The Mood Disorders

TOURO

Live Lecture

08/05/2025

1500-1700

&

Live ZOOM

08/08/2024

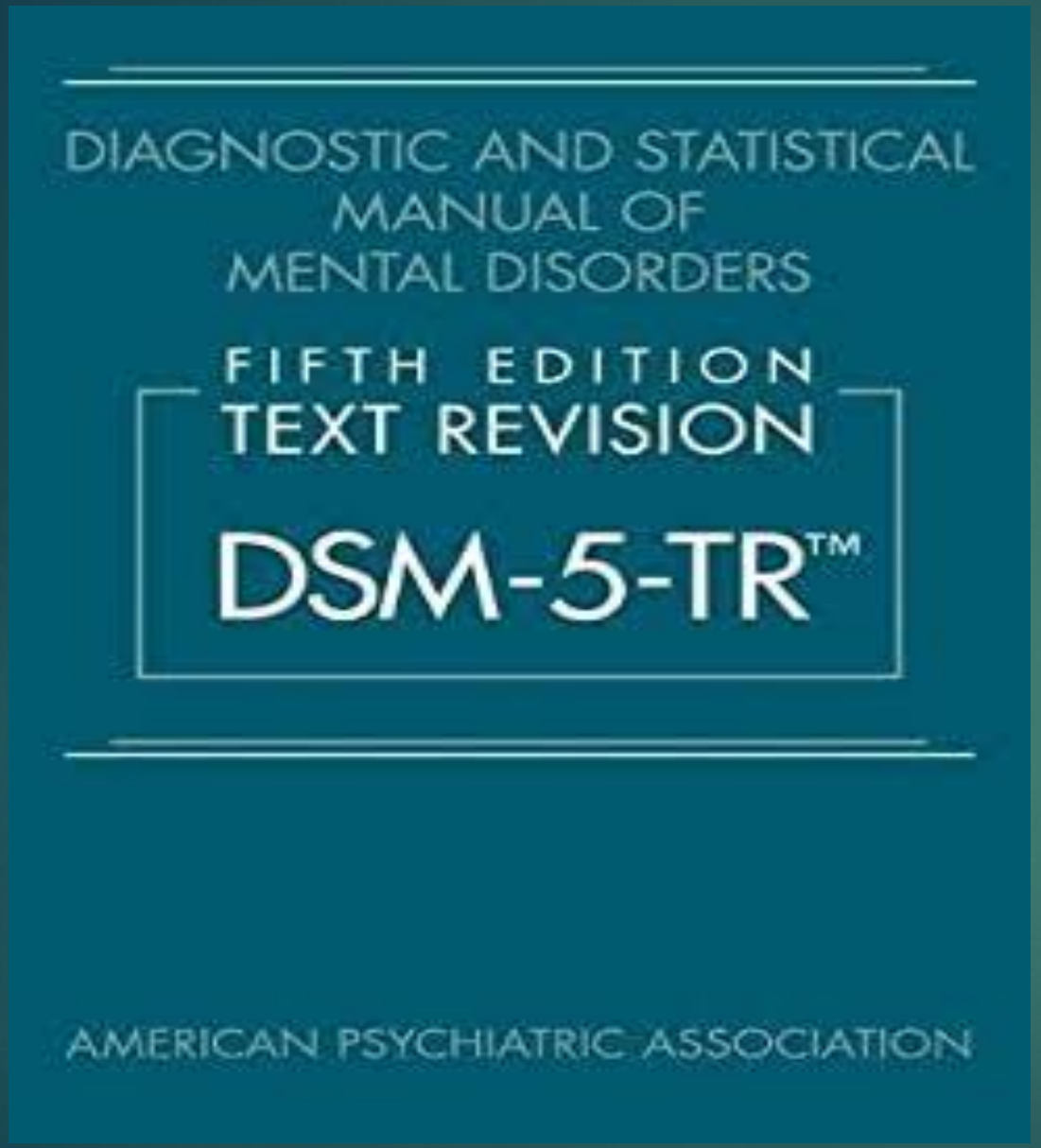
0800-1000

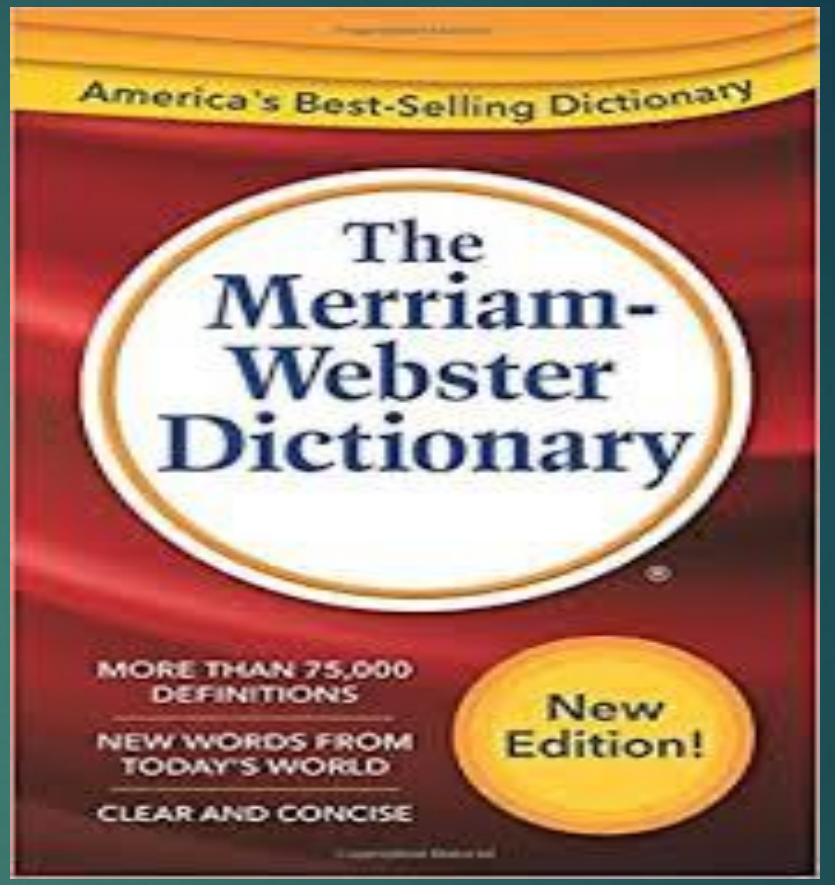
Jeffrey Zwerin, D.O.

Objectives

At the end of this lecture, each student will have a greater understanding of:

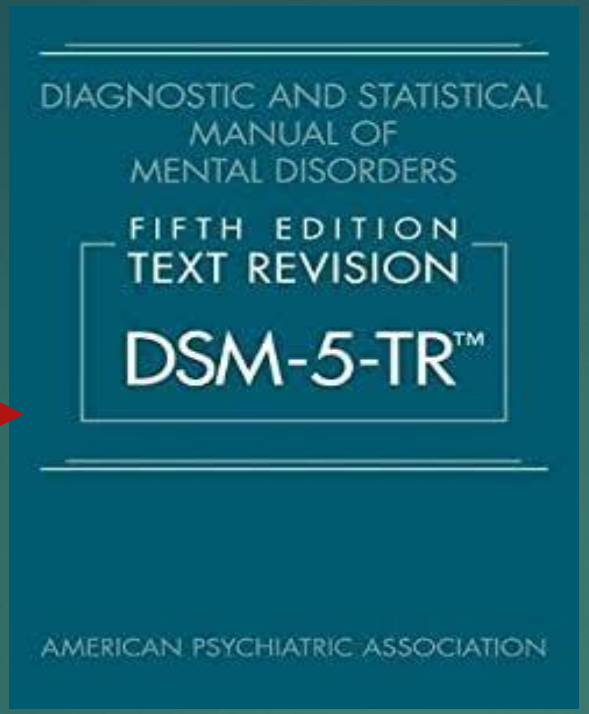
1. The Epidemiology and Etiology of Mood Disorders.
2. The Genetic studies of Mood Disorders, including family studies.
3. The names of the Mood Disorders in DSM-5 TR
4. The DSM-5-TR criteria for each of the Mood Disorders
5. The different specifiers used to describe the Mood Disorders
6. The differential Diagnoses of Mood Disorders,
7. The following disorders: Post-partum Depression, Premenstrual Dysphoric (PMDD), Seasonal Affective Disorder, and Persistent Depressive Disorder (dysthymia).
8. The basic treatment of patients experiencing a mood disorder.
9. How to assess if someone is experiencing a depression (mnemonics)
10. How to assess if someone is experiencing a manic episode.
11. The difference between a grief reaction and a major depressive disorder.
12. When as a PCP to refer a patient to a psychiatrist.

