to identify patients suffering with mood disorders. The chapter discusses the nosology of mood disorders along with the clinical features and etiology of each of the mood disorders. There is detailed description of differential diagnosis and the cultural variations in the symptom manifestation for this group of disorders. The chapter also discusses the current empirically based treatment modalities available for the mood disorders.

INTRODUCTION

Mood disorders get their name from the fact that their main feature is abnormality of mood. According to the ICD-10, the mood disorders are classified as follows:

- Depressive episode
- Manic episode
- Bipolar Affective Disorder
- Recurrent Depressive Disorder
- Persistent Mood Disorder (including dysthymia and Cyclothymia)
- Other mood disorders (including mixed affective episode and recurrent brief depressive disorder)

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CLINICAL FEATURES

In this section we will discuss the clinical features for all the mood disorders.

Depressive Episode

A typical depressive episode is characterised by the following features lasting for a minimum of two weeks:

- **Depressed Mood** — the most important feature of depressive episode is the sadness of mood. This mood does not improve substantially in circumstances where ordinary feelings of sadness would generally alleviate, for example after hearing good news. There is a loss of interest and/or pleasure in almost all activities (pervasive sadness). The loss of interest in daily activities results in social withdrawal, decreased ability to function in occupational and interpersonal areas and decreased involvement in previously pleasurable activities.

- **Depressive Cognition** — Negative thoughts (‘depressive cognitions’) are important symptoms which can be divided into three groups namely worthlessness, helplessness and hopelessness. In feeling worthless, the patient thinks that he is failing in everything that he does and that other people see him as a failure; he no longer feels confident, and discounts any success as a chance happening for which he can take no credit. Pessimistic thoughts concerning future prospects are termed as hopelessness. The patient expects the worst. He foresees failure in his work, the ruin of his finances, misfortune for his family, and an inevitable deterioration in his health. These ideas of hopelessness are often accompanied by the thought that life is no longer worth living may progress to thoughts of, and plans for, suicide. It is important to ask about these ideas in every patient. Feelings of guilt often take the form of unreasonable self-blame about minor matters.

- **Goal-directed behaviour** — Lack of interest and enjoyment, known as anhedonia is frequent though not always complained of spontaneously. The patient shows no enthusiasm for activities and hobbies that he would normally enjoy. He feels no zest for living and no pleasure in everyday things. He often withdraws from social encounters. Reduced energy is characteristic. The patient feels lethargic, finds everything an effort, and leaves tasks unfinished.

- **Psychomotor Changes** — Psychomotor retardation is frequent (though, as described later, some patients are agitated rather than slowed up). In more severe depression, the retarded patient walks and acts slowly. Slowing of thought is reflected in the patient’s speech; there is a long delay before questions are answered, and pauses in conversation may be so long that they would be intolerable to a non-depressed person. Agitation is a state of restlessness that is experienced by the patient as inability to relax and is seen by an observer as restless activity. In younger patients (less than 40 years of age), retardation is more common and is characterised by slowed thinking and activity, decreased energy and monotonous voice. In severe form, the patient can become stuporous. In older patients, agitation is more common. It often persists with marked anxiety, restlessness.

- **Biological symptoms** — Disturbance of biological functions is common and includes sleep disturbance, diurnal variation of mood, loss of appetite, loss of weight and amenorrhoea. These symptoms are particularly common in the elderly depressives and severe depression.
Understanding Mood Disorders

and may also be reported moderate depression. Sleep disturbance in depressive disorders is of several kinds. Most characteristic is early morning awakening, but delay in falling asleep and waking during the night. Early morning waking occurs 2 or 3 hours before the patient’s usual time; he does not fall asleep again, but lies awaken, feeling unrefreshed. Weight loss along with decreased appetite is also reported in depressive disorders excess. Other physical complaints in depressive disorders complaints of fatigue, and aching discomfort anywhere in the body. Complaints about any pre-existing physical disorder usually increase and hypochondriacal preoccupations are common.

• **Other Psychiatric features** — Several other psychiatric symptoms may occur as part of a depressive disorder, and occasionally one of them dominates the clinical picture. They include depersonalization, obsessional symptoms, panic attacks, and dissociative symptoms such as fugue or loss of function of a limb. Complaints of poor memory are also common; depressed patients commonly show deficits on a wide range of neuropsychological tasks, but impairments in the retrieval and recognition of recently learned material may be particularly prominent. About 15-20% of depressed patients have psychotic symptoms like delusions, hallucinations, grossly inappropriate behaviour or stupor. The psychotic features can be either mood congruent (which are understandable in light of depressed mood) or mood incongruent (which are not directly related to depressive mood).

