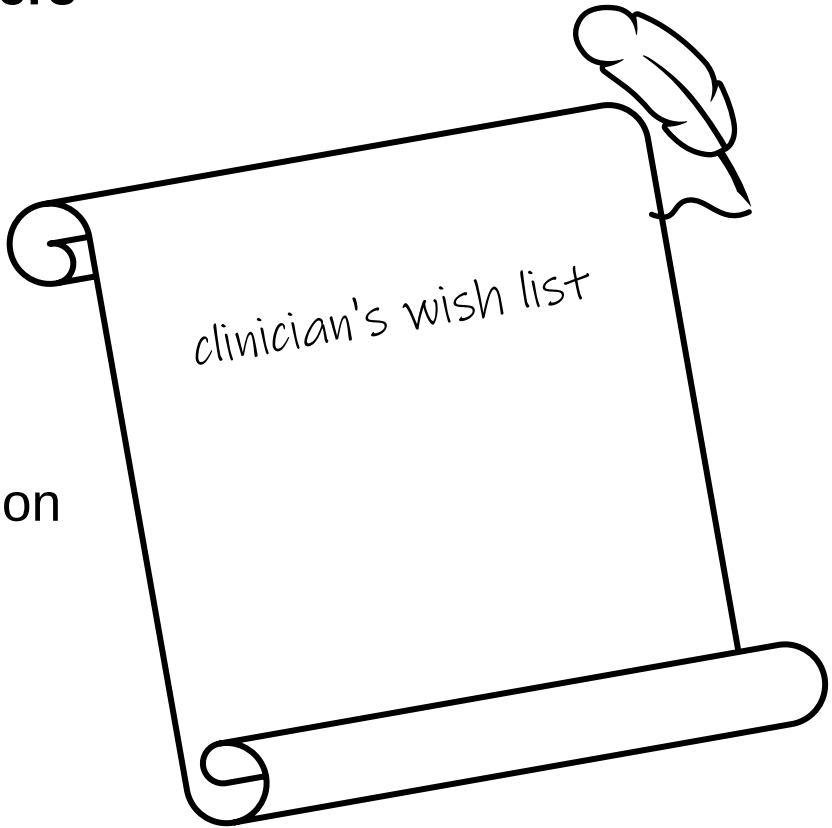
Mood (Affective) Disorders

September 9 2024 Marie Zipser

sanatoriumKILCHBERG
PRIVATKLINIK FÜR PSYCHIATRIE
UND PSYCHOTHERAPIE

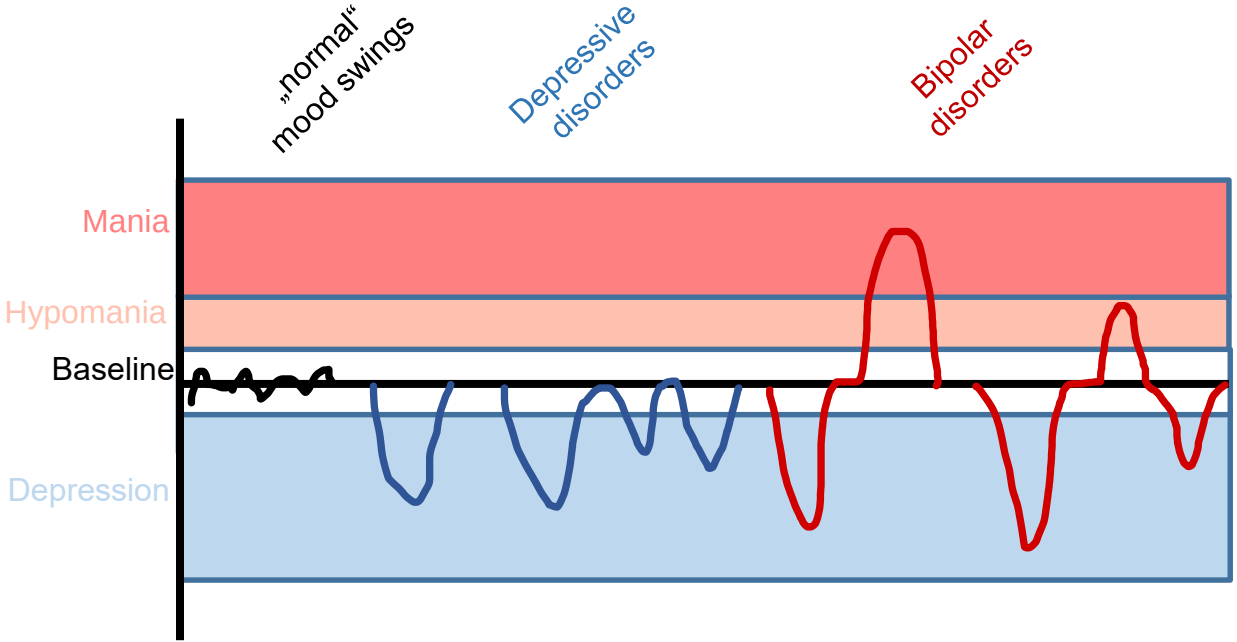
Affective Disorders – Mood Disorders

Clinical presentation
Diagnosis
Epidemiology
Prevention
Treatment
Suicidal ideation and suicide prevention
Differential diagnosis
Comorbidities



Mood Disorders

Depressive disorders – Bipolar and related disorders



Modified after Schäfer, Reif, Juckel, Therapie-Tools Bipolar Disorders, Beltz 2016