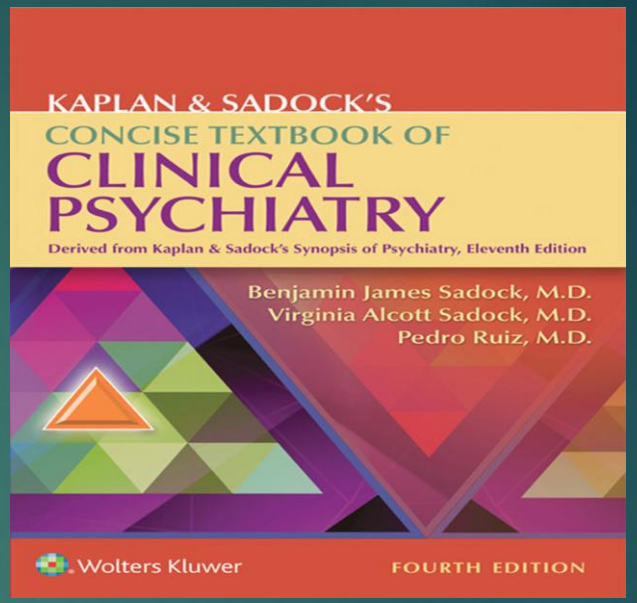


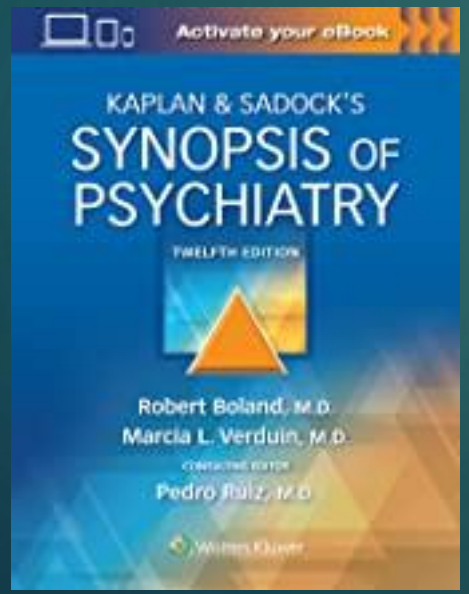


SHOULD I TRY TO MEMORIZE THE DSM-5 -TR REFERENCE BOOK?


DESK REFERENCE
TO THE
DIAGNOSTIC CRITERIA
FROM
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FIFTH EDITION
TEXT REVISION
DSM-5-TR™
AMERICAN PSYCHIATRIC ASSOCIATION


KAPLAN & SADOCK'S
CONCISE TEXTBOOK OF
CLINICAL
PSYCHIATRY
Derived from Kaplan & Sadock's Synopsis of Psychiatry, Eleventh Edition
Benjamin James Sadock, M.D.
Virginia Alcott Sadock, M.D.
Pedro Ruiz, M.D.
Wolters Kluwer
FOURTH EDITION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KAPLAN & SADOCK'S
SYNOPSIS OF
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Robert Boland, M.D.
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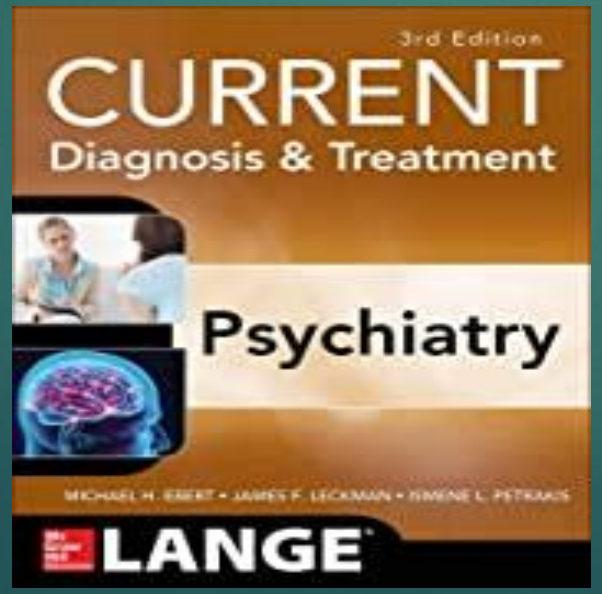
3rd Edition
CURRENT
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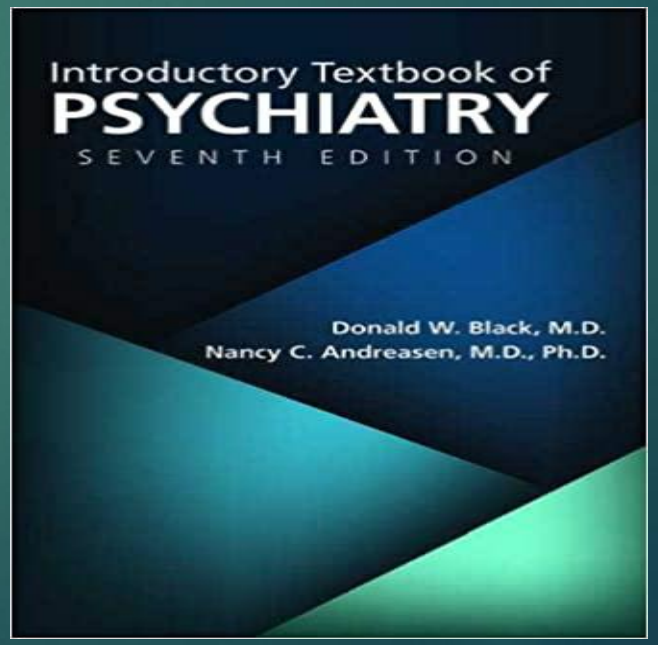
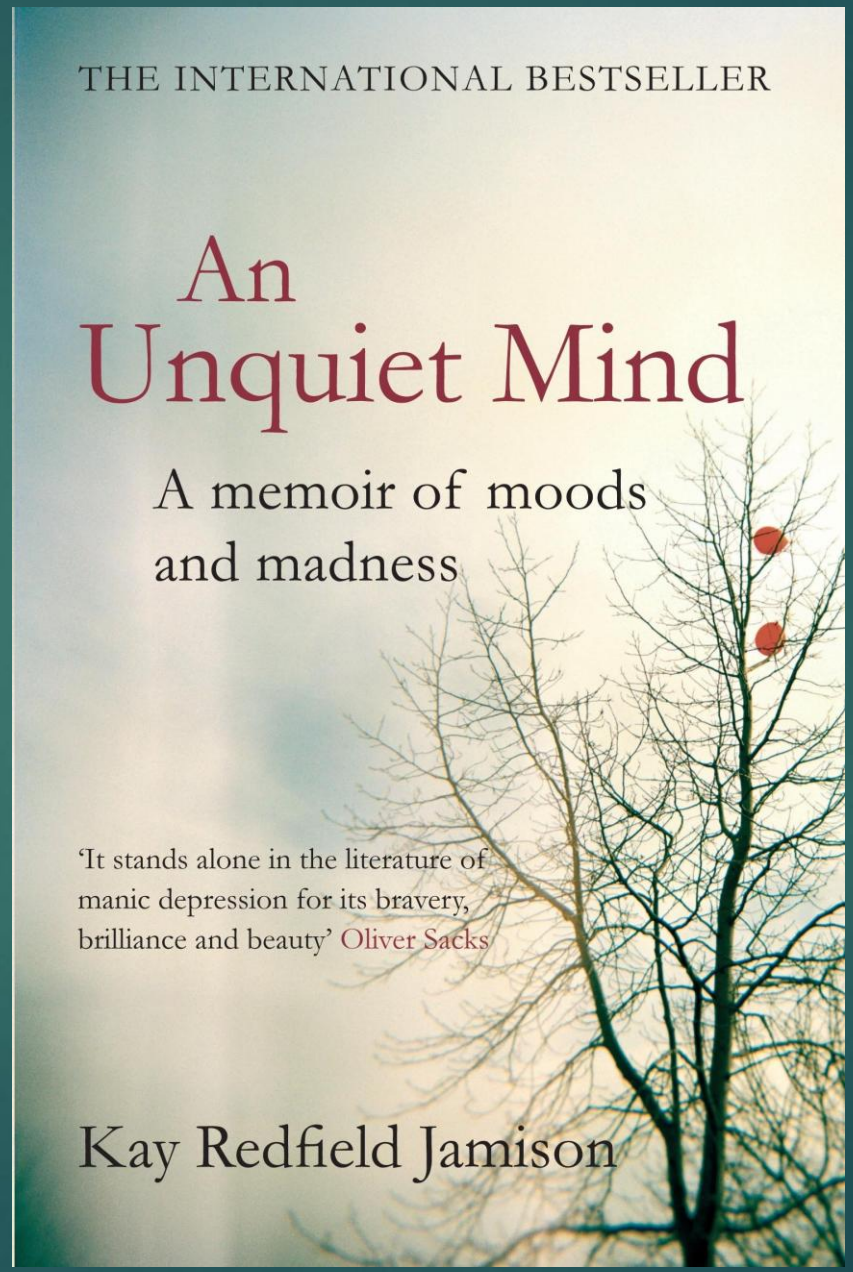
Psychiatry
LANGE


Introductory Textbook of
PSYCHIATRY
SEVENTH EDITION
Donald W. Black, M.D.
Nancy C. Andreasen, M.D., Ph.D.

