



Mood (Affective) Disorders

September 12th 2022 Marie Zipser

sanatoriumKILCHBERG
PRIVATKLINIK FÜR PSYCHIATRIE
UND PSYCHOTHERAPIE

Affective Disorders – Mood Disorders

Clinical presentation

Diagnosis

Epidemiology

Prevention

Treatment

Suicidal ideation and suicide prevention

Differential diagnosis

Comorbidities

Affective Disorders – Mood Disorders

Clinical presentation

Diagnosis

Epidemiology

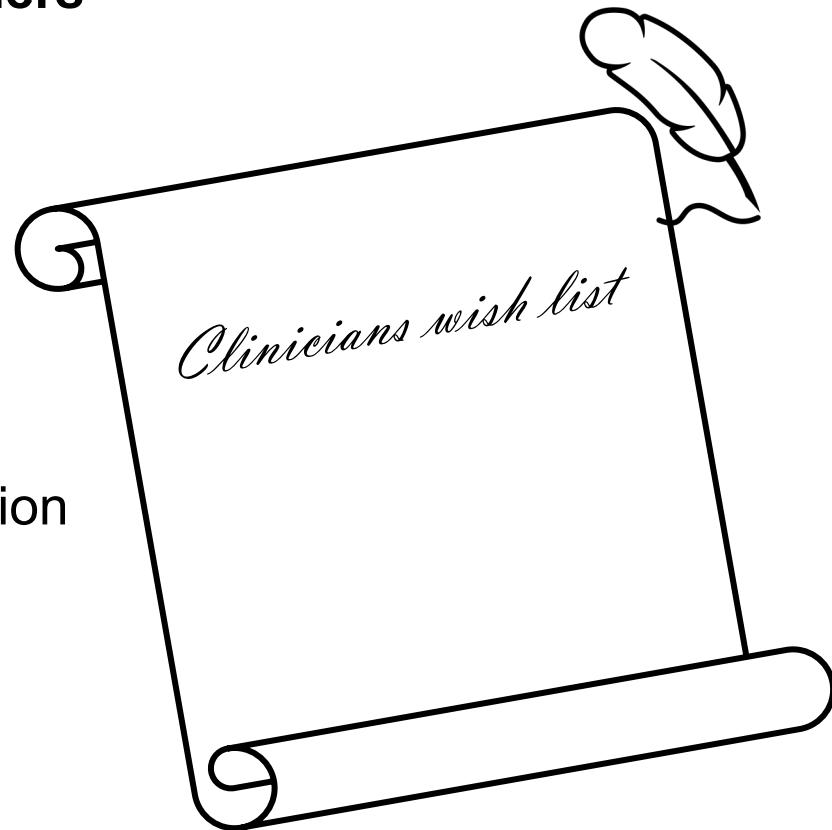
Prevention

Treatment

Suicidal ideation and suicide prevention

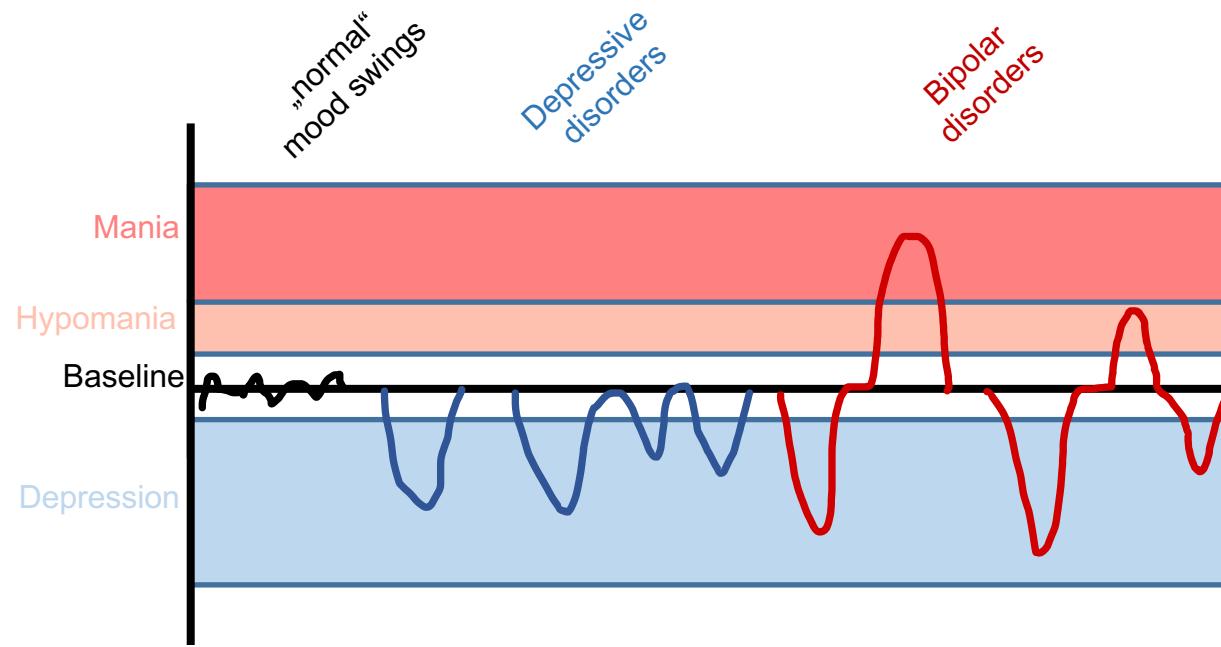
Differential diagnosis

Comorbidities



Mood Disorders

Depressive disorders – Bipolar and related disorders

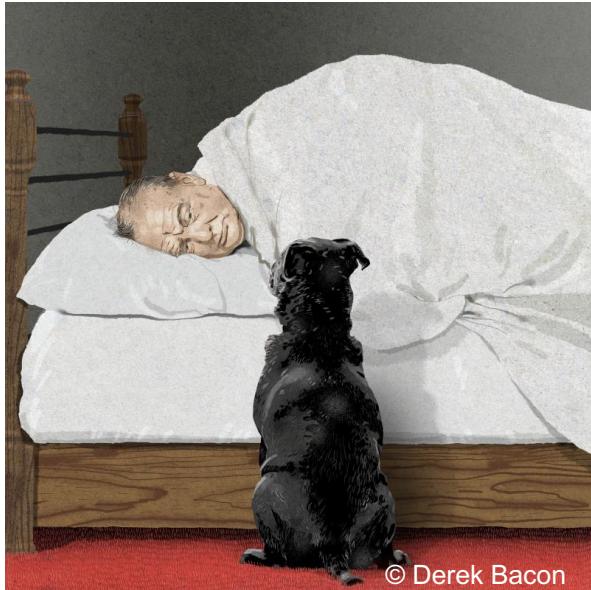


Depression – Clinical Presentation



Winston Churchill

Depression – Clinical Presentation



5 Common Myths about Depression

1. Depression is something rare and unusual
2. Depression is just a kind of sadness
3. Depressed people are not high achievers
4. Depression is a rich-world problem
5. Depression is hopeless

Depression – Common Myths

1. Depression is something rare and unusual

Depression – Common Myths

1. ~~Depression is something rare and unusual~~

- Over 300 million people worldwide suffer from depression – 5% of the global population, comparable to the US population of 320 million.
- Some 10-15% of new mothers suffer from post-partum depression.

Depression – Common Myths

2. Depression is just a kind of sadness

Depression – Common Myths

2. ~~Depression is just a kind of sadness~~



J.K. Rowling

“Depression is the most unpleasant thing I have ever experienced...

It is that absence of being able to envisage
that you will ever be cheerful again.

The absence of hope.

That very deadened feeling, which is so very different from feeling sad.

Sad hurts but it's a healthy feeling. It is a necessary thing to feel.