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

5 common myths about depression, Ceri Parker, April 2017, World Economic Forum

Depression – Clinical Presentation

Winston Churchill

Depression – Clinical Presentation

Depression – Epidemiolgy and Pathogenesis

- 5% of adults suffer from depression, 300 million people
  (WHO Institute of Heath Metrics and Evaluation. Global Health Data Exchange)

- Life time prevalence 16-20% (Ebmeier 2006, Bijl 1998)

- ♀:♂ = 2 : 1 (Jacobi 2014)

- Pathognesis 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)

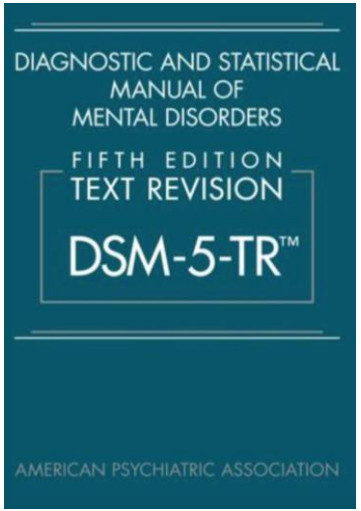
  although suicide attempts are more frequent in women)
- Depressed people have a higher risk of dying from other causes (Rush 2007)

Depression – Diagnosis

Depression – Diagnosis

Depression – Diagnosis
IT‘S ONLY WORDS (BEE GEES)

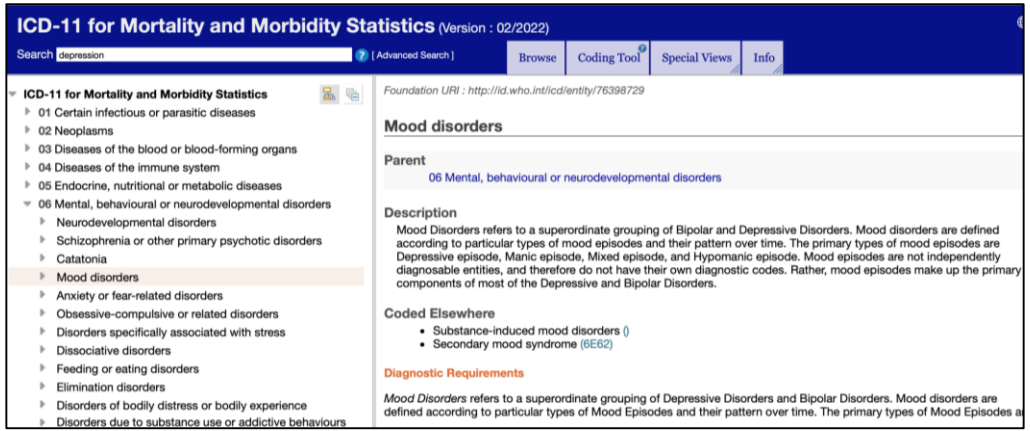
DSM-5 (American Psychiatric Association)



ICD-11

(WHO 02/2022)

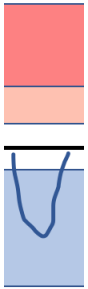
Old „Affective Disorders“ from ICD-10
New „Mood Disorders“



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 (core)
- Markedly diminished interest or pleasure (core)
- 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.

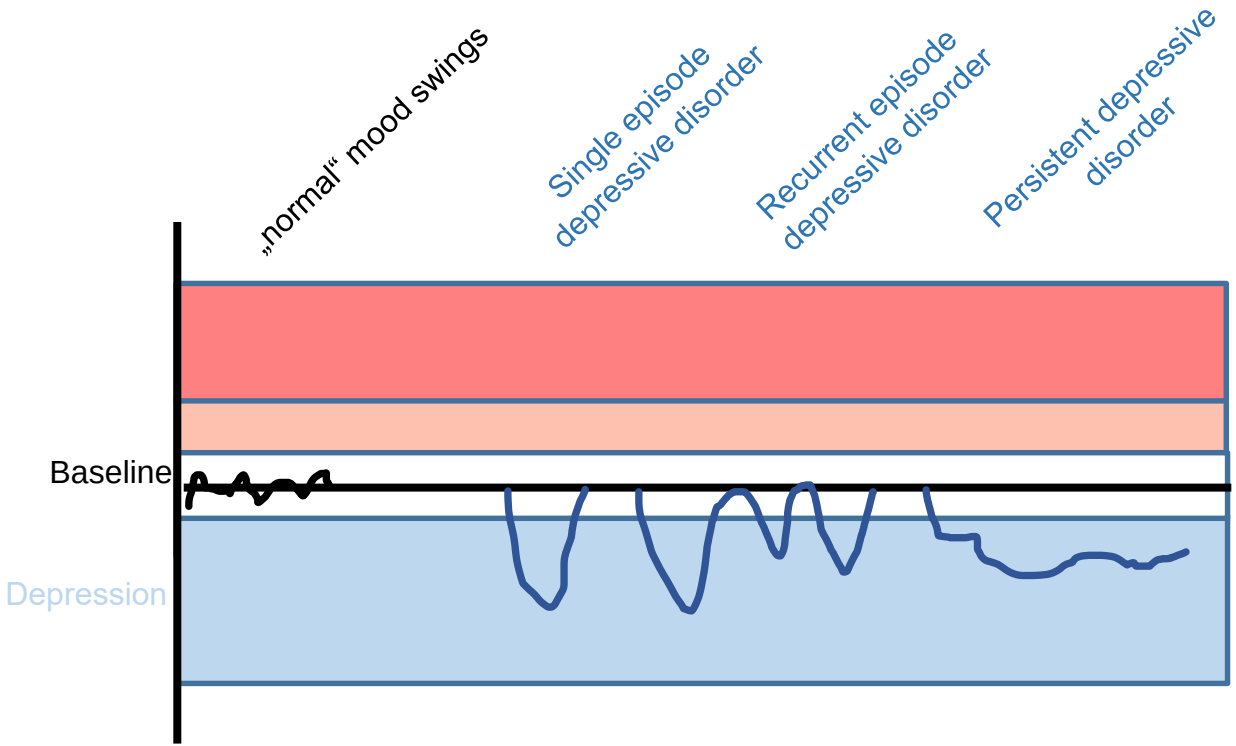
D: At least one major depressive episode is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E: There has never been a manic episode or a hypomanic episode.