A fantastic memoir of Dr. Kay Jamison's struggles to overcome bipolar disorder.
She is currently on staff in the Department of Psychiatry at Johns Hopkins University,



Even if you do not become a psychiatrist, reading this book, and others recommended in this course, will make you a more empathic physician when treating patients with emotional illness.

Also, a great talking point on interviews especially for those pursuing a psychiatry residency.

Module Exams and General Questions

- I am available at almost any time to answer any psychiatry questions, be it in regards to a general question you may have or simply one concerning a module exam. I also answer questions regarding getting into a psychiatry residency.
- **What to do**:
- 1. **Email** me at: jzwerin@touro.edu
  - 2. Email me your question, or
  - 3. Ask for a meeting via phone or ZOOM.
    - ✓ Typically I respond very rapidly to questions
    - ✓ Always feel free to ask a question to help clarify ANYTHING that we cover in the course.
- What **NOT** to do:
- 1. **Wait** till 2300-2400 on the night before an exam to email me me your question(s).
- 2. **Wait** until you are about to begin the exam to try to ask me a question.
- 3. **Worry** that you will bother me by asking a question.

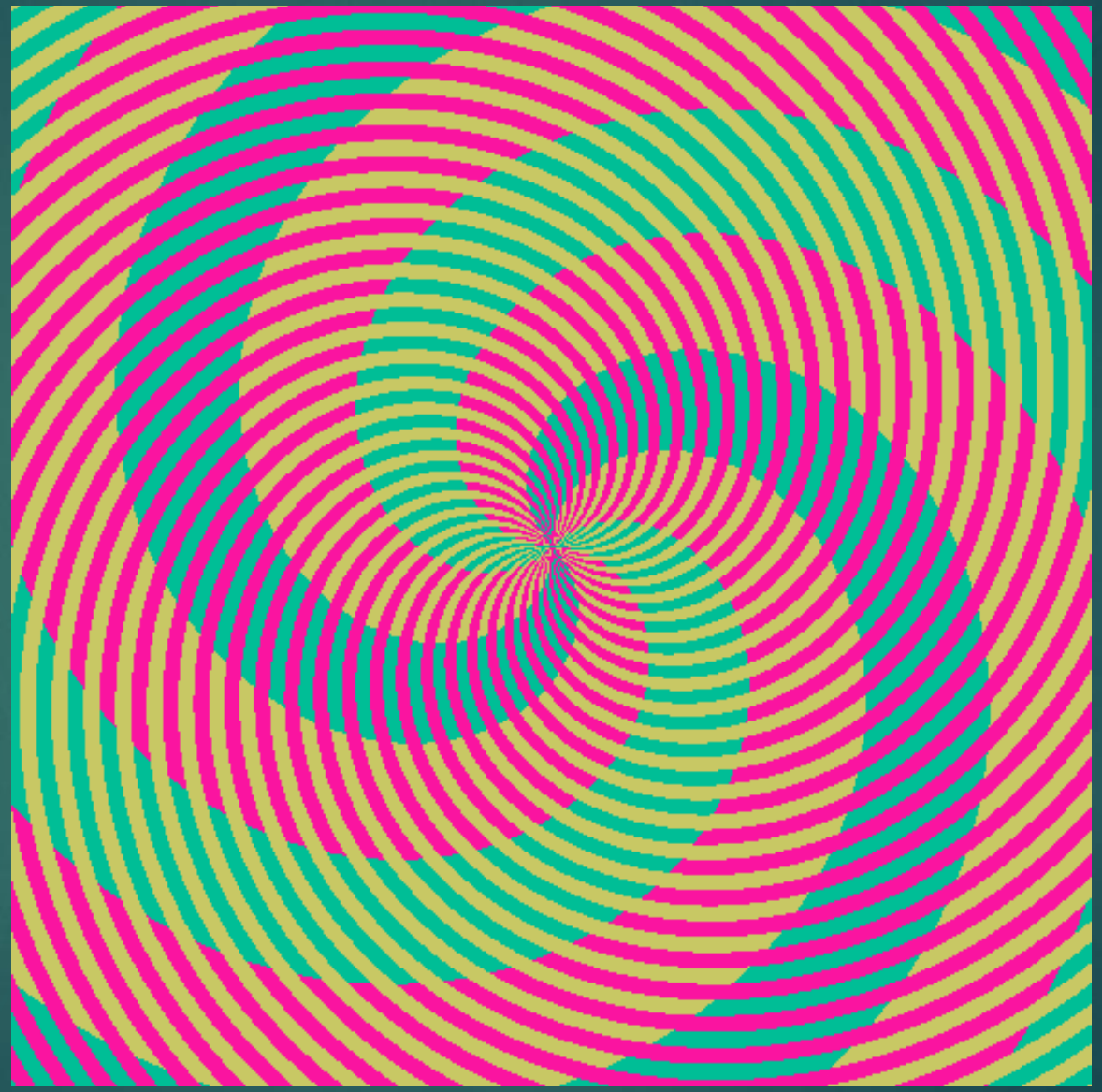
A WORD ABOUT VIDEOS

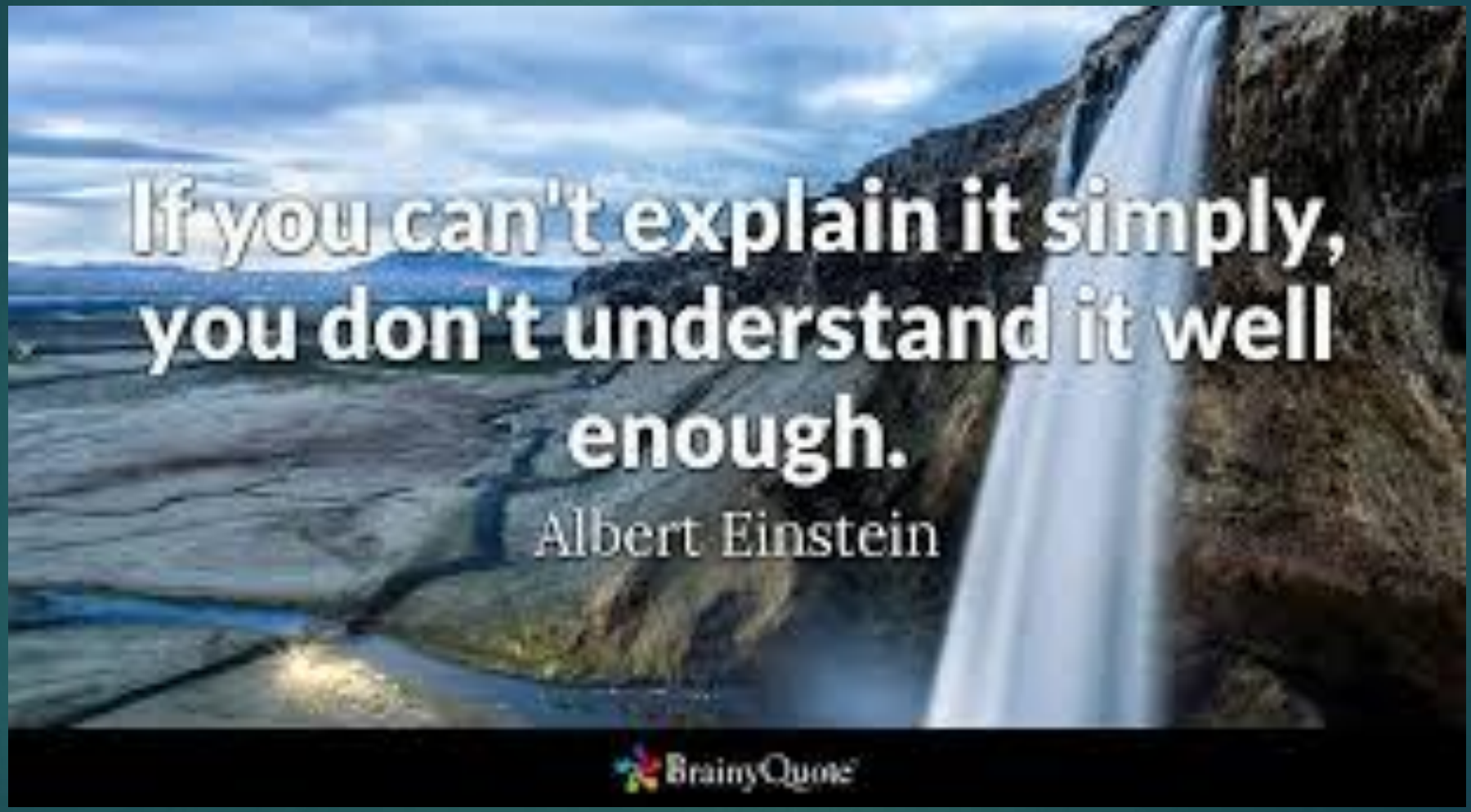
- In this course we will see **many** video clips!!
- I began to utilize them after attending several APA workshops recommending the use of videos to teach psychiatry to medical students.
- A few clips that I use are from Hollywood movies. A few are from YouTube.
- The majority of the clips involve board certified psychiatrists interviewing patients.
- Some clips may be over 20 years old. (Some ~70 years old) (Movies)
  - Remember the concepts illustrated are what matters, and not when the movie/interview was filmed.
- Most, but not all are in color.
- So, why do I show all these videos?
  - The videos reinforce visually what is discussed in the lecture.
  - Many students have told me they have reviewed them in prep for module exams and boards and found them to be very useful.
  - I truly believe they will help you to remember important concepts and DSM-5-TR diagnostic criteria

- I hope you will enjoy them!!