Depression is very different.“

Depression – Common Myths

3. Depressed people are not high achievers

Depression – Common Myths

3. ~~Depressed people are not high achievers~~



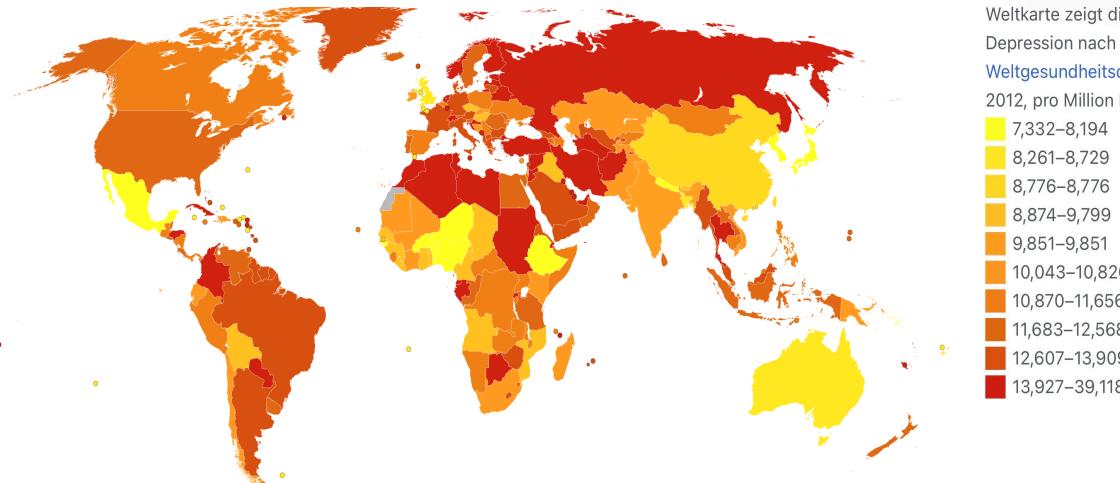
Depression – Common Myths

4. Depression is a rich-world problem

Depression – Common Myths

4. ~~Depression is a rich world problem~~

- It's universal, affecting rich and poor countries alike
- What varies around the world is your chance of being diagnosed and treated



Depression – Common Myths

5. Depression is hopeless

Depression – Common Myths

5. ~~Depression is hopeless~~

- It may be more complicated than healing a broken leg, but there is a range of treatments for depression

„My black dog seems quite away
from me now – it is such a relief.
All the colours come back
into the picture.“



© Derek Bacon

Depression – Common Myths

5. ~~Depression is hopeless~~

- It may be more complicated than healing a broken leg, but there is a range of treatments for depression

„My black dog seems quite away
from me now – it is such a relief.
All the colours come back
into the picture.“



Depression – Epidemiology and Pathogenesis

- 5% of adults suffer from depression, 300 million people (WHO Institute of Health Metrics and Evaluation. Global Health Data Exchange)
- Life time prevalence 16-20% (Ebmeier 2006, Bijl 1998)
- ♀ : ♂ = 2 : 1 (Jacobi 2014)
- Pathogenesis unclear
 - Genetic (50% increased risk with first grade family)
 - environmental
 - psychological

Depression – Prognosis

- 50-85% recurrent depression (Kempermann 2008)
- Serious health condition especially when severe and recurrent
- Risk to commit suicide
 - USA 3.4% (7% for men and 1% for women (Blair-West, 2001)
although suicide attempts are more frequent in women)
- Depressed people have a higher risk of dying from other causes (Rush 2007)

Depression – Diagnosis



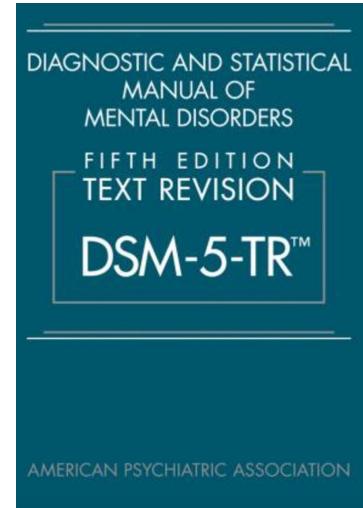
Depression – Diagnosis



Depression – Diagnosis

IT'S ONLY WORDS (BEE GEES)

DSM-5 (American Psychiatric Association)



ICD-11
(WHO 02/2022)

Old „Affective Disorders“ from ICD-10
New „Mood Disorders“

ICD-11 for Mortality and Morbidity Statistics (Version : 02/2022)

Search depression [Advanced Search] | Browse | Coding Tool | Special Views | Info

Foundation URI : <http://id.who.int/icd/entity/76398729>

Mood disorders

Parent
06 Mental, behavioural or neurodevelopmental disorders

Description
Mood Disorders refers to a superordinate grouping of Bipolar and Depressive Disorders. Mood disorders are defined according to particular types of mood episodes and their pattern over time. The primary types of mood episodes are Depressive episode, Manic episode, Mixed episode, and Hypomanic episode. Mood episodes are not independently diagnosable entities, and therefore do not have their own diagnostic codes. Rather, mood episodes make up the primary components of most of the Depressive and Bipolar Disorders.

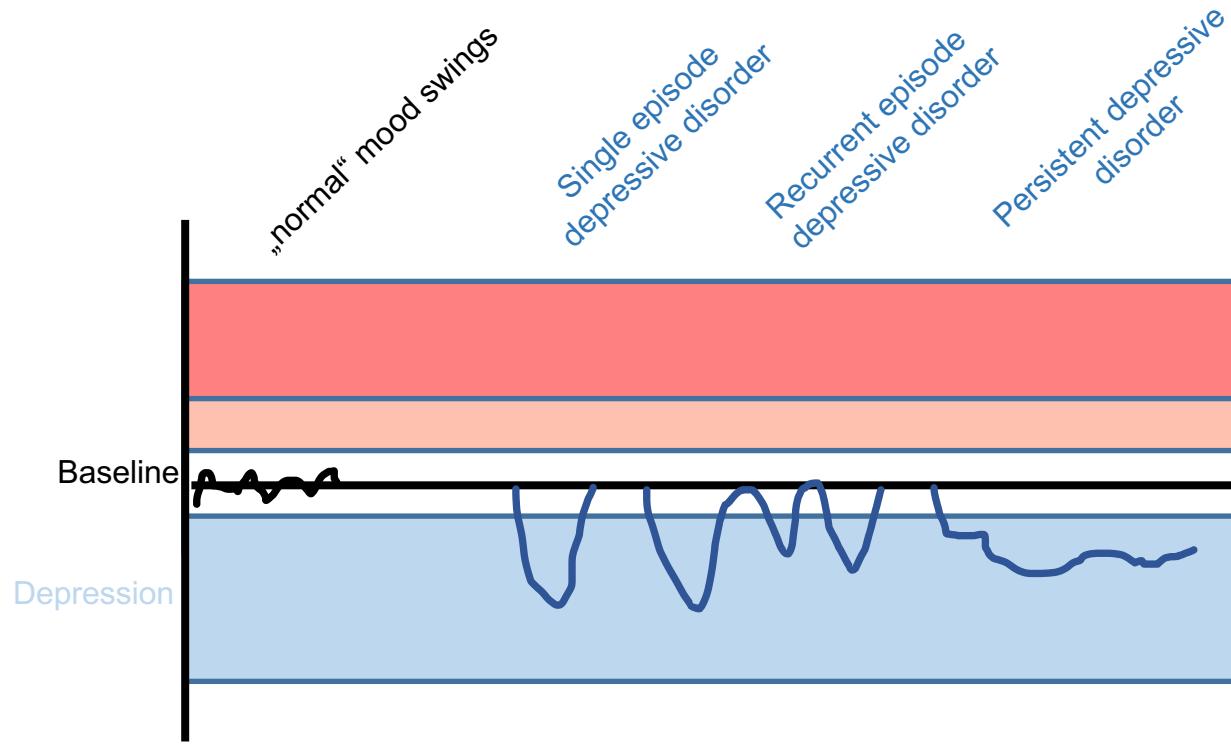
Coded Elsewhere

- Substance-induced mood disorders (0)
- Secondary mood syndrome (6E62)

Diagnostic Requirements

Mood Disorders refers to a superordinate grouping of Depressive Disorders and Bipolar Disorders. Mood disorders are defined according to particular types of Mood Episodes and their pattern over time. The primary types of Mood Episodes are

Depressive Disorders – Diagnosis DSM-5



Major Depressive Episode – Diagnosis DSM-5

A: Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood
- Markedly diminished interest or pleasure
- Weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation



Major Depressive Episode – Diagnosis DSM-5

- B: The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C: The episode is not attributable to the physiological effects of a substance or another medical condition.
- D: At least one major depressive episode is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophasic disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E: There has never been a manic episode or a hypomanic episode.