**Mania**

The central features of mania include elevation of mood, increased activity and self important ideas. A manic episode is typically characterised by the following features (symptom should be present for a minimum duration of one week):

• **Elevated/ Expansive/ Irritable Mood** — The patient seems cheerful and optimistic; some patients might be irritable rather than elated and this irritability may turn into anger.

• **Psychomotor Activity** — There is an increase in the patient’s psychomotor activity, which may range from overactivity and restlessness to manic excitement. The activity is usually goal directed and is influenced by external stimuli.

• **Speech and Thought** — Speech of manic patients is often rapid and copious as thoughts crowd into their minds in quick succession. When the disorder is more severe, there is flight of ideas and it is difficult to follow the train of thought. Expansive ideas are common. Patients believe that their ideas are original, their opinions important, and their work of outstanding quality. Many patients become extravagant, spending more than they can afford. Sometimes there are grandiose delusions and the patient may believe that they are religious prophets or has some super natural powers. At times, there are delusions of persecution also and the patient starts believing that people are conspiring against him because of his special importance.

• **Other psychiatric features** — Sleep is usually reduced with a decreased need for sleep. Appetite is usually increased in the initial phase but later it may decrease due to marked over activity. Insight into the illness is usually absent. Psychotic features are usually present and include delusions and hallucinations.
Bipolar Mood (or Affective) Disorder

This disorder is characterised by recurrent episodes of mania episode and depression in the same patient at different times. These episodes can occur in any sequence. Bipolar mood disorder is further classified into bipolar I (episodes of mania and depression) and bipolar II disorders (episodes of hypomania and depression).

Recurrent Depressive Disorder

This disorder is characterised by recurrent (at least two) depressive episodes. The current episode in recurrent depressive disorder is specified as mild/moderate/severe without psychotic symptoms/severe with psychotic symptoms, or in remission.

Persistent Mood Disorders

As per ICD 10, persistent mood disorders are characterised by persistent mood symptoms which last for more than 2 years (1 year in children and in adolescents) but are not severe enough to be labelled as even hypomanic or mild depressive episode. If the symptoms consist of persistent mild depression, the disorder is called as dysthymia; and if symptoms consist of persistent instability of mood between mild depression and mild elation, the disorder is called as cyclothymia (Akiskal, 2000).

Seasonal Affective Disorder

The seasonality of a depressive disorder can also be specified. To diagnose a seasonal mood disorder, a regular temporal relationship should exist between the depression and a particular time of year. An individual should demonstrate at least 2 episodes of depressive disturbance in the previous 2 years, and seasonal episodes should substantially outnumber non-seasonal episodes. Patients with seasonal affective disorder are more likely to report atypical symptoms such as hypersomnia and increased appetite.

Mixed Affective Episode

Depressive and manic symptoms sometimes occur at the same time. Patients who are overactive and overtalkative may be having profoundly depressive thoughts. In other patients, mania and depression follow each other in a sequence of rapid changes; for example, a manic patient may become intensely depressed for a few hours and then return quickly to his manic state.

PROCEED TO CLINICAL PRESENTATION

Etiology

Table 1 below outlines the proposed etiological factors for various mood disorders (Gelder et al. 2005).

<table>
<thead>
<tr>
<th>Genetics</th>
<th>High concordance rates between monozygotic and dizygotic twins. Linkage of chromosome 4,12,18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biochemical</td>
<td>Involvement of monoamine and serotonin system. Acetylcholine and GABA system involved</td>
</tr>
</tbody>
</table>

*table 1 contd...*
table 1 contd...