Note: This lecture and or the video(s) that accompany it contain content that may elicit uncomfortable feelings in some students.

Spiral




If you can't explain it simply,
you don't understand it well
enough.
Albert Einstein
BrainyQuote

Overview of Mood Disorders

- **Mood:** Pervasive and sustained emotion or feeling tone that affects an individual's behavior and colors one's perception of being in the world.
- From a psychiatric perspective mood abnormalities are conceptualized as having two primary states or poles: depression and mania
- Disorders of Mood: (Affective Disorders)
  - A. Bipolar Disorder
  - B. Depressive Disorder
  - C. Other disorders

Overview

Mood Disorders:

- Have a high prevalence, and high mortality rate.
- The leading psychiatric problem seen in **primary care** settings.
- For people ages 15-45 depression leads to 10.3% of all costs of biomedical illnesses world-wide.
- Bipolar disorder with extreme mood swings ranks 6th among world's most disabling illnesses
- **Good news**: When correctly diagnosed and treated, the mood disorders usually respond well!

Epidemiology of Mood Disorders

- **I. Lifetime Prevalence**
- A. Major Depressive Disorder: 17%
- B. Bipolar I + Bipolar II: 2%
- C. Persistent Depressive Disorder (Dysthymia): 2.5%
- (A+B+C ~ 20% of population)
- D. Cyclothymia: 0.5-6.3%

II. **Sex:**

- MDD: 2 female /1 male,
- Bipolar: 3 female/ 2 male

Epidemiology

- **Comorbidity**

  Individuals with a major mood disorder are at increased risk of having one or more additional comorbid disorders.

  a. Alcohol/substance abuse-dependence
  b. Panic disorder
  c. Obsessive compulsive disorder (OCD)
  d. Social Anxiety disorder

  Individuals with substance use disorders + anxiety disorders have an increased risk of lifetime or current comorbid mood disorder.

  So be sure to assess for a mood disorder if they have such disorders

Epidemiology of Mood Disorders

- **III Age of Onset**
- A. Bipolar disorder: 25 years
- B. Major depressive Disorder: 32 years
- C. Persistent depressive Disorder (dysthymia) : 31 years

Etiology of Mood Disorders

- **Theories**
  - A. Genetics
  - B. Biochemical (neurotransmitter and/or receptor dysfunction
  - C. Neuroendocrine dysregulation (HPA) (Hypothalamic Pituitary Axis)
  - D. Immunological disturbance
  - E. Sleep disturbances
  - F. Psychosocial Factors (e.g., response to loss)
  - G. Neuroimaging Studies

Genetics

- Although they are felt to be independent disorders, Bipolar Disorder and Major Depressive Disorder are thought to share some common genetic factors (Bipolar Disorder is felt to also share some genes with Schizophrenia).
- The likelihood of developing either of these illnesses depends in part on the combined, small effects of variations in many different genes affecting brain functioning, none of which is powerful enough to cause the disease itself.
- The identification of specific gene variations is beginning to lead to a more complete understanding of these disease states.

Genetic Studies

- Concordance Rates for Bipolar Disorder in monozygotic twins had been found to be approximately 60%, with a 19% rate in dizygotic twins.
- In Unipolar or Major Depressive Disorder, there is an approximate rate of 54% for monozygotic concordance and a 24% dizygotic concordance rate.

Family Studies

- Affective (mood) disorders are clearly familial
- The rate of MDD in 1st degree relatives with MDD is 2-3 times the rate in controls.
- The rate of Bipolar Disorder in 1st degree relatives with Bipolar Disorder is 4-18 times that of controls (depending on the study)
- Among relatives with patients with MDD there is a tendency for BD to occur more frequently than it does in controls.
- In some studies the most frequent mood disorder in relatives with BD is not BD, but MDD; BD is the next most frequent.

The Bipolar Disorders

DSM-5-TR Bipolar and Related Disorders

- 1. Bipolar I Disorder
- 2. Bipolar II Disorder
- 3. Cyclothymic Disorder
- 4. Substance/medication induced bipolar and related disorder
- 5. Bipolar and related disorder due to another medical condition.
- 6. Other specified bipolar and related disorder.
- 7. Unspecified bipolar and related disorder.

Bipolar I Disorder

- The occurrence of at least one **manic** or **mixed episode**
- Typically Bipolar I disorder is characterized by recurrent episodes of **BOTH** mania and depression, which can be separated by intervals of months to years.
- Episodes typically lead to marked psychosocial morbidity due to the effect of a severe recurrent illness on work and/or interpersonal relationships.
- Functioning of the individual during periods between episodes may be good or even excellent

Bipolar I Disorder

- DSM- 5-TR Criteria
  - **Manic Episode**
- **A**. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting ≥ 7 days, present most of the day, nearly every day(or **any duration if hospitalization is needed.**)

Bipolar I Disorder

- DSM- 5 TR Criteria **Manic Episode** (continued)
- **B**. During the period of mood disturbance, and increased energy or activity, ≥ 3 of the following symptoms are present to a significant degree represent a noticeable change from usual behavior:
  - 1. Inflated self-esteem or **grandiosity**
  - 2. **Decreased need to sleep** (e.g. rested after 3 hrs. of sleep).
  - 3. More talkative than usual or **pressure** to keep talking
  - 4. Flight of ideas or subjective sense thoughts are racing

Bipolar I Disorder

- DSM- 5-TR Criteria **Manic Episode** (continued)
- **B**. During the mood disturbance and increased energy or activity, **≥ 3** of the following symptoms are present to a significant degree and are a noticeable change from usual behavior
  - 5. **Distractibility** (i.e., attention too easily drawn to unimportant or irrelevant eternal stimuli) as reported or observed
  - 6. **Increased goal-directed activity** (school, socially, work, sexually) **or psychomotor agitation** (i.e., purposeless non-goal directed activity)
  - 7. Excessive involvement in activities that have high chance for painful consequences (e.g., unrestrained **buying sprees, sexual indiscretions, or foolish business deals, extramarital affairs, etc..**

Bipolar I Disorder

- DSM- 5-TR Criteria **Manic Episode** (continued)
- **C.** Mood disturbance is sufficiently severe to cause **marked impairment** in social, occupational functioning **or** to necessitate **hospitalization** to prevent harm to self or others, **or** there are **psychotic features**. **(This is very important!!)**

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

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication or ECT) but lasts at a fully syndromal level beyond the physiological effect of that treatment, is sufficient evidence of a manic episode, and therefore a Bipolar I disorder diagnosis.

Note: 1. Criteria A-D constitute a manic episode.

2. At least 1 manic episode is needed to make the diagnosis of bipolar I disorder.

Bipolar Disorder I

Psychotic or Hospitalization

> 7days

Recurring Manic Episodes and Or Mixed Episode

+/-

Major Depressive Episodes

(Typically occur, BUT Not Required)

Bipolar I Disorder **Manic Episode** Clinical Findings

- Mood typically is cheerful, enthusiastic and expansive
- Mood can be irritable, especially if patient feels thwarted. Such irritable patients can be difficult to manage.
- Due to euphoria, such patients have limited insight.
- Many will blame friends and family for their problems
- Some believe they have special powers or abilities beyond their education or intellect.
  - Feel they are capable or writing books/songs, or flying a jet, or doing brain surgery,
  - Get into risky business ventures.
- Inflated esteem and grandiosity may reach delusional proportions.
  - Claim they are religious figures, such as Christ, rock stars, or famous athletes, can cause wind to blow or the sun to shine. etc.

Bipolar I Disorder Manic Episode Clinical Findings
(continued)

- Increased goal directed activity or energy.
  - Such energy is usually accompanied by poor judgment.
- Often spend money excessively (3 cars all on credit…lose home)
- Commit to projects they cannot complete
- Involved in extramarital affairs.
- Usually require less sleep: often only getting 2-3 hours of sleep nightly.
- May go to bars, call friends at all hours of the night.
- Typically talk excessively and manifest pressured speech (a hallmark of mania)
  - Hard to get a word in edgewise, may even talk when no one is listening
  - May manifest flight of ideas.) (Skip from on topic to another).
- Perhaps as high as 50% of hospitalized patients have psychotic symptoms
  - Delusions occur in up to 75% of manic patients
  - Hallucinations

Manic Episode Course and Outcome

- Onset usually abrupt
- Episodes usually last days to months
- Manic episodes tend to be briefer than depressive episodes.
- Often episode of mania is followed by an episode of depression.
- Some patients with bipolar disorder recover fully, but many will have recurrent episodes of mild depression.
- **Complications** of mania:
  - **Social:** Marital discord, divorce, business and financial issues, sexual indiscretions
  - **Drug** and alcohol abuse: Increases during an episode.
  - **Cardiac**: Hyperactivity may be an issue for patients with cardiac problems
- When a patient switches to depression: May lead to an increased risk for suicide.