Depression

Identify biomarkers of depression

Depression – Prevention

Effective prevention rests on accurate prediction

Depression – Prevention

Effective prevention rests on accurate prediction

Who is at risk of developing depression?

Depression – Prevention

Effectiveness of an online insomnia program (SHUTi) for prevention of depressive episodes (the GoodNight Study): a randomised controlled trial

Helen Christensen et. al, Lancet Psychiatry 2016

- Insomnia is a symptom of depression
- Insomnia leads to depression
- Can the early and adequate treatment of insomnia prevent depression?

Depression – Prevention

Effectiveness of an online insomnia program (SHUTi) for prevention of depressive episodes (the GoodNight Study): a randomised controlled trial

Helen Christensen et. al, Lancet Psychiatry 2016

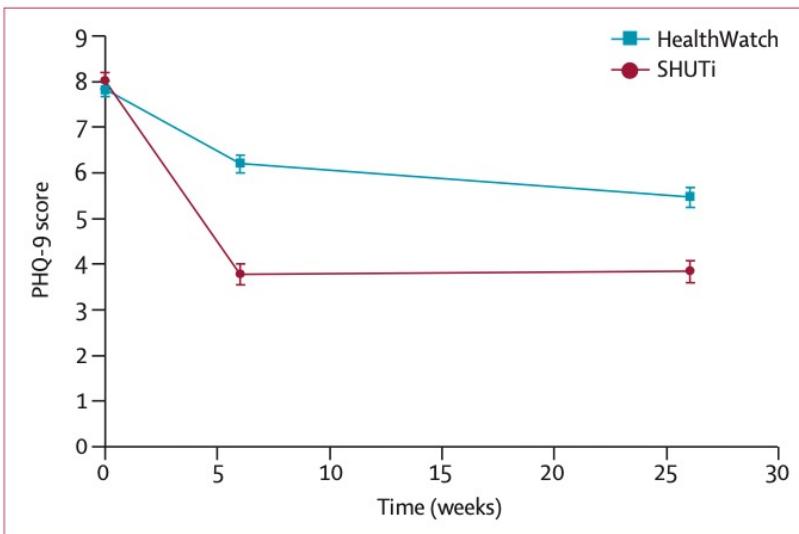


Figure 2: Comparison of PHQ-9 depression estimated marginal mean scores at baseline, 6 weeks, and 6 months

Error bars show SEs. PHQ=Patient Health Questionnaire.

Depression – Prevention

Effectiveness of an online insomnia program (SHUTi) for prevention of depressive episodes (the GoodNight Study): a randomised controlled trial

Helen Christensen et. al, Lancet Psychiatry 2016

- Online cognitive behaviour therapy for insomnia treatment is a practical and effective way to reduce depression symptoms
- Online cognitive behaviour therapy for insomnia could be capable of reducing depression at the population level

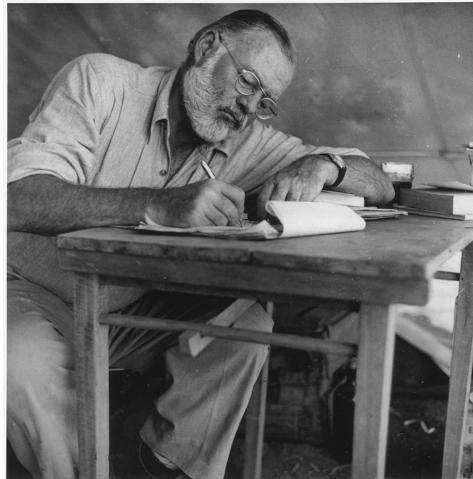
How to prevent depression?

Mood Disorders – Suicidal Ideation

- Having thoughts, ideas or ruminations about the possibility of ending one's own life

Mood Disorders – Suicide

- Virginia Woolf and Ernest Hemingway committed suicide after being depressive



Mood Disorders – Suicidal Ideation

- Suicide accounts for nearly one million deaths each year worldwide
- Suicide attempts are more frequent still
- Unipolar depression is among the most commonly cited risk factors for suicidal thoughts and behaviours
- Depression is the most common mental illness among suicide decedents
- Suicide is a leading cause of death among young adults and the rate of suicide among young adults has been increasing for decades

Depression – Suicide-Prevention

- Effective prevention rests on accurate prediction

Depression – Suicide-Prevention

- Effective prevention rests on accurate prediction

*Suicidal behaviour in mood disorders -
who, when, and why?*

Predict individual risk to commit suicide

Depression – Suicide-Prevention

Healthcare campaigns



Dare to talk about suicidal thoughts
Listen in case of suicidal thoughts
Seek for help if someone has suicidal thoughts



STAY ALIVE app

Suicide affects more than one life, talking might save lives

Depression – Suicide-Prevention

- Healthcare campaigns
- Therapeutic relationship, talk about suicidal ideation
- Lithium in bipolar depression prevents suicide attempts
- Attempted Suicide Short Intervention Program (ASSIP Gysin-Maillart, JAMA, October 2018)

Depression – Treatment

„No two people are affected the same way by depression and there is no "one-size-fits-all" for treatment. It may take some trial and error to find the treatment that works best for you“

Depression – Treatment

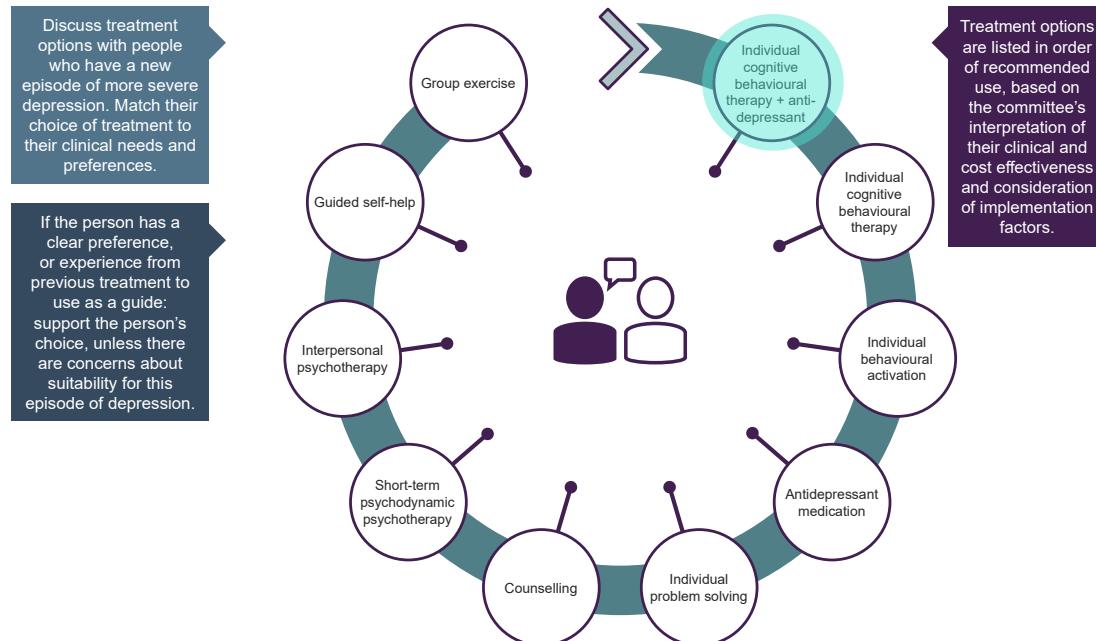
Depression in adults: discussing first-line treatments for more severe depression