<table>
<thead>
<tr>
<th>Psychoanalytical Theories</th>
<th>Depression- Loss of libidinal object, introjection of the lost object, fixation in the oral sadistic phase of development, intense craving for narcissism or self love. Mania- reaction formation to depression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Various stressful life events</td>
</tr>
<tr>
<td>Cognitive Behavioural Theories</td>
<td>Caused due to depressive cognitions, learned helplessness.</td>
</tr>
</tbody>
</table>
An organic brain lesion should always be considered especially in middle-aged or older patients with expansive behaviour and no past history of affective disorder. In the absence of gross mood disorder, extreme social disinhibition (for example urinating in public) strongly suggests frontal lobe involvement. In such cases appropriate neurological investigation is essential. In younger adults, infection with HIV or head injury may lead to the manifestation of mania. The distinction between mania and excited behaviour due to drug misuse depends on the history and an examination of the urine for drugs before treatment with psychotropic drugs is stated. Drugs induced states usually subside quickly with treatment (Angst, 2000).

**CULTURAL INFLUENCES ON EXPRESSION OF MOOD DISORDERS**

Cultural influences on the presentation of depression can be significant. The practitioner should be aware of differences in the expression of psychological distress in patients from other countries or cultures. Some cultural patterns are mentioned in the *DSM-IV-TR*; for example, major depressive disorder may be expressed as fatigue, imbalance, or neurasthenia in patients of Asian origin. Culturally distinctive experiences (e.g., fear of being bewitched, experience of visitations from the dead) should be distinguished from actual hallucinations or delusions that may be part of a major depressive episode with psychotic features.

**Psychoeducation**

Education plays an important role in the successful treatment of major depressive disorder. Over the long term, patients may also become aware of signs of relapse and may seek treatment early. Patients should be aware of the rationale behind the choice of treatment, potential adverse effects, and expected results. The involvement of the patient in the treatment plan can enhance medication compliance and referral to counseling.

Family members also need education themselves about the nature of depression and may benefit from supportive interactions. Engaging family can be a critical component of a treatment plan, especially for pediatric and late-onset depression. Family members are helpful informants, can ensure medication compliance, and can encourage patients to change behaviours that perpetuate depression (e.g., inactivity).

**Pharmacotherapy**

Antidepressants are the treatment of choice for depressive episodes. Antipsychotic drugs act rapidly and are the mainstay of the treatment of acute mania. Mood stabilizers are used in the prophylaxis of mania and bipolar disorder. In very rare cases electroconvulsive therapy may have to be used (Semple et al. 2005). If the patient is having self neglect, very low food/liquid intake he/she may have to be hospitalized.

**Psychotherapy**

Psychodynamic psychotherapy, interpersonal therapy, cognitive-behavioural therapy, behaviour therapy, family therapy, supportive psychotherapy, and group psychotherapy have all been used for the treatment of mood disorders. In mild cases, psychosocial interventions are often recommended as first-line treatments. The APA guideline supports this approach, but notes that combining
psychotherapy with antidepressant medication may be more appropriate for patients with moderate to severe major depressive disorder.

Several factors appear to be related to the response to psychotherapy, including age at the onset of depression, severity of depression, presence of comorbid psychiatric disorders (e.g., anxiety, dysthymia, substance abuse), lack of support, parental psychopathology, family conflict, exposure to stressful life events, socioeconomic status, quality of treatment, therapist’s expertise, and motivation of both patient and therapist. A combination of the particular elements of cognitive-behavioural therapy, interpersonal therapy, psychodynamic psychotherapy, and other psychotherapies may be brought together in the best interests of the patient.

Cognitive-behavioural therapy (CBT) is first-line treatment for depression that is directed and time limited, usually involving between 10 and 20 treatments. CBT was specifically designed to treat depression, and its use in treating major depressive disorder is based on the premise that patients who are depressed have a distorted view of themselves, the world, and the future. These cognitive distortions contribute to their depression and can be identified and counteracted with CBT.

Many clinicians find psychodynamic psychotherapy to be useful in the treatment of depression in youths. Psychodynamic psychotherapy can help youths understand themselves, identify feelings, improve self-esteem, change maladaptive patterns of behaviour, interact more effectively with others, and cope with ongoing and past conflicts. However, although controlled studies using psychodynamic psychotherapy for the treatment of depression in children and adolescents are greatly needed, these studies are also particularly difficult to design and expensive to conduct.

Interpersonal therapy focuses on problem areas of grief, interpersonal roles, disputes, role transitions, and interpersonal difficulties. Mufson and Fairbanks found that interpersonal therapy may be useful in the acute treatment of adolescents with major depressive disorder, and that the rate of relapse is relatively low after acute interpersonal therapy treatment.

REFERENCES