Manic Episode Course and Outcome
(continued)

- Mixed Features: Some patients may exhibit both manic and depressive symptoms within a single episode of illness.
  - Such patients may be talkative, energetic and expansive, yet seemingly moments later may burst into tears and complain of feeling hopeless and suicidal.
  - Associated with higher likelihood of alcohol abuse and suicide attempt, greater likelihood of rapid cycling and greater likelihood of a lifetime diagnosis of bipolar disorder.

Bipolar II Disorder

Bipolar II Disorder

- DSM- 5-TR Criteria **Hypomanic Episode**
- **A**. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting **≥ 4** consecutive days present most of the day, nearly every day. (Note: in **Bipolar I ≥ 7 days**)

Bipolar II Disorder

- DSM- 5-TR Criteria **Hypomanic Episode** (continued)
- **B.** During the mood disturbance and increased energy or activity, **≥ 3** of the following have persisted, represent a noticeable change from the usual behavior and have been present to a significant degree
  - 1. Inflated self-esteem or grandiosity
  - 2. Decreased need to sleep (e.g. rested after 3 hrs. of sleep).
    - (College)
  - 3. More talkative than usual or pressure to keep talking
  - 4. Flight of ideas or a sense thoughts are racing
  - 5. Easily distracted as reported or observed
  - 6. Increased goal-directed activity (school, socially, work, sexually) or psychomotor agitation
  - 7. Excessive involvement in activities that have high chance for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish business deals.

Bipolar II Disorder

- DSM- 5-TR Criteria **Hypomanic Episode** (continued)
- C. Unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
- D. The mood disturbance and change in functioning are noticeable by others.
- E. **Episode is NOT** severe enough to cause marked change in social or occupational functioning **or** to **require hospitalization**. (**Note**: Thus, if a patient is placed in a hospital the diagnosis automatically is Bipolar I and NOT Bipolar II.)
- F. Episode not due to effects of a substance (e.g., a drug of abuse, medication, other treatment)
- **Note**: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication or ECT) but lasts at a fully syndromal level beyond the physiological effect of that treatment, is sufficient evidence of a hypomanic episode diagnosis.

Bipolar II Disorder

- **Important points to remember to make this diagnosis:**
  - 1. **Must** meet requirements for **≥ 1** hypomanic episode **AND** have **≥ 1** major depressive episode. (Note: We will discuss the criteria for a Depressive Disorder later in this lecture)
  - 2. There can **NEVER** have been a manic episode.
  - Those patients who only experience manic episodes and NOT depressive episodes are termed : **unipolar mania or "pure mania"**
  - 3. The hypomanic episodes cannot be better explained by any other psychiatric disorder such as schizophrenia, schizoaffective disorder, etc.
  - 4. Symptoms of depression, or unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in functioning
  - **No** delusional thinking or hallucinations **(So not Psychotic). (If psychotic=Bipolar I)**
  - **No** hospitalization. **(If hospitalized=Bipolar I)**
  - **NOT** markedly impaired occupational or social functioning. **(If impaired=Bipolar I)**
  - **Rapid cycling:** ≥ 4 mood episodes (hypomanic or major depressive) in last 12 months.

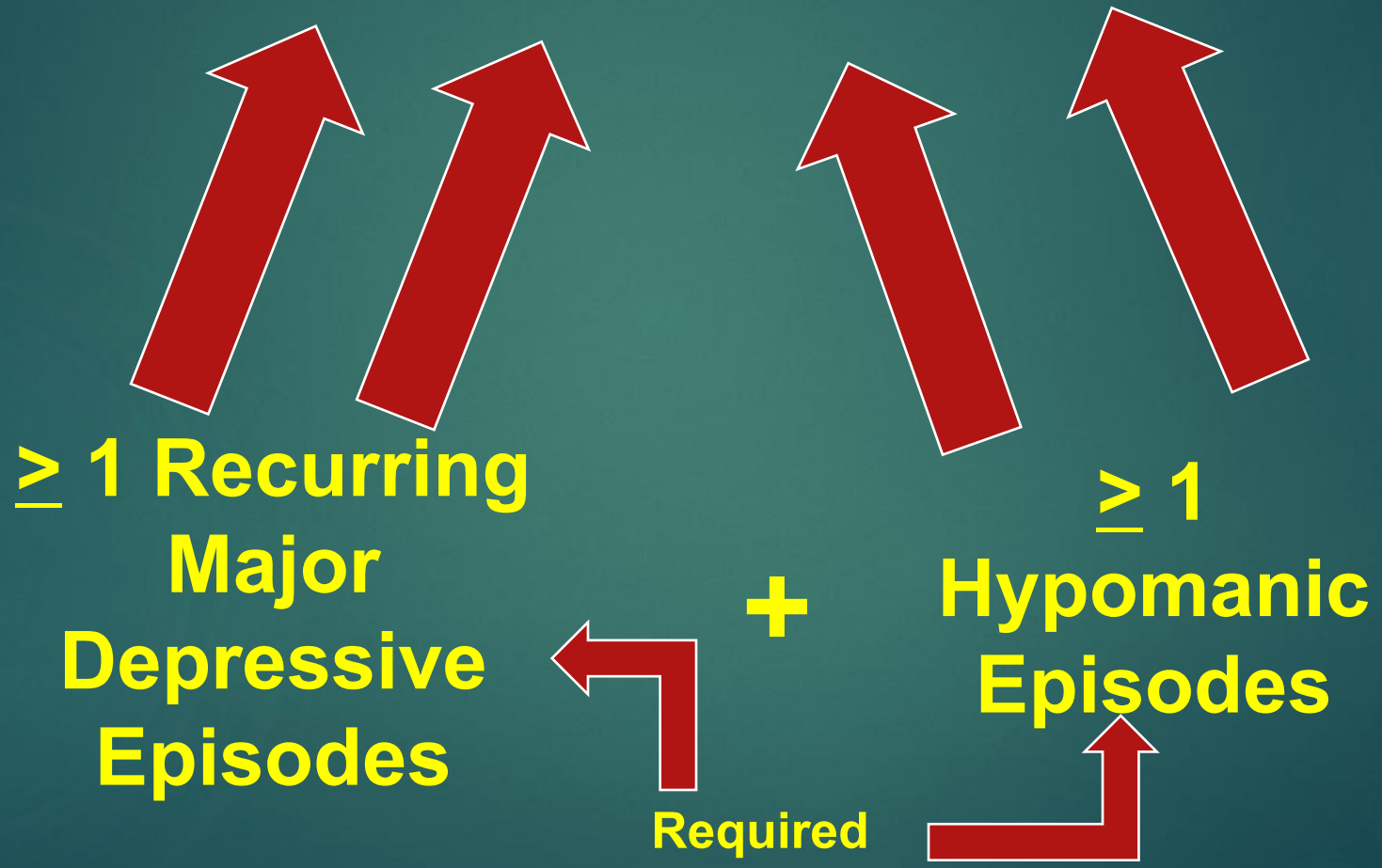
Bipolar II Disorder *(continued)*

- Other Important points regarding Bipolar II:
  - 5. Characterized by periods of hypomania that occurs either before or after periods of depression but may occur independently.
  - 6. These "mild manic episodes" not severe enough to require hospitalization.
    - However, may cause personal, work or social difficulties.
  - 7. Symptoms do not met full criteria for a manic episode.
  - 8. High rate of comorbidity disorders such as substance abuse.
  - 9. **More depressive episodes symptoms than bipolar I counterparts.**
  - 10. Like manic episodes, hypomanic episodes are often followed by a crash into a depressive episode.