Depression – Treatment

Moderate depressive episode: psychotherapy **AND** antidepressant (DGPPN)

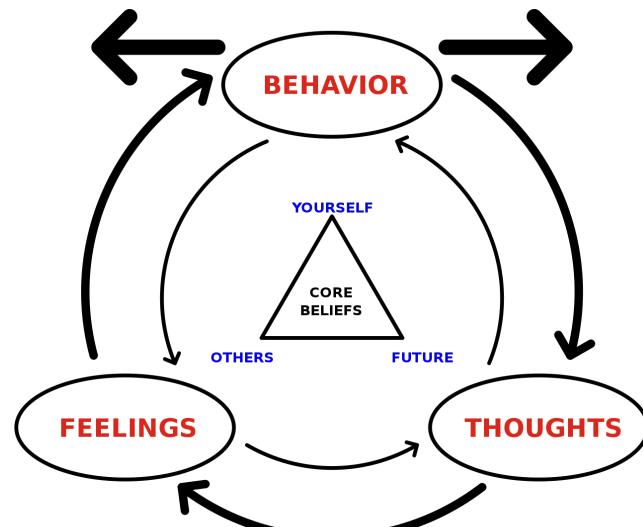
Depression in adults: discussing first-line treatments for more severe depression



Depression – Treatment: Psychotherapy

- Setting
 - outpatient – inpatient
 - individual – group – family – couple

- Method
 - Cognitive Behavioral Therapie (CBT)
 - Psychodynamic Psychotherapy
 - Interpersonal Psychotherapy (IPT)
 - person-centered psychotherapy



Depression – Treatment: Psychotherapy

- Psychotherapy works in depression
Effectiveness depends on severity, chronicity, symptoms
- Psychotherapy as good as antidepressants (Gloaguen 1998, de Rubeis 1999, Hollon 2002)
- „common factors“
 - quality of therapeutic relationship
 - raise hope
 - psychoeducation
 - patients skills
 - problem solving

Depression – Treatment: Psychotherapy

Why is psychotherapy effective?

Depression – Treatment: Medication

- Antidepressants in Switzerland

Tabelle 2: Antidepressiva – Wirkmechanismus und Standarddosierungen.

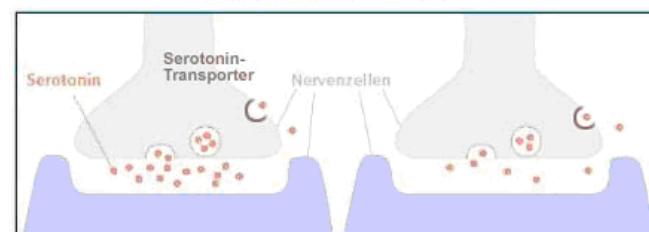
Generischer ^a Name (alphabetisch) CH	Handelsname	Traditionelle strukturelle Klassifikation ^b	Klassifikation gemäß neurochemischem Wirkungsmechanismus ^c	Anfangsdosis ^d (mg/d)	Standarddosis ^d (mg/d)	Plasmaspiegel ^e (therapeutischer Bereich) [ng/ml]
Agomelatin	Valdoxan®		MT-Agonist	25	25–50	
Amineptin	(nicht zugelassen)			100	200–300	
Amitriptylin ⁱ	Saroten® Ret.	TZA		25–50	100–300	80–200*
Amoxapin	(nicht zugelassen)	TetraZA		50	100–400	
Bupropion ^g	Wellbutrin XR®		NDRI	150	150–450**	
Citalopram ⁱ	Seropram®		SSRI	20	20–40 (60)	
Clomipramin ^{h,j}	Anafranil®	TZA		25–50	100–250	175–450*
Desipramin	(nicht zugelassen)	TZA		25–50	100–300	100–300
Dibenzepin	Noveril TR®	TZA		120–180	240–720	
Dosulepin	(nicht zugelassen)	TZA		75	75–150	
Dothiepin	(nicht zugelassen)	TZA		25–50	100–300	
Doxepin ⁱ	Singuan®	TZA		25–50	100–300	
Duloxetin ^{h,k}	Cymbalta®		SNRI	30–60	60–120	
Escitalopram ⁱ	Cipralex®		SSRI	10	10–20	
Fluoxetin	Fluctine®		SSRI	20	20–60	
Fluvoxamini	Floxyfral®		SSRI	50	100–300	
Imipramin	Tofranil®	TZA		25–50	100–300	175–300*
Isocarboxazid	(nicht zugelassen)			20	20–60	
Johanniskraut ⁱ	Depripiva® Hyperplant® Rx Rebalance® Rx	Phytopharmacon		500–1000	Trockenextrakt	
Lofepramin	(nicht zugelassen)	TZA		70	140–210	
Maprotilin	Ludiomil® a.H.	TetraZA		25–50	150–225	
Mianserin	Tolvon®	TetraZA	Noradrenalin-Wiederauf- nahmehemmung + prä- synapt. Alpha2-Blockade	30	60–120	
Milnacipran	(nicht zugelassen)		SNRI	50–100	100–200	
Mirtazapin	Remeron®		NASSA (Alpha2-Antagonist)	15	15–45	
Moclobemid	Aurorix®		RIMA	150	300–600	
Nortriptylin	Nortriplen® a.H.	TZA		25–50	75–200	70–170
Paroxetin ^{h,l,j}	Deroxat®		SSRI	20	20–40 (60)	
Phenelzini	(nicht zugelassen)		MAOI	15	30–90	
Protriptylin	(nicht zugelassen)	TZA		10	20–60	
Reboxetin	Edronax®		NARI	4–8	8–12	
Sertralin ^{h,l,j}	Zoloft®		SSRI	50	50–150	
Setiptilin	(nicht zugelassen)	TetraZA		3	3–6	
Tianeptin	(nicht zugelassen)		Serotonin-(5-HT-)Wieder- aufnahmeverstärker	12,5	25–37,5	
Tranylcypromin ⁱ	(nicht zugelassen)		MAOI	10	20–60	
Trazodon	Trittico®			50–100	200–600	
Trimipramin ^{h,i}	Surmontil®	TZA		25–50	100–300	
Venlafaxini	Efexor®	SNRI		37,5–75	75–375	195–400*
Viloxazin	(nicht zugelassen)			100	200–500	
Vortioxetin	Brintellix®	SSRI	Agonist 5HT1A und 1B, Antagonist 5HT3/7/1D	5	20	

Depression – Treatment: Medication

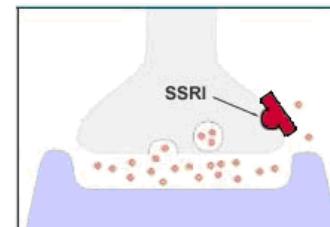
- Many substances
- Do not differ in terms of „antidepression“
- Different ways of action (e.g. SSRI, SNRI)
- Different side effects
- SSRI and „new“ antidepressants
 - first line
 - well tolerated
 - less side effects compared to „old“ tricyclic AD
 - low cardiotoxicity

