Affective Disorders

http://www.bristol.ac.uk/medical-school/hippocrates/psychethics/
Affective Disorders

- Depression
- Mania / Hypomania
- Bipolar mood disorder
- Recurrent depression
- Persistent mood disorders
- Others
Depression

Epidemiology:
- Lifetime prevalence: 10-20%
- Mean age of onset: 27
- M:F – 1:2
- 4th leading cause of disease burden
- Co-morbid with anxiety and substance abuse
Depression

Aetiology:

- Genetics
- Neurological
  - low 5HT/tryptophan
  - low DA metab. (HVA)
  - low NA
  - HPA axis - high cortisol
Schematic of a neural model of depression

Dominance of limbic activity in the reciprocal relation between the dorsal cortex, which includes the dorsolateral prefrontal cortex (DLPFC); and the limbic system, which includes the amygdala, hippocampus, insula, and parts of the anterior cingulate cortex (ACC).
Depression

Aetiology:

- Psychological – negative beliefs
- Environment - parental deprivation
  - relationship with parents
    - life events
    - poverty
- Personality - Obsessive-compulsive; Histrionic
Aetiology:

- **Physical** - Chronic pain, Hypothyroidism, Multiple sclerosis, Parkinson's disease, stroke, hyperparathyroidism, Cushings syndrome.

- **Medications** - Antihypertensives, steroids, sedatives, chemotherapy agents, antipsychotics

- **Life events**
Depression

Clinical features:

ICD-10

- A: depressed mood
  - loss of interest
  - decreased activity

- B: reduced concentration
  - reduced self-esteem and confidence
  - guilt
  - self-harm thoughts
  - disturbed sleep
  - reduced appetite
  - pessimistic thoughts
Severity:

- Mild
- Moderate
- Severe
- Psychotic symptoms - delusions
  - hallucinations
Differential diagnosis

- Physical causes
- Adjustment disorder
- Normal sadness
- Bereavement
- Dementia
- Substance misuse
- Postnatal depression/Puerperal illness
Depression

Course & prognosis:
- Average length of episode: 6 months
- 80% have further episodes
- Recurrence: 25% in 6 months
  - 30-50% in 2 years
- Prognosis: - psychotic symptoms
  - alcohol use
  - early onset
  - social support
  - age
Treatment of depression

- Antidepressant drugs-
  - SSRI s
  - SNRI, NaSSa, NARI,
  - Tricyclic antidepressants
  - MAOIs

Lithium augmentation

ECT

Antipsychotics in severe depression with psychosis
Treatment

- Psychotherapy
  - Cognitive (CBT)
  - Interpersonal
  - Psychodynamic
  - Cognitive analytical therapy
  - Mindfulness based therapy
  - Family therapy
Mild depression
- Low-intensity psychosocial interventions
  - individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
  - computerised CBT (CCBT)1
  - a structured group physical activity programme.
- Drug treatment
  Do not use antidepressants routinely to treat persistent sub threshold depressive symptoms
Moderate or severe depression
Combination of antidepressant medication and a high-intensity psychological intervention (CBT or interpersonal therapy [IPT]).

Continuation and relapse prevention
Continue medication for at least 6 months after remission of an episode of depression.

Psychological interventions for relapse prevention
– individual CBT
– mindfulness-based cognitive therapy
Bipolar mood disorder

Bipolar affective disorder – Type 1
Type 2
Rapid cycling BPAD
Bipolar mood disorder

- Life-time prevalence: 1%
- M:F – 1:1
- Mean age of onset: 21
Aetiology

- Genetics
- Neurochemical abnormalities
- Life events
- Environmental factors
- Organic causes
Mania

Clinical features:

A: Pervasive elated / expansive / irritable mood

B: inflated self-esteem / grandiosity
   - racing thoughts
   - more talkative
   - decreased need for sleep
   - distractibility
   - psychomotor agitation
   - excessive involvement in pleasurable activities
Mania / Hypomania

Mania:
- Social & Occupational functioning - impaired
- Psychotic symptoms - present
- Hospitalization - required
Other mood disorders

- Rapid cycling
- Seasonal affective disorder
- Post-partum depression
- Atypical depression
- Mixed affective episode
Differential diagnosis

- Organic causes
- Schizoaffective disorders
- Cyclothymia
- Puerperal disorders
Treatment of Mania/Bipolar disorder

- Antipsychotic drugs (Olanzapine / Risperidone / Haloperidol)
- Benzodiazepines – short term
- Mood stabilizers:
  - Lithium, Carbamazepine, Valproate, Lamotrigine
NICE- Managing episodes of mania and hypomania

- Stop antidepressant (if taking)
- Taking into account side effects and future prophylaxis:
  - an antipsychotic (normally olanzapine, quetiapine or risperidone), especially if symptoms are severe or behaviour disturbed
  - valproate if symptoms have responded before (but avoid in women of childbearing potential)
  - lithium if symptoms have responded before, and are not severe

- Short-term benzodiazepine (such as lorazepam*) for behavioural disturbance or agitation
NICE - Managing depressive symptoms

- Not taking antimanic medication – Patients who are prescribed an antidepressant should also be prescribed an antimanic drug.

- Taking antimanic medication
  Appropriate dose and adjust it if necessary.

- Mild depressive symptoms
  Arrange a further assessment, normally within 2 weeks,
  If symptoms do not improve, follow the advice for moderate or severe depression.

- Moderate or severe depressive symptoms
  Consider:
  - prescribing an SSRI (but not paroxetine in pregnant women), or
  - adding quetiapine, if the patient is already taking an antimanic drug that is not an antipsychotic.
  - if there is no significant improvement after an adequate trial of drugs, consider a structured psychological therapy focused on depressive symptoms, problem solving, improving social functioning, and medication concordance
ECT - only for rapid and short-term improvement of severe symptoms after other treatments have proved ineffective or if the condition is life-threatening, in people with:

– severe depressive illness
– a prolonged or severe manic episode.
– catatonia.
Long-term treatment for bipolar disorder – Consider if

- A manic episode involving significant risk and adverse consequences
- Bipolar I disorder has had two or more acute episodes
- Bipolar II disorder has significant functional impairment, is at significant risk of
- Suicide or has frequent episodes.

Choice of drug- lithium, olanzapine or valproate
Psychological treatments - CBT, IPT
Psycho education
Social interventions –support groups
Healthy lifestyle
Relapse prevention
Prognosis

- Average episode length – 4 months
- 1st manic episode – 90% further manic and depressive episodes
- Poor prognosis in rapid cycling
- 10% commit suicide, rate of attempted suicide higher.
References

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