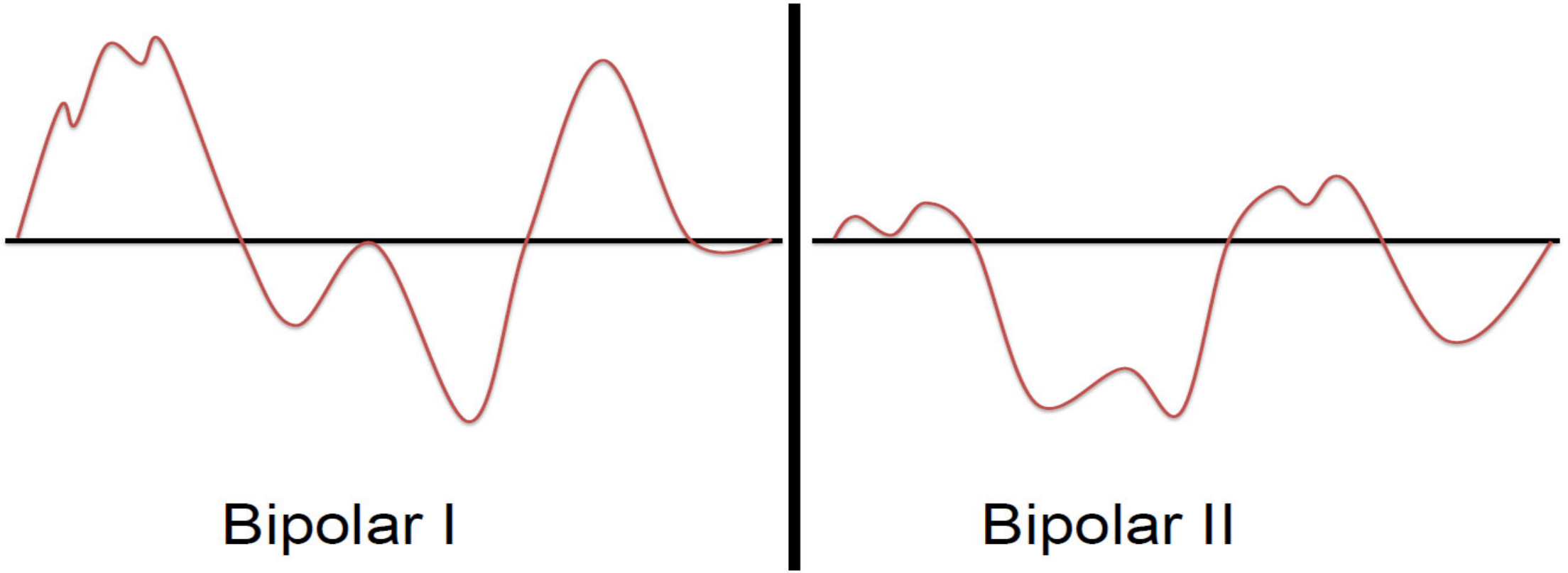
Bipolar II Disorder

- Remember: To meet criteria for a Bipolar II Disorder one must meet the criteria for a current or past **Hypomanic** episode **AND**
- criteria for a current or past **Major Depressive episode**.

Bipolar Disorder II



Bipolar Disorders



Bipolar I

Full manic episodes (at least 1 week duration)

Bipolar II

Hypomanic episodes (at least 4 days duration)

Cyclothymic Disorder

Bipolar Related Disorders

DSM-5-TR Criteria Cyclothymic Disorder

- A. For **> 2 years**, numerous periods with **hypomanic symptoms** which are not sufficient to meet criteria for a hypomanic episode and numerous periods with **depressive symptoms** that are not sufficient to meet criteria for a major depressive episode.
- B. During the 2 year period hypomanic and depressive periods have been present for **>** 50% of the time, and the individual has **not been without the symptoms for > 2 months** at a time.
- C. Criteria for a major depressive, manic, or hypomanic episode have **never** been met.

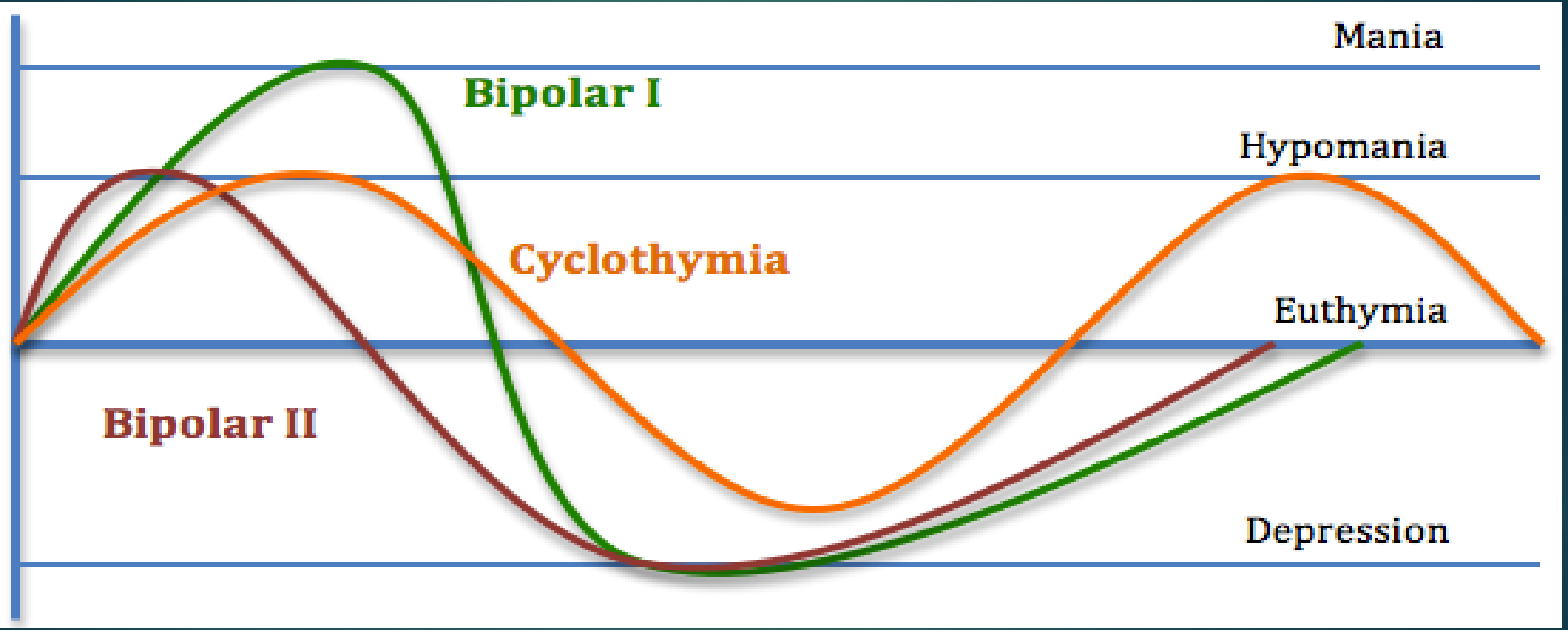
Bipolar Related Disorders

- DSM-5 –TR Criteria **Cyclothymic Disorder (continued)**

- D. Symptoms in Criteria A are not better explained by schizoaffective disorder, schizophrenia, other psychotic disorder, etc.
- E. Symptoms not due to effects of a substance (e.g., a drug of abuse or a medication) or another medical condition (e.g., hyperthyroidism)
- F. Symptoms do cause clinically significant distress or impairment in social occupational or other important areas of functioning.
- Note: **Cyclothymia** is the **mildest form of bipolar disorder**
  - When depressed these individuals do not meet criteria for a major depression
  - Patient tends to swing from high to low with chronic mild instability of mood.

Bipolar Related Disorders

- DSM-5-TR Criteria **Cyclothymic Disorder (continued)**
- Diagnostic features to keep in mind:
  - A Chronic fluctuating mood disorder
  - Involves numerous periods of hypomanic symptoms and periods of depressive symptoms.
  - **Hypomanic symptoms are insufficient in number/ severity/pervasiveness, or duration to meet criteria for a hypomanic episode**
  - **Depressive symptoms are insufficient in number/ severity/ pervasiveness, or duration to meet full criteria for a major depressive disorder (MDD)**
  - Symptom free periods must be no longer than 2 months.
  - If after 2 years, the patient develops a major depressive, manic or hypomanic episode then the diagnosis becomes:
    - Major depressive disorder,
    - Bipolar I or II disorder, and the diagnosis of Cyclothymic disorder is dropped


Mania
Bipolar I
Hypomania
Cyclothymia
Euthymia
Bipolar II
Depression

Bipolar Related Disorders

- DSM-5-TR Criteria **Substance/Medication-Induced Bipolar and Related Disorder**
- A. Prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.
- B. Evidence from the history, PE or LAB or both (1) and (2):
  - 1. Symptoms in criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
  - 2. Involved substance/medication is capable of producing the symptoms in Criterion A.
- C. Disturbance not better explained by a bipolar or related disorder
- D. Disturbance does not occur exclusively during a delirium
- E. Causes significant distress or impairment in areas of functioning.

Examples: Amphetamines, Steroids, Cocaine, PCP, etc.

Bipolar Related Disorders

- DSM-5 –TR Criteria **Bipolar and Related Disorder due to Another Medical Condition**
- A. Prominent and persistent period of abnormally elevated, expansive, or irritable mood or abnormally increased activity or energy that predominates in the clinical picture
- B. Evidence from the history, PE or LABS that the disturbance is direct result of another medical condition.
- C. Disturbance not due to another mental disorder.

  D. Disturbance does not occur exclusively during the course of a delirium.
- E. Symptoms cause clinically significant distress or impairment in social occupational or other important areas of functioning.
- Examples: Cushing's Disease, Multiple sclerosis, stroke, TBI
  - Do a complete PE and order LABS.