Depression – Treatment: Medication

- Selective Serotonin Reuptake Inhibitors (SSRIs) prevent the reuptake of serotonin into the cells
- SSRI lead to increased levels of serotonin in the brain
- Assumption that low levels of certain neurotransmitters, e.g. serotonin contribute to depressive symptoms



enough serotonin in healthy people not enough serotonin in depressed people



SSRI leads to more serotonin in the synaptic gap

Depression – Treatment: Medication

- Antidepressants **take time – usually 2 to 4 weeks – to work**, and often, symptoms such as sleep, appetite and concentration problems improve before mood lifts.
- Children, teenagers and young adults under 25 may experience an **increase in suicidal thoughts or behavior** when taking antidepressants, especially in the first few weeks after starting.
- Side effects include **weight gain, sedation, effects on sexual function**
- **30% do not respond** to treatment (Rush 2016)
- Continue antidepressant medication minimum **6 months** beyond remission (Kempermann 2008)

Depression – Treatment: Medication

- The review included 14 studies (16 comparisons)
- Both TCAs and SSRIs are significantly more effective than placebo
- Numbers needed to treat ranged from 7 to 16 for Tricyclic Antidepressants (TCAs) and from 7 to 8 for SSRIs
- Numbers needed to harm (NNH for withdrawal due to side effects) ranged from 4 to 30 for TCAs and from 20 to 90 for SSRIs

Antidepressants versus placebo for depression in primary care
(Review)

B. Arroll, Cochrane Library 2014

s

Depression – Treatment: Placebo Effect

Placebo effects in psychiatry: mediators and moderators

Katja Weimer, Review Lancet Psychiatry 2016

- Although placebos have been used in general medicine for almost 200 years, their use in psychiatry is less well documented.
- They reviewed 31 meta-analyses and systematic reviews of more than 500 randomised placebo-controlled trials across psychiatry.
- When the placebo effects in RCTs were compared with the no-treatment controls in minor depression, the data suggested that about 81% of the placebo effects could be attributed to spontaneous symptom variation and recovery.

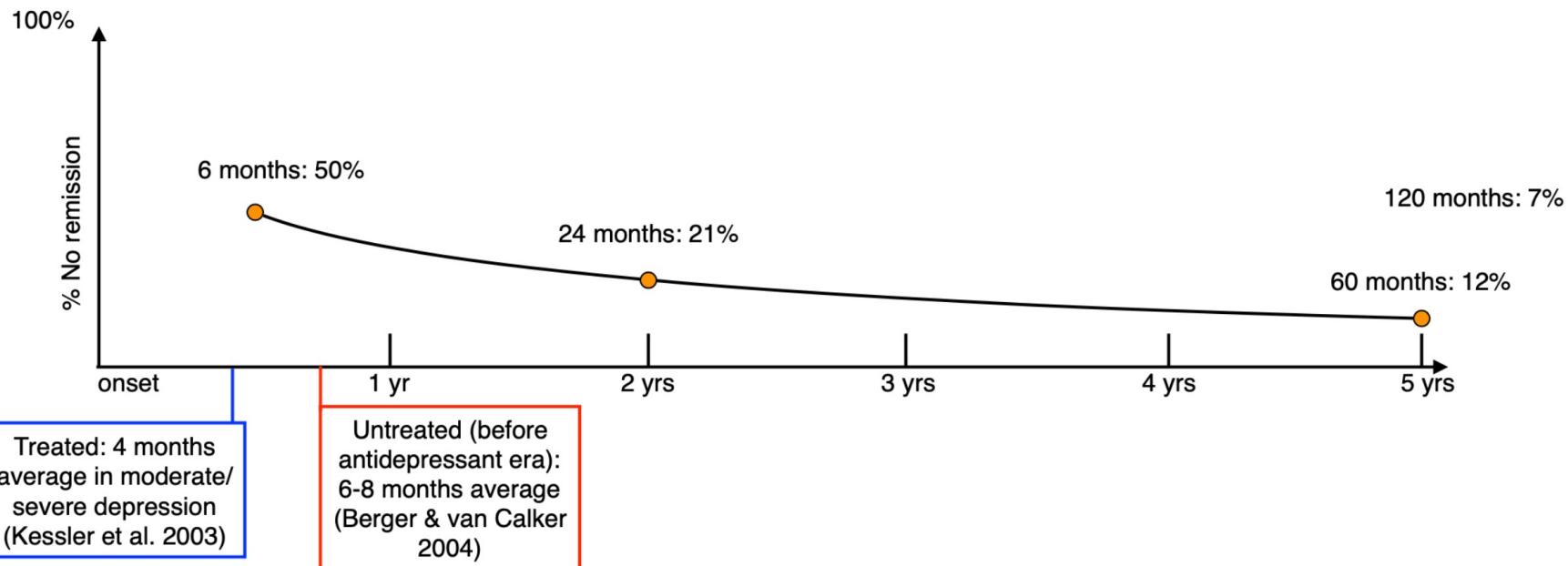
Depression – Treatment: Placebo Effect

Placebo effects in psychiatry: mediators and moderators

Katja Weimer, Review Lancet Psychiatry 2016

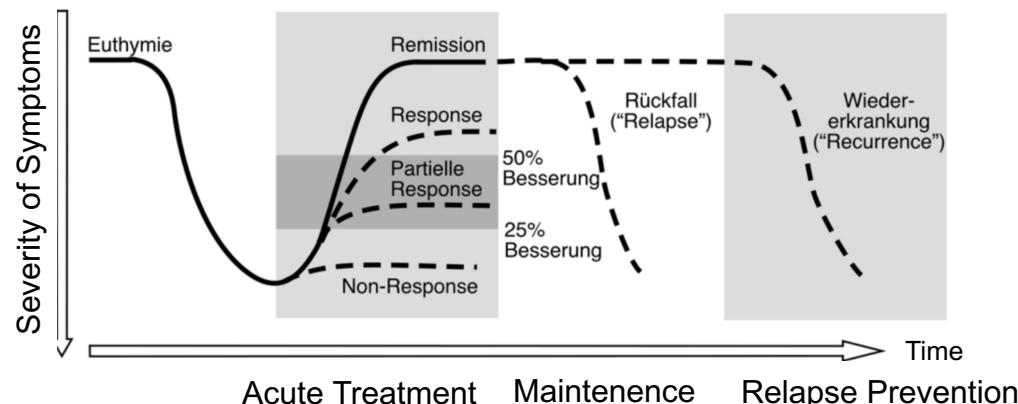
- Non-drug therapy in psychiatry (e.g. psychotherapy interventions, bright-light therapy) share the difficulty, if not inability, to provide the interventions in a blinded or even double-blinded way.
- Review of present knowledge of placebo responses in psychiatry shows that the placebo response is evident and effective in all disorders.
- Predictors of placebo response are still widely unknown.