Depression

- Identify biomarkers of depression
- Accurate prediction → prevention

Depressive Disorders – Diagnosis DSM-5



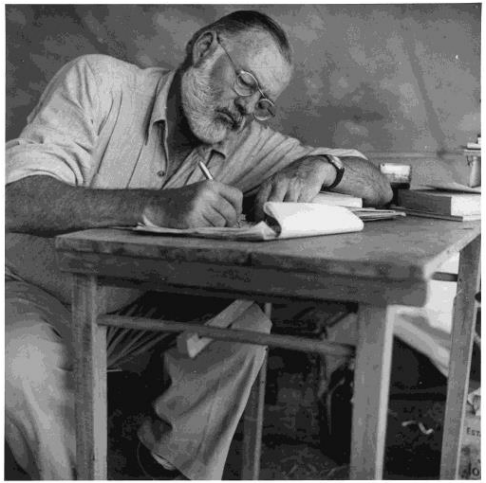
Modified after Schäfer, Reif, Juckel, Therapie-Tools Bipolar Disorders, Beltz 2016

Mood Disorders – Suicidal Ideation

- 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 – Suicide

- Leading cause of death among young adults
- Rate of suicide among young adults increasing for decades

- Nearly one million deaths each year worldwide
- (Suicide attempts even more frequent!)

- Unipolar depression among most commonly cited risk factors for suicidal thoughts/behaviours

- Depression most common mental illness among suicide decedents

Jessica D. Ribeiro, BJPsych 2018 Daniel W Capron, PsychiatryRes. 2014

Depression – Suicide-Prevention

- 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 can save lifes

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, 2018)

Depression – Treatment

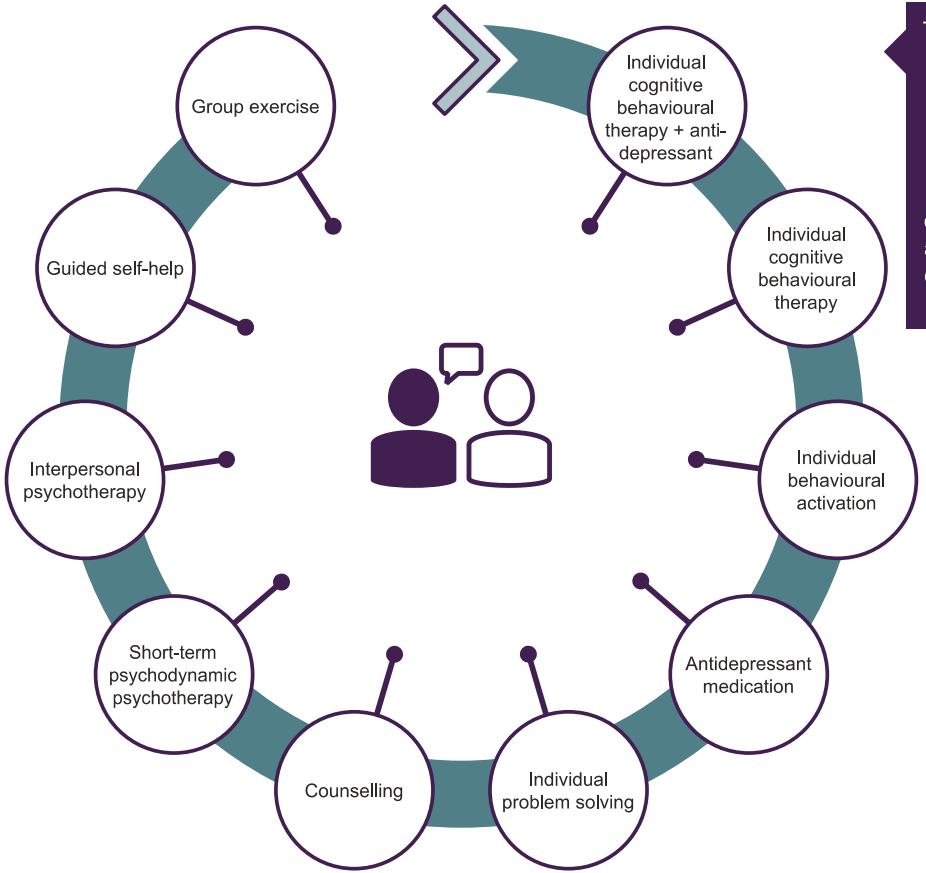
„No two people are affected the same way by depression and there is no "one-size-fits-all" for treatment. It may take some trial and error to find the treatment that works best for you.“

National Institute of Mental Health, https://www.nimh.nih.gov/health/topics/depression

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

Discuss treatment options with people who have a new episode of more severe depression. Match their choice of treatment to their clinical needs and preferences.

