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

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)

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.

Clinical features:

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

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

**NICE GUIDELINES**

**Mild depression**
- Low-intensity psychosocial interventions
  - Individual guided self-help based on the principles of cognitive behavioural therapy (CBT)
  - Computerised CBT (CCBT)
- A structured group physical activity programme.

**Drug treatment**
- Do not use antidepressants routinely to treat persistent sub threshold depressive symptoms

**NICE GUIDELINES**

**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

**Actiology**

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

**Bipolar mood disorder**

- Life-time prevalence: 1%
- M:F – 1:1
- Mean age of onset: 21
**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 if 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.

**NICE GUIDELINES**

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.

**NICE GUIDELINES**

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

**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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