Specifiers for Bipolar and Related Disorders

- Specify if with:

1. With Anxious distress.
2. With mixed features
   a. Manic or hypomanic episode with mixed features
   b. Depressive Episode with mixed features
3. With rapid cycling
4. With Melancholic features
5. With atypical features
6. With psychotic features
7. With catatonia
8. With Seasonal Pattern (SAD)

Specifiers for Bipolar and Related Disorders

1. With **Anxious distress**: presence of at ≥ 2 of the following symptoms during the majority of days of the current or most recent episode of mania, hypomania or depression
   a. Feeling keyed up or tense
   b. Feeling unusually restless
   c. Difficulty concentrating due to worry
   d. Fear that something awful will happen
   e. Feeling the individual might lose control of himself or herself.

Specifiers for Bipolar and Related Disorders

2. With **Mixed features** : Can apply to current manic, hypomanic or depressive episode in bipolar I or bipolar II

   Manic or hypomanic episode with mixed features (≥3 of following noted majority of days

   a. Prominent **dysphoria** or depressed mood as noted by either subjective report (feels sad or empty) or observation of others (appears tearful)

   b. Diminished Interest or pleasure in all, or almost all activities

   c. Psychomotor retardation noted by others nearly everyday.

   d. Feeling of **fatigue** or loss of energy

   e. Feelings of worthlessness or excessive or inappropriate guilt

   f. Recurrent thoughts of death(not just fear of dying) recurrent suicidal ideation with or without a plan or an actual attempt.

   g. Feeling the individual might lose control of himself or herself.

Specifiers for Bipolar and Related Disorders

3. With **Mixed features** : Can apply to current manic, hypomanic or depressive episode in bipolar I or bipolar II

   Depressive episode with mixed features (≥3 of following manic/hypomanic symptoms noted majority of days

   a. **Elevated expansive Mood**

   b. **Inflated self esteem or grandiosity**

   c. More talkative than usual or **pressure** to keep talking.

   d. **Flight of ideas** or feeling one's thoughts are racing

   e. **Increase of energy** or goal directed activity(socially/work/sexually or at school)

   f. Increased or **excessive involvement in activities** that have high potential for painful consequences(buying sprees, sexual indiscretions, foolish business ventures)

   g. **Decreased need for sleep**(Feel rested despite less sleep than usual. (This not insomnia)

Specifiers for Bipolar and Related Disorders

4. With Rapid Cycling : Can apply to bipolar I or bipolar II disorder

   Presence of ≥4 episodes in prior 12 months that meet criteria for manic, hypomanic or depressive episode.

Note: These patients are typically more difficult to treat and need to be under the care of a psychiatrist.

Specifiers for Bipolar and Related Disorders

5. **With Melancholic features** :

A. **One or more** is present during the most severe period of the current episode.

1. Loss of pleasure in all or almost all activities (anhedonia)
2. Lack of reactivity to usually pleasurable stimuli (Does not feel any better when something good occurs)

B. Three or more of the following:

1. Distinct quality of depressed mood with profound despondency, despair, /or moroseness or an "empty mood".
2. Depression routinely worse in the morning
3. Early morning awakening (EMA) (at least 2 hours before usual awakening)
4. Marked psychomotor retardation or agitation)
5. Significant anorexia or weight loss. (I lost my appetite. I have no desire to eat. I Lost 10 pounds in the last month)
6. Excessive or inappropriate guilt

Specifiers for Bipolar and Related Disorders

6. With Atypical features : These features predominate during majority of days of current or most recent major depressive episode

A. **Mood reactivity**:

Mood brightens in response to an actual or or potential positive event(s). (Ex: Visit by grandchildren, compliments by others

B. Two or more of the following features :

1. Significant weight gain or or increase in appetite.
2. Hypersomnia
3. Leaden paralysis (arms or legs feel like lead)
4. Long standing pattern of interpersonal rejection sensitivity that results in significant social or occupational impairment.

Specifiers for Bipolar and Related Disorders

7. With Psychotic features : Presence of delusions or hallucinations.

   a. Mood Congruent:

      During manic episodes the content of the delusions and hallucinations is consistent with manic themes such as grandiosity, invulnerability etc.

      Ex. While manic voices tell her she is world's greatest surgeon

   b. Mood Incongruent:

      Content of hallucinations and delusions are inconsistent with the episode polarity themes as noted above.

      Ex. While depressed hears voices say she is world's greatest scientist.

Specifiers for Bipolar and Related Disorders

8. With Catatonia: (Will be more fully discussed in schizophrenia lecture)
    1. The patient seems lifeless
    2. Mute
    2. Exhibits negativism
    3. Exhibits automatic obedience
    4. Waxy flexibility (rare)
    5. Mannerisms (rare)
    6. Immobility

Specifiers for Bipolar and Related Disorders

9. With Peripartum Onset:

   Applies to Manic, Bipolar I or II, or Major Depression in Bipolar I or II.

   Onset is during pregnancy or in the 4 weeks following delivery.

We will discuss this topic in greater detail when we discuss the Depressive Disorders later in this lecture.

Specifiers for Bipolar and Related Disorders

9. With Seasonal Pattern

We will discuss this topic in detail when we discuss the Depressive Disorders later in this lecture.

The Depressive Disorders

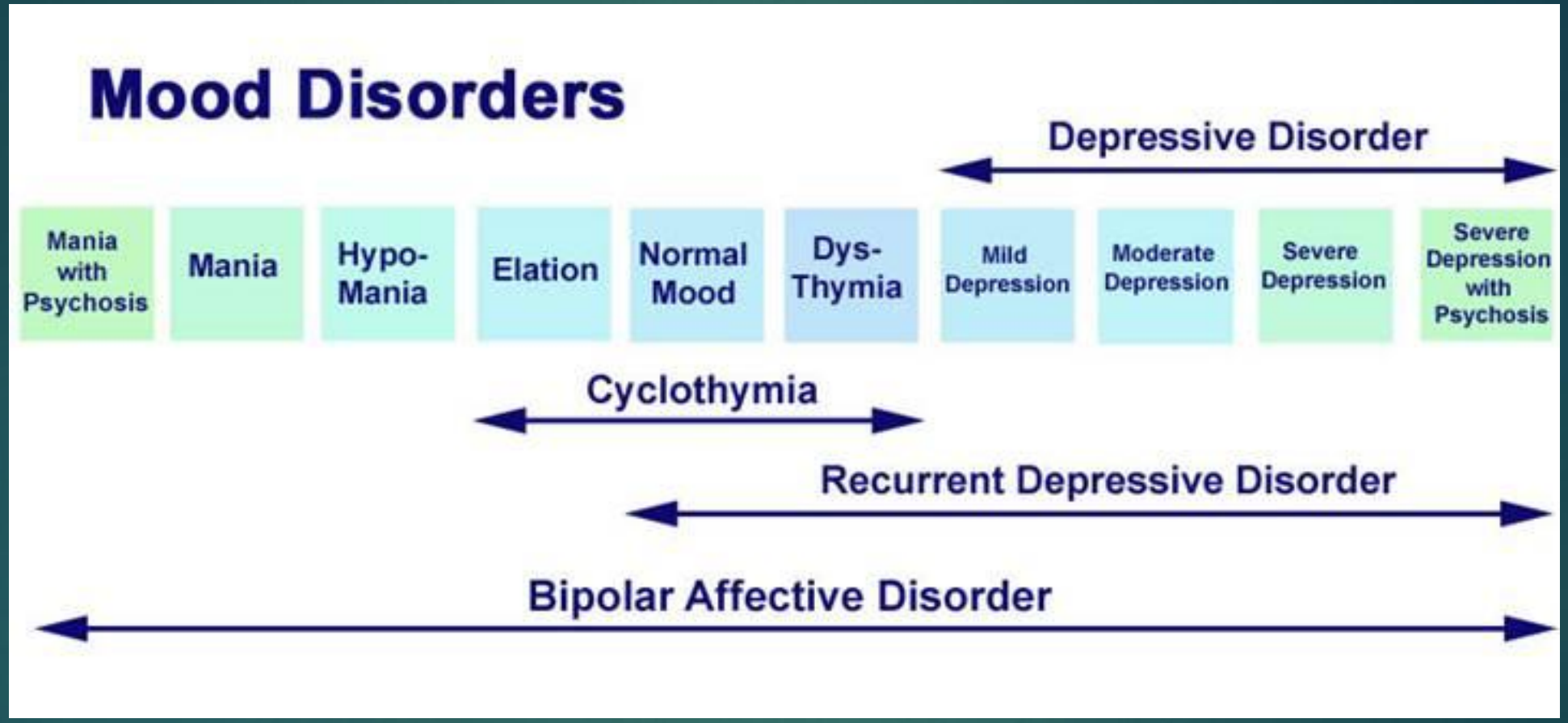
DSM-5-TR Types of Depressive and Related Disorders

1. Major Depressive Disorder, single episode
2. Major Depressive Disorder, recurrent
3. Persistent Depressive Disorder (Dysthymia)
4. Substance / medication induced depressive disorder
5. Premenstrual dysphoric disorder
6. Depressive Disorder due to another medical condition
7. Other specified depressive disorder
8. Unspecified depressive disorder

Major Depressive Disorder
(MDD)