If the person has a clear preference, or experience from previous treatment to use as a guide: support the person's choice, unless there are concerns about suitability for this episode of depression.

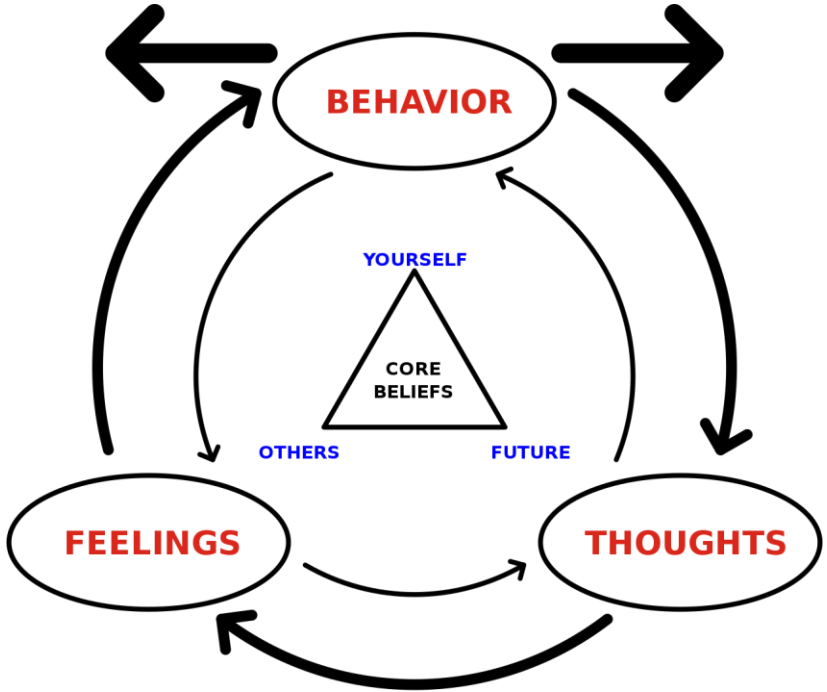


Treatment options are listed in order of recommended use, based on the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors.

NICE National Institute for Health and Care Excellence

Depression – Treatment: Psychotherapy

- Setting
  - outpatient – inpatient
  - individual – group – family – couple
- Method
  - Cognitive Behavioral Therapy (CBT)
  - Psychodynamic Psychotherapy
  - Interpersonal Psychotherapy (IPT)
  - …



S3-Guideline Unipolar Depression, German Society for Psychiatry and Neurology 2015
Psychotherapy of Depression, Treatment Recommendation, Küchenhoff 2012, Revision 2016

Depression – Treatment: Psychotherapy

- Psychotherapy is effective
  Effectiveness depends on severity, chronicity, symptoms, comorbidities

- Psychotherapy as effective as antidepressants
  (Gloaguen 1998, de Rubeis 1999, Hollon 2002)

- „common factors“
  quality of therapeutic relationship
  raise hope
  psychoeducation
  patients skills
  problem solving

S3-Guideline Unipolar Depression, German Society for Psychiatry and Neurology 2015
Psychotherapy of Depression, Treatment Recommendation, Küchenhoff 2012, Revision 2016

Depression – Treatment: Medication

- Antidepressants approved in CH

Tabelle 2: Antidepressiva – Wirkmechanismus und Standarddosierungen.

Generischer[a] Name (alphabetisch)	Handelsname CH	Traditionelle strukturelle Klassifikation[b]	Klassifikation gemäss neurochemischem Wirkungsmechanismus[b]	Anfangsdosis[c] (mg/d)	Standarddosis[d] (mg/d)	Plasmaspiegel* (therapeutischer Bereich) [ng/ml]
Agomelatin	Valdoxan®		MT-Agonist	25	25–50	
Amineptin	(nicht zugelassen)			100	200–300	
Amitriptylin[f]	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,i]	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	
Doslepin	(nicht zugelassen)	TZA		75	75–150	
Dothiepin	(nicht zugelassen)	TZA		25–50	100–300	
Doxepin[i]	Sinquan®	TZA		25–50	100–300	
Duloxetin[i,k]	Cymbalta®		SNRI	30–60	60–120	
Escitalopram[i]	Cipralex®		SSRI	10	10–20	
Fluoxetin	Fluctine®		SSRI	20	20–60	
Fluvoxamin	Floxyfral®		SSRI	50	100–300	
Imipramin	Tofranil®	TZA		25–50	100–300	175–300*
Isocarboxazid	(nicht zugelassen)			20	20–60	
Johanniskraut[l]	Deprivita® Hyperiplant® Rx Rebalance® Rx	Phytopharmakon		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	Nortrilen® a.H.	TZA		25–50	75–200	70–170
Paroxetin[h, i, j]	Deroxat®		SSRI	20	20–40 (60)	
Phenelzin[i]	(nicht zugelassen)		MAOI	15	30–90	
Protriptylin	(nicht zugelassen)	TZA		10	20–60	
Reboxetin	Edronax®		NARI	4–8	8–12	
Sertralin[h, i, 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[f, i]	Surmontil®	TZA		25–50	100–300	
Venlafaxin[j]	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	