Depression – Outcomes



Depression – Outcomes

- Non-response trial and error
- increase dosage
- change to or add another antidepressant
- add another substance

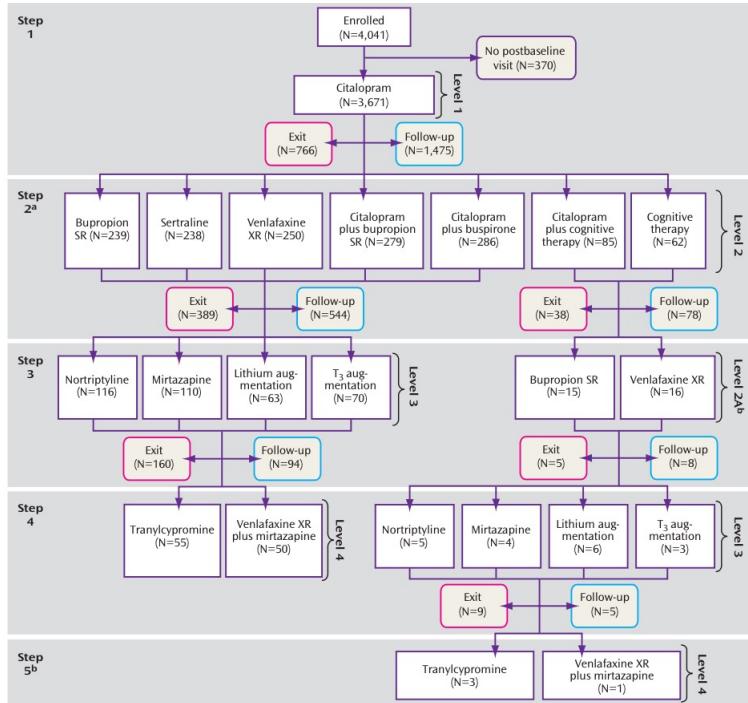


Schema: Course of unipolar depression, Kupfer 1991

Depression – Outcomes

Acute and Longer-Term Outcomes in Depressed Outpatients Requiring One or Several Treatment Steps: A STAR*D Report

A. John Rush Am J Psychiatry 2006



^a Nine participants entered step 2 without a step 1 postbaseline visit being recorded.

^b Only possible for participants who received cognitive therapy alone or cognitive therapy plus citalopram at step 2.

Depression – Outcomes

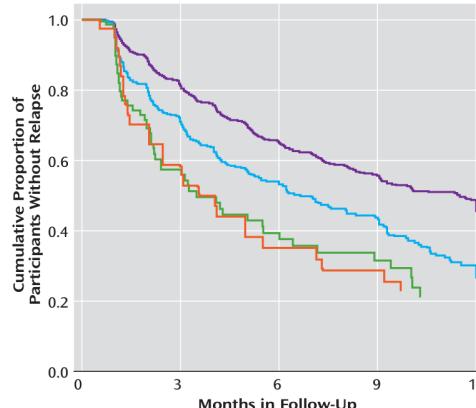
- The QIDS-SR16 remission rates were 36.8%, 30.6%, 13.7%, and 13.0% for the first, second, third, and fourth acute treatment steps

Acute and Longer-Term Outcomes in Depressed Outpatients Requiring One or Several Treatment Steps: A STAR*D Report

A. John Rush Am J Psychiatry 2006

FIGURE 2. Relapse During Follow-Up Phase by Number of Acute Treatment Steps for All STAR*D Participants^a

Step 1 N= 1,475	803	529	347	98
Step 2 N= 622	300	190	115	29
Step 3 N= 102	37	22	15	3
Step 4 N= 49	20	12	9	2
Total N=2,248	1,160	753	486	132



^a Significant overall difference among steps ($\chi^2=69$, df=3, p<0.0001). Significant post-hoc comparisons with Bonferroni corrections revealed significant differences between steps 1 and 2 and steps 1 and 3.

Depression – Outcomes

Acute and Longer-Term Outcomes in Depressed
Outpatients Requiring One or Several Treatment Steps:
A STAR*D Report

A. John Rush Am J Psychiatry 2006

- The overall cumulative remission rate was 67%
- Overall, those who required more treatment steps had higher relapse rates during the naturalistic follow-up phase
- Lower relapse rates were found among participants who were in remission at follow-up entry than for those who were not after the first three treatment steps.

Depression – Outcomes

Acute and Longer-Term Outcomes in Depressed
Outpatients Requiring One or Several Treatment Steps:
A STAR*D Report

A. John Rush Am J Psychiatry 2006

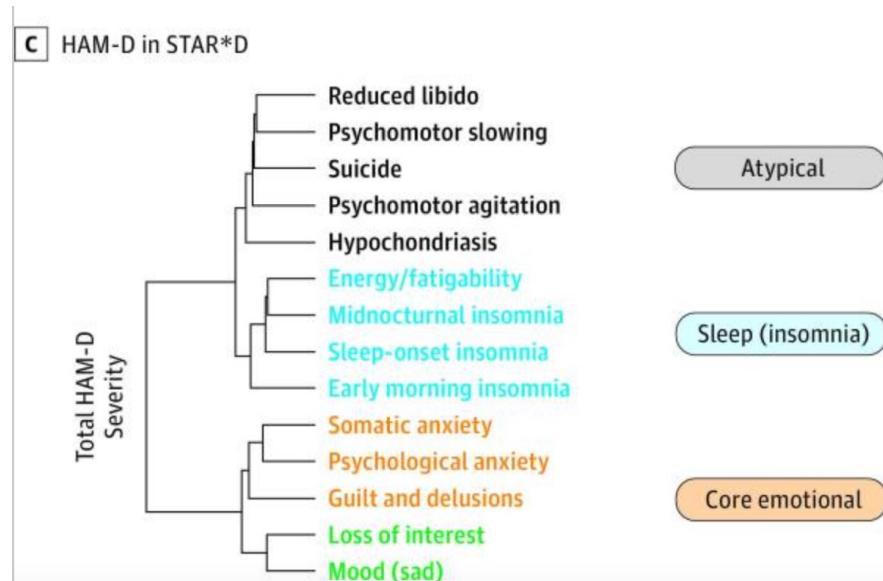
- When more treatment steps are required, lower acute remission rates (especially in the third and fourth treatment steps) and higher relapse rates during the follow-up phase are to be expected.
- Studies to identify the best multi-step treatment sequences for individual patients and the development of more broadly effective treatments are needed.

Depression – Outcomes

Reevaluating the Efficacy and Predictability of Antidepressant Treatments

A Symptom Clustering Approach

Adam M. Checkroud, Jama Psychiatry 2017

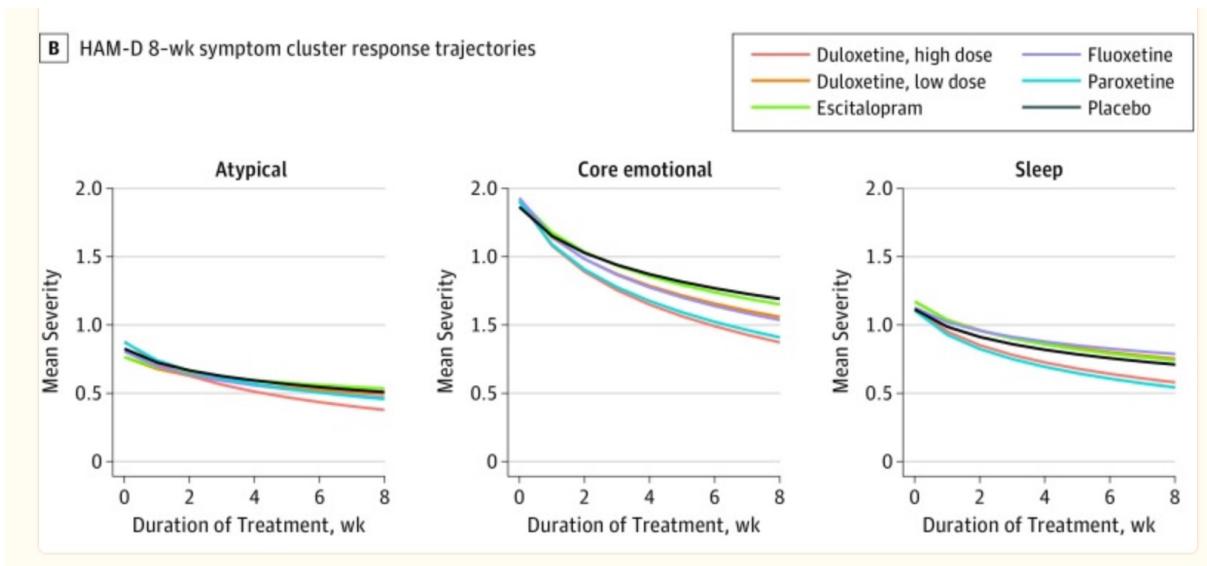


Depression – Outcomes

Reevaluating the Efficacy and Predictability of Antidepressant Treatments

A Symptom Clustering Approach

Adam M. Checkroud, Jama Psychiatry 2017



Depression – Outcomes

Reevaluating the Efficacy and Predictability of Antidepressant Treatments

A Symptom Clustering Approach

Adam M. Checkroud, Jama Psychiatry 2017

- Antidepressant medications can be selected to benefit specific clusters of symptoms in depression

Depression – Outcomes

Reevaluating the Efficacy and Predictability of Antidepressant Treatments

A Symptom Clustering Approach

Adam M. Checkroud, Jama Psychiatry 2017

- Antidepressant medications can be selected to benefit specific clusters of symptoms in depression

Who benefits from antidepressants?