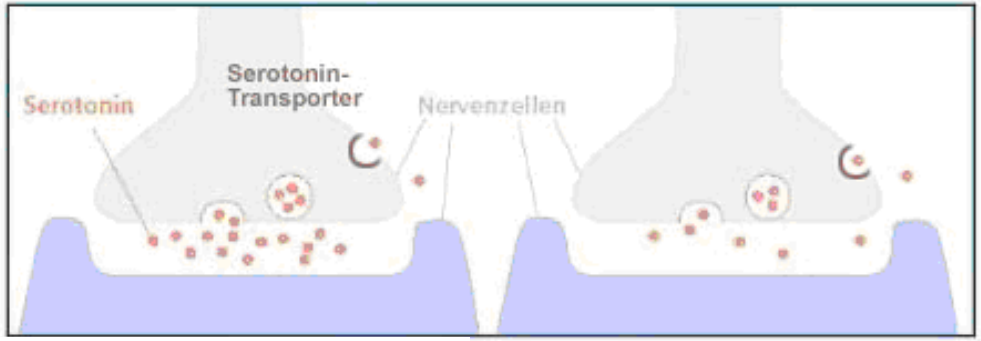
Holsboer-Trachsler SWISS MEDICAL FORUM 2016

Depression – Treatment: Medication

- Many substances
- Do not differ vastly in terms of „antidepressive efficacy“
- 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

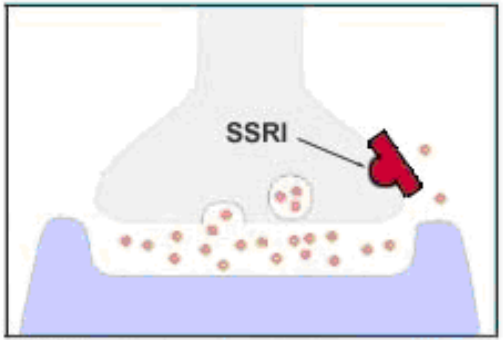
Depression – Treatment: Medication

- Selective Serotonin Reuptake Inhibitors (SSRIs) prevent reuptake of serotonin
- SSRI lead to increased serotonin levels in synaptic gap
- Assumption: low levels of certain neurotransmitters, e.g. serotonin contribute to depressive symptoms
- (long-term modulation of brain networks and network effects: unknown)



sufficient serotonin in healthy people

low serotonin in depressed people



SSRI → more serotonin in synaptic gap

Depression – Treatment: Medication

- Antidepressants take time – 2 to 4 weeks!
  → Symptoms 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!

- Side effects include weight gain, sedation, sexual dysfunction

- Efficacy varies with severity of depression (severe > moderate > mild)

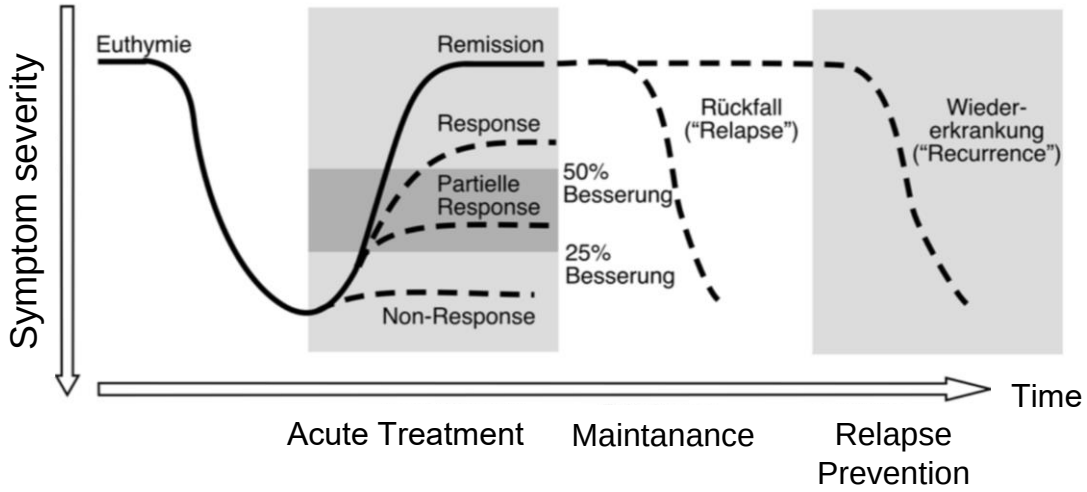
- Continue antidepressant medication ≥ 6 months beyond remission (Kempermann 2008)

- 30% do not respond to treatment (Rush 2016)

Guidelines of the American Psychiatric Association
NICE Guidelines

Depression – Outcomes

- Non-response:
  trial and error
- Increase dosage/
  intensify psychotherapy
- Change to another
  antidepressant
- Augmentation:
  add another substance

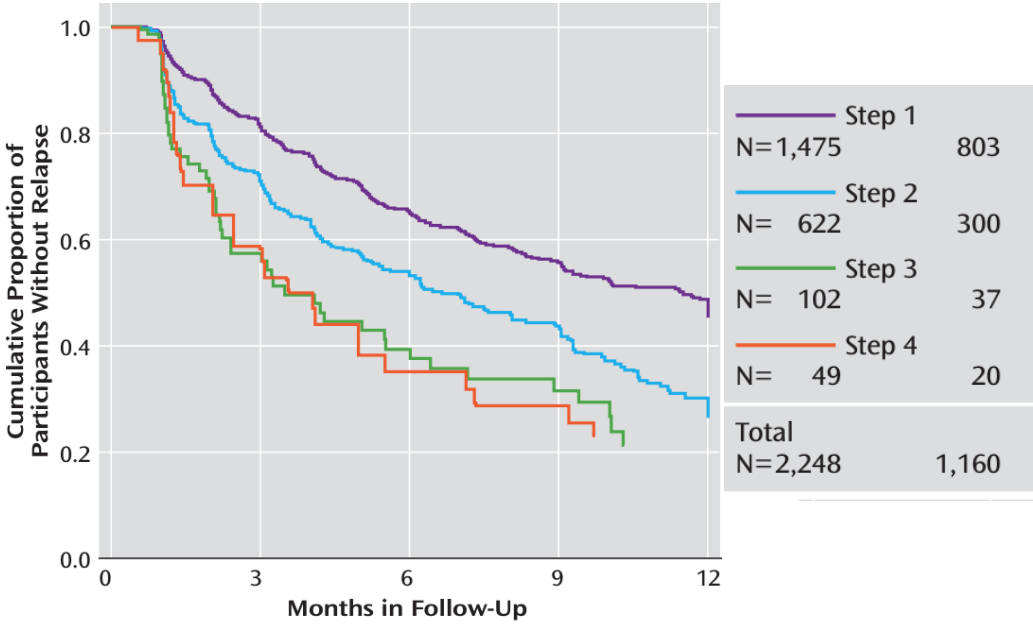


Course of unipolar depression (Kupfer 1991)

Depression – Outcomes

- Remission rates (QIDS SR-16):
  - step 1 36.8%
  - step 2 30.6%
  - step 3 13.7%
  - step 4 13.0%
- Cumulative remission rate 67%

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



[a] Significant overall difference among steps (χ^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.

Rush, Am J Psychiatry 2006

Depression – Treatment

- Non-Responders and severe depression
  - Esketamine nasal spray (NMDA antagonist) → short term effect
  - Electroconvulsive therapy
  - (Transcranial magnetic stimulation)
  - (Implanted vagus nerve stimulation)

- Phototherapy in depression with seasonal pattern

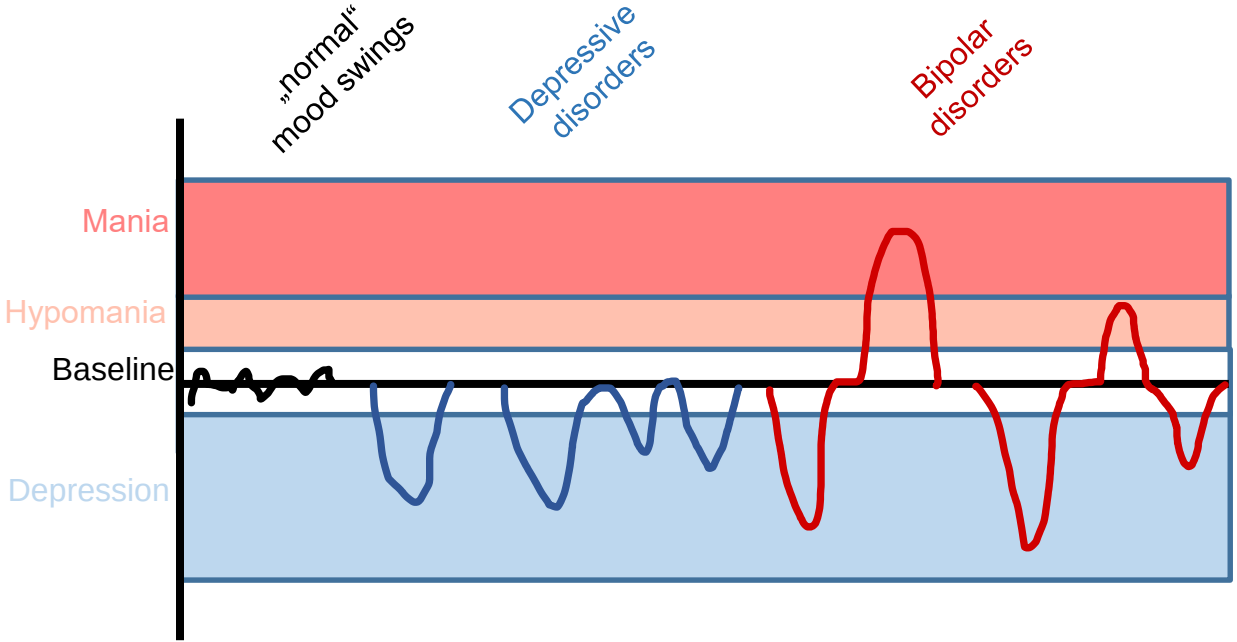
Holsboer-Trachsler SWISS MEDICAL FORUM 2016

Depression – Treatment: Psychotherapy & Antidepressants

- Who benefits from which treatment? And how long?
  - Psychotherapy? Which kind?
  - Antidepressant? Which one?
  - Other therapies? Sport? Light? ECT?
  - Differential effect?
  - Discontinuation possible or not?
  - (No therapy necessary?)