How to predict individual treatment response?

Depression – Treatment

- Non-Responders and severe depression
 - electroconvulsive therapy
 - transcranial magnetic stimulation
 - implanted vagus nerve stimulation
 - Ketamine (anesthetic)
- Bright-light therapy in seasonal depression (with seasonal pattern)



Depression – Measure Therapeutic Response

- Becks Depression Inventory

21-item, self-report rating inventory

measures characteristic attitudes and symptoms of depression

10-15minutes

0-63 points

20-28 moderate depression

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.

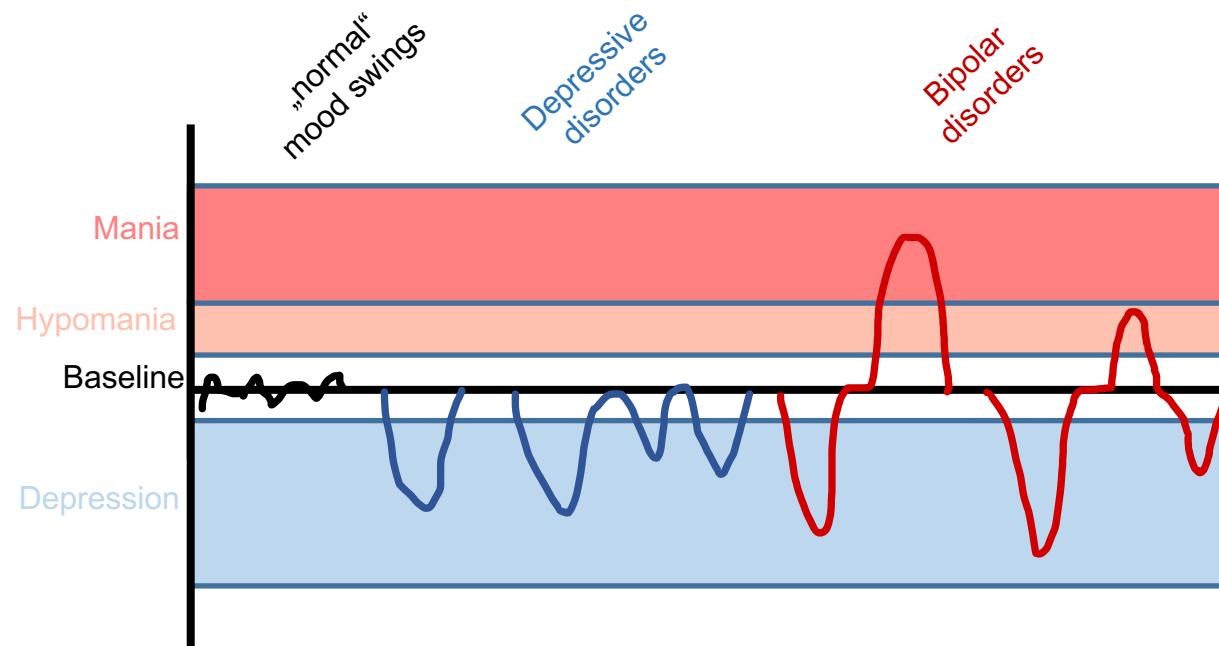
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

Depression – Measure Therapeutic Response

How to measure individual therapeutic response?

Mood Disorders

Depressive disorders – Bipolar and related disorders



Bipolar Disorder – Clinical Presentation

“Having the motivation to change the world one moment, then not having the motivation to even wash yourself”

“Bipolar hypomania can be scary, maybe not because of the hypomania, but because of the depression afterward.”

Bipolar Disorder – Clinical Presentation

BIPO极性障碍 SYMPTOMS

BIPO极性障碍 INCLUDES MANIC EPISODES:

Elevated, expansive or irritable mood

More talkative than usual

Distractibility

Inflated self-esteem or grandiosity

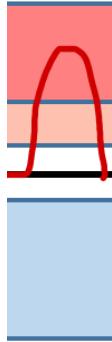
Involvement in activities that have a high potential for painful consequences

BIPO极性障碍 INCLUDES DEPRESSION EPISODES:



Manic Episode – Diagnosis DSM-5

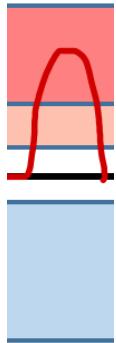
A: A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).



Manic Episode – Diagnosis DSM-5

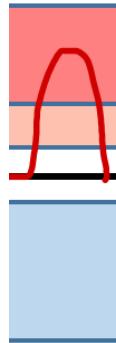
B: **three (or more) of the following symptoms** are present to a significant degree and represent a noticeable change from usual behavior:

- Inflated self-esteem or **grandiosity**.
- **Decreased need for sleep** (e.g., feels rested after only 3 hours of sleep).
- More **talkative** than usual or pressure to keep talking.
- **Flight of ideas** or subjective experience that thoughts are racing.
- **Distractibility** (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- Increase in **goal-directed activity** (either socially, at work or school, or sexually) or psychomotor agitation.
- Excessive involvement in activities that have a high **potential for painful consequences** (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)



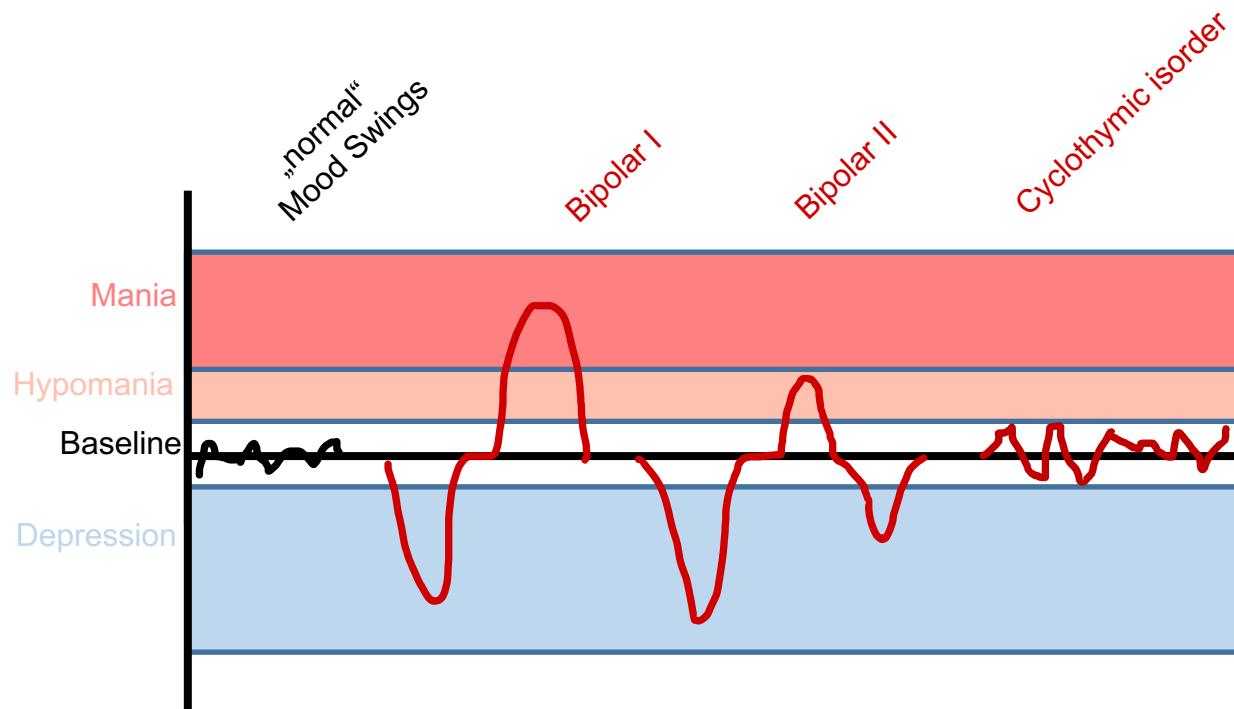
Manic Episode – Diagnosis DSM-5

C: The mood disturbance is sufficiently severe to cause marked **impairment in social or occupational functioning** or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.



D: The episode is **not attributable to the physiological effects of a substance** (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

Bipolar and related Disorders – Diagnosis DSM-5



Bipolar Disorders – Epidemiology and Pathogenesis

- ca. 3% (Baldessarini 2002; Kessler 1994; Weissman 1996; Jonas 2003; Szadoczky 1998; Faravelli 1990; Levav 1993; Meyer 2000; Kessler 2005; Merikangas 2007)
- Genetics, environmental (stress), personality (Haack 2010)

Bipolar Disorders – Prognosis

- Most bipolar patients have few episodes, 10% more than 10 episodes (APA Guidelines 1994, Goodwin 2007)
- Many bipolar patients show residual symptoms that impair psychosocial function (Benazzi 2001)
- 15 bis 20 % of patients with bipolar disorder commit suicide, usually during depressive phase (Veiby 2013, Guze and Robins 1970)

Depression vs. Bipolar Disorder BD

- Close to 60% of BD individuals are initially diagnosed as having unipolar depression
- Only 20% of BD individuals during a depressive episode receive the correct diagnoses of BD within the first year of seeking treatment
- Latency from onset to diagnosis and appropriate treatment averages 5–10 years
- Misdiagnosing BD as unipolar depression has many potentially deleterious consequences
 - inappropriate medication
 - switching to mania due to antidepressants
 - increased number of suicides and suicide attempts

Depression vs. Bipolar Disorder BD

Predict the risk of developing mania symptoms?

Bipolar Disorders – Treatment

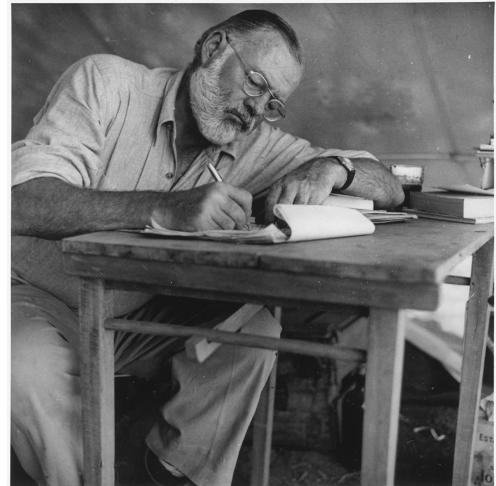
- Manic episode
 - Neuroleptics (e.g. Olanzapine, Risperidone, Quetiapine, Haloperidol)
 - Anticonvulsant medication (Carbamazepine, Valproate)
- Depressive episode
 - Neuroleptics (antidepressants)
 - Psychotherapy
- Maintenance treatment
 - Prophylaxis (Lithium)
 - Psychotherapy
 - Psychosocial intervention

Mood Disorders – Comorbidities

- Disorders that are often coexistent with each other

Mood Disorders – Comorbidities

- Disorders that are often coexistent with each other
- Ernest Hemingway:
Depression and alcohol dependence



Mood Disorders – Comorbidities

- **Psychiatric Comorbidities**

Anxiety 30% (Holzboer-Trachsler 2016)

Personality disorders 30-40% (Zimmermann 1994, Tyrer 1995)

Dementia up to 50% (Guidline German Society of Psychiatry, Psychotherapy and Neurology)

Disorders due to substance use

1/3 of all patients with mood disorders suffer from addiction once in lifetime (Kessler 1994)

24% of men and 48% of women with alcohol addiction suffer from depression (Soyka 2008)

- **Other Comorbidities**

Parkinsons Disease

Multiple Sclerosis

Mood Disorders – Comorbidities

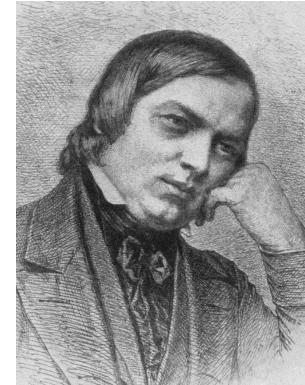
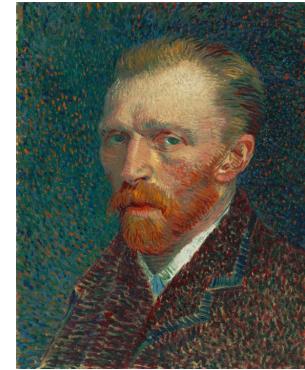
How to treat both?

Mood Disorders – Differential Diagnosis

- Other diseases that could be causing the symptoms

Mood Disorders – Differential Diagnosis

- Other diseases that could be causing the symptoms
- Vincent van Gogh: Bipolar disorder or organic mental disorder
lead poisoning
arsenic poisoning
inherited metabolic disorder
- Robert Schumann: Depression and/or Syphilis?



Mood Disorders – Differential Diagnosis

- Psychiatric Differential Diagnoses

- Schizoaffective

- Schizophrenia

- Personality disorder

- Dementia

- Other Differential Diagnoses

- Metabolic e.g. Thyroid

- Infection of the brain (e.g. Syphilis)

Mood Disorders – Differential Diagnosis

Develop tests for differential diagnosis

Clinicians wish list



- Identify biomarkers of depression
- Who is at risk of developing depression?
- How to prevent depression?
- Why is psychotherapy effective?
- Predict individual treatment response
- Predict individual risk to commit suicide
- Predict the risk of developing mania
- Develop tests for differential diagnosis



Thank you very much for your attention

Appendix

Depression

Treatment – Sources for this presentation

Depression in adults: treatment and management NICE guideline
29 June 2022 (National Institute for Health and Care Excellence UK)

S3-Leitlinie/Nationale Versorgungs Leitlinie Unipolare Depression
2015 currently under Revision (Deutschen Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, DGPPN)

<http://www.nimh.nih.gov/health/topic/depression>
(Guidelines of the American Psychiatric Association, Revision in process)

Die Akutbehandlung depressiver Episoden
Behandlungsempfehlungen der Schweizerischen Gesellschaft für Angst und Depression (SGAD)

Bipolar Disorders

Treatment – Sources for this Presentation

Bipolar disorder: assessment and management NICE

2014 Last updated: 11 February 2020 (National Institute for Health and Care Excellence UK)

S3-Leitlinie zur Diagnostik und Therapie Bipolarer Störungen

2019, Update 2020 (Deutschen Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde)

PRACTICE GUIDELINE FOR THE Treatment of Patients With Bipolar Disorder

(2010, American Psychiatric Association, APA)