Mood Disorders

Depressive disorders – Bipolar and related disorders



Modified after Schäfer, Reif, Juckel, Therapie-Tools Bipolar Disorders, Beltz 2016

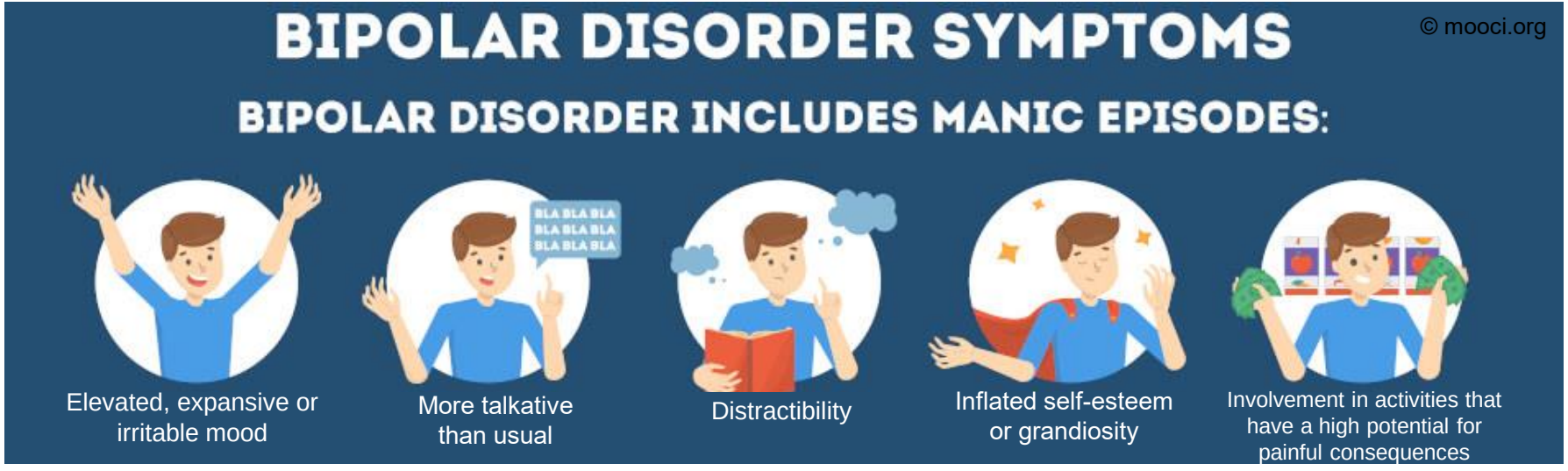
Bipolar Disorder – Clinical Presentation

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

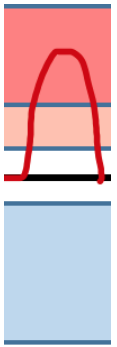
“Bipolar hypomania can be scary, maybe not because of the hypomania, but because of the depression afterward.“

Quotes on Bipolar Disorder, healthyplace.com

Bipolar Disorder – Clinical Presentation



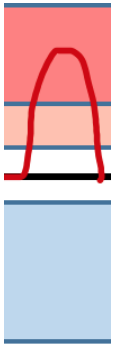
Manic Episode – Diagnosis DSM-5



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

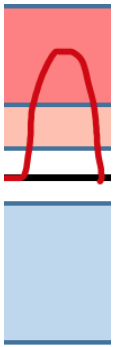


B: three (or more) of the following symptoms are present to a significant degree and represent a noticeable change from usual behavior:

- 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

B: three (or more) of the following symptoms are present to a signif… …ual beh…



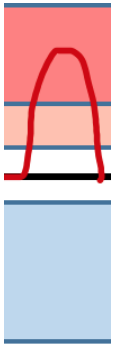
- …
- …
- …
- …
- …external
- …xually)
- …ndiscretions, or foolish business investments)

Psychotic symptoms:

- Delusions (grandiosity, erotomania)
- Verbal hallucinations

Irritability + agitation + psychotic symptoms
→ aggresive behaviours! 😵

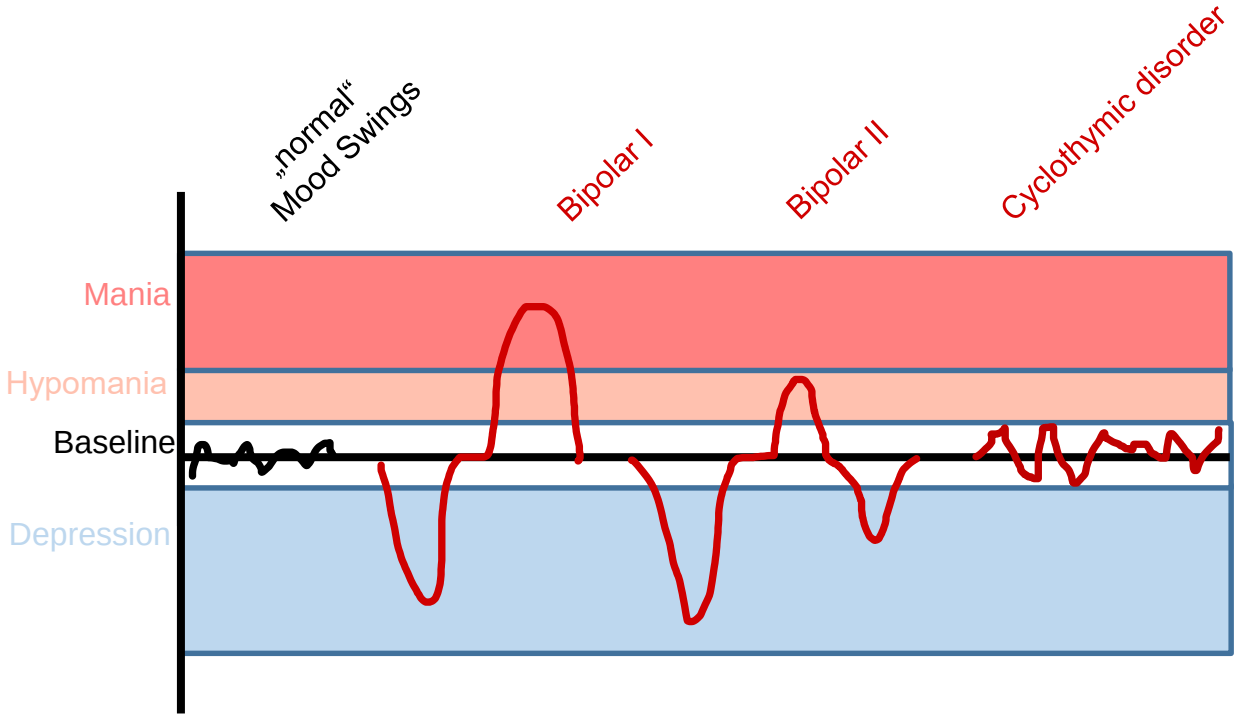
Manic Episode – Diagnosis DSM-5



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 I: ≥ 1 manic episode, followed by ≥ 1 depressive episode

Bipolar II: ≥ 1 depressive episode, followed by ≥ 1 hypomanic episode

Bipolar Disorders – Epidemiolgy and Pathogenesis

- lifetime prevalence 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 traits (?) (Haack 2010)

Bipolar Disorders – Prognosis

- Most have few episodes, 10% >10 episodes (APA Guidelines 1994, Goodwin 2007)
- Residual symptoms impair psychosocial function (Benazzi 2001)
- 15 - 20 % suicide, usually during depressive phase or mixed episodes!!! (Veiby 2013, Guze and Robins 1970)

Depression *vs.* Bipolar Disorder BD

- Close to 60% of BD individuals are initially diagnosed as having unipolar depression → 5 – 10 years on average for approriate diagnosis & treatment

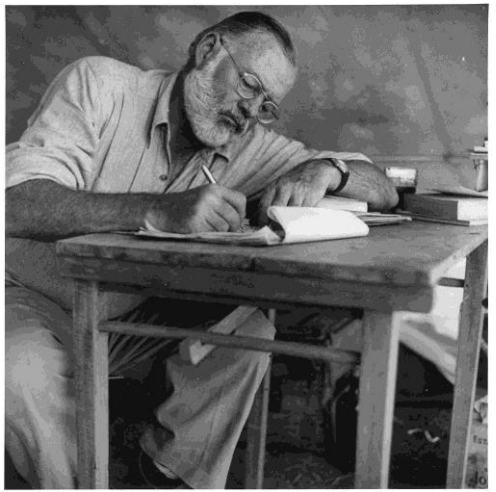
- Misdiagnosing BD as unipolar: deleterious consequences!
  - no prophylaxis for future episodes → recurrent episode
  - antidepressants → switch to manic episode
  - ↑ suicide attempts/suicide

Jorge Renner Cardoso de Almeida *et al.* Biol Psychiatry. 2013

Mood Disorders – Comorbidities

- Disorders that are often coexistent with each other

- Ernest Hemingway:
  Depression (or BD?) and alcohol dependence



Mood Disorders – Comorbidities

- Psychiatric Comorbidities
  - Anxiety 30% (Holsboer-Trachsler 2016)
  - Personality disorders 30-40% (Zimmermann 1994, Tyrer 1995)
  - Dementia up to 50% (Guideline 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
  - Parkinson‘s Disease
  - Multiple Sclerosis

Bipolar Disorders – Treatment

- **Manic episode → often only possible as inpatient treatment!**
  Antipsychotics (e.g. aripiprazole, asenapine, olanzapine, **quetiapine**)
  Mood stabilizers (valproate, lithium, carbamazepine)
  Acute: benzodiazepines, haloperidole, olanzapine

- **Depressive episode → antidepressants lead to high risk of switching into manic episode!**
  Antipsychotics (quetiapine, lurasidone, olanzapine)
  Mood stabilizers (valproate, carbamazepine, lithium, lamotrigine)
  Combination (e.g. lurasidone + valproate, lithium + valproate, quetiapine + lithium)
  (SSRI only in combination with antipsychotic, e.g. olanzapine + fluoxetine)
  Psychotherapy

- **Maintenance treatment → prevention of episodes!**
  Mood stabilizer (e.g. lithium, lamotrigine), antipsychotics (e.g. quetiapine, aripiprazole) or combination!
  Psychotherapy
  Psychosocial intervention

Guideline GermanSociety of Psychiatry Psychotherapy and Neurology, 2019

Bipolar Disorder

- Identify risk for bipolar disorder in patients presenting with depression
- Predict bipolar episodes
- Differential treatment → in particular maintenance treatment
- Predict risk for suicide → prevention

clinician's wish list

summary

Thank you very much for your attention

sanatoriumKILCHBERG
PRIVATKLINIK FÜR PSYCHIATRIE
UND PSYCHOTHERAPIE

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)