Overview

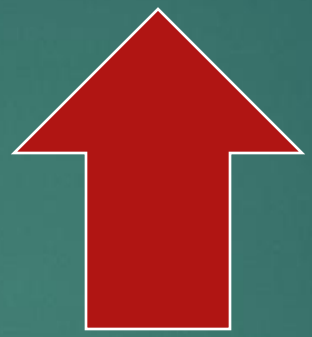
- **Major Depressive Disorder**
  - Patients who experience ONLY major depressive episodes: (Also called Unipolar Depression) (One must have **>1** major depressive episode to be diagnosed with MDD)


Mood Disorders
Depressive Disorder
Mania with Psychosis
Mania
Hypo-Mania
Elation
Normal Mood
Dys-Thymia
Mild Depression
Moderate Depression
Severe Depression
Severe Depression with Psychosis
Cyclothymia
Recurrent Depressive Disorder
Bipolar Affective Disorder

Major Depressive Disorder (MDD)
(Previously called Unipolar Depression)

- 1. World Health Organization ranks unipolar major depression as 11th greatest cause for disability and mortality in world
- 2. US ranks MDD 2nd among all diseases and injuries for cause of disability
- 3. Persistent depressive disorder ranks # 20
- 4. MDD highly recurrent
  - A. Recurrence in 2 years is > 40%
  - B. After 2nd episode recurrence in 5 years ~ 75%
- 5. In addition to substantial illness-associated morbidity, MDD is associated with the loss of 10 years of life.
- 6. Mortality studies indicate that cardiovascular disease is the most common cause of excess mortality.

Major Depressive Disorder (Unipolar Depression)



Only Major Depressive Episodes

Major Depressive Episode

- DSM 5-TR Criteria

A. Five (or more) of the following symptoms present during the same 2-week (14 day) period and is a change from prior functioning.

Major Depressive Episode

DSM 5-TR (continued)

A. Criteria **(≥5 or more of following criteria)**

- At least one of the symptoms must be either: # 1 or #2 below

1. Depressed mood most of the day, nearly everyday evidenced by subjective report (e.g., feels sad, empty **hopeless**) or observation of others (e.g., appears tearful)
2. Markedly diminished interest or pleasure in all or most activities daily or almost daily (anhedonia)
3. Significant weight loss (not dieting) or gain (e.g. a change of > 5% body weight in month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia almost daily
5. Psychomotor agitation or retardation nearly daily

Major Depressive Episode

- DSM 5 Criteria ***(continued)***

6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (may be delusional), nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (not merely self-reproach or guilt about being sick)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific **plan** for committing suicide.

Major Depressive Episode

- DSM 5 Criteria ***(continued)***
- **B**. Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- **C**. The episode is not due to the effects of a substance or another medical condition
- **Note**:
  - Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required to make the diagnosis of a bipolar I disorder.
  - There has never been a manic or hypomanic episode

	GRIEF	VS.	MAJOR DEPRESSIVE DISORDER
CLINICAL FINDINGS	1. Emptiness & Loss 2. Dysphoria decreases over days to weeks 3. Thoughts of deceased with pangs 4. May have periods of positive emotions 5. Thoughts are of deceased 6. Self-esteem preserved 7. Thoughts of death and dying typically involve deceased, or joining deceased		1. Persistent depressed mood, no pleasure or happiness. 2. Dysphoria is persistent comes in waves (pangs of grief) 3. Not tied to specific thoughts/person 4. Pervasive unhappiness and misery 5. Self-critical, pessimistic ruminations 6. Worthlessness, self-loathing 7. Thoughts of ending one's life, worthlessness, not deserving to live, or unable to cope with pain of depression

Major Depressive Disorder

- Important issues
- 1. MDD is associated with high mortality, (suicide mainly, but also poor recovery while medically ill)
- 2. There is no specific lab test to diagnose MDD. (You must do a careful psychiatric assessment (MSE)
- 3. Prevalence: In US 7% in 12 months.
  - However 18-24 y/o: are 3x higher than 60+ and
  - females 1.5-3x higher rate than males beginning in early adolescence
- 4. After hospitalization for initial episode approx. 50% recover in first year.

Major Depressive Disorder

Important issues (continued)

- 6. About 25% suffer another major depressive disorder within 6 months after hospitalization.
- 7. 30-50% have another episode in 2 years
- 8. 50-75 have another episode in 5 years
- 9. Lower relapse rate with prophylactic medication!!!
- 10. Incidence of completed suicides in patients who require hospitalization is 15% (This is a more severely ill sub-population) (Observe carefully post discharge)
- Most common onset is during late twenties to mid-forties.

Major Depressive Episode

- As major depression is the most common psychiatric illness, that clinicians in any branch of medicine will encounter, it is worthwhile to commit at least one the following two mnemonics to memory. It is important to remember to always ask about such symptoms, when doing a mental status evaluation (MSE) on a **new** patient or any patient with depression who you are already treating.

SIG:ECAPS Prescribe energy capsules	DIWSMEGCS Depression is worth studiously memorizing extremely grueling criteria sorry.
1. Sleep	1. Depressed Mood
2. Interest	2. Interest
3. Guilt	3. Weight
4. Energy	4. Sleep
5. Concentration	5. Motor activity
6. Appetite	6. Energy
7. Psychomotor	7. Guilt
8. Suicide	8. Concentration
	9. Suicide
Note: Depression is not part of this mnemonic	

Major Depressive Disorder

- Clinical Findings
- A. Alteration in mood:
  - A person feels sad, despondent, down in dumps, etc.
  - A few will complain of being tense of irritable with only minor sadness or
  - Unable to feel pleasure or enjoy things they had in past. (Anhedonia)
- B. Vegetative (or somatic) symptoms
  - Decreased appetite (usually with weight loss)
  - Increased Appetite (Less frequently noted) eats more often and gains weight. (Atypical depression.)
  - Insomnia
    - Initial Insomnia: difficulty falling asleep (DFA)
    - Middle Insomnia: Awaken in middle of night and stay awake for an hour or two and finally fall asleep again.
    - Terminal Insomnia: Awaken early in the morning and unable to fall asleep again. (EMA) Such patients often have more severe depression.
  - Hypersomnia: Some patients may complain of feeling tired all the time and need to spend 10-14 hours in bed daily.

Major Depressive Disorder

- Clinical Findings (continued)
- C. Difficulty Concentrating:
  - Psychomotor retardation
    - May sit in a chair for hours with out talking or just staring into space.
    - Will speak in low tone; very slowly and replies are brief.
  - Psychomotor Agitation
    - Patients are restless and seem nervous. Often pace about the room. May wring hands or perform repetitive gestures such as drumming fingers on a table or pulling on their hair
- D. Energy:
  - Complain of fatigue or having no energy. Note in PCP this is often a presenting problem.
- E. Feelings:
  - Worthlessness and guilt are commonly noted.
  - Lose confidence in themselves so do not take exams, forget to work or assume responsibility
  - May become hopeless. (Note: I was always very concerned if someone felt hopeless!)

Major Depressive Disorder

- Clinical Findings (continued)
- F. Functioning During the Day:
  - Diurnal variation: Patients typically feel worse in the morning but improve somewhat during the day and feel best in the evening. (Worst AM…Best PM)
- G. Thoughts of death and dying:
  - Suicide:
    - May be seen as an escape from their suffering or as deserved punishment for their perceived "misdeeds".
    - May express belief that others would be better off without them.
    - As suicide risk is high in depressed individual it MUST be discussed. (Malpractice not to do so!!)

Major Depressive Disorder

- Clinical Findings (continued)
  - H. Sex Drive
    - May decrease markedly, so patient may have no interest in sex or may experience impotence or anorgasmia.
  - I. Masked depression:
    - The full depressive syndrome is not obvious as the patient does not report a depressed mood.
      - Older patients my complain of somatic symptoms such as insomnia, loss of appetite, and energy to the PCP.
      - When depression is later appropriately treated the somatic symptoms end.
  - J. Psychotic Symptoms:
    - 20% experience psychotic symptoms
      - Mood congruent: Hear voice of God telling them are are terrible and will burn in hell.
      - Mood Incongruent: I am being spied upon because I developed a time machine and they want to steal it from me.

Major Depressive Disorder

- **Clinical Outcome**
  - May begin either suddenly or gradually
  - Untreated episode lasts weeks to months
  - May last for years untreated, but usually clears within 6 months spontaneously
  - If treated appropriately the prognosis for a single depressive episode is very good.
  - A large percentage of patients will have a recurrence of depression at some point in their lives.
  - About 20% will develop a chronic form of depression
  - Approximately 10-15 % of those hospitalized for MDD will commit suicide.
    - Factors that increase suicide risk
      - Divorced, living alone, alcohol or substance abuse, being > 40 years of age, history of a prior attempt, having a suicide plan especially if detailed.
      - Patients who are considered a high risk for suicide should be involuntarily hospitalized for their safety
  - Drug and alcohol abuse: Patients who try to treat themselves for depression with sedatives, alcohol and or stimulants lead to other serious issues making recovery more challenging.

Major Depressive Disorder

Definitions

1. Response- a 50% reduction in symptoms sustained for 2 weeks.

   (~50% all patients with uncomplicated depressive symptoms)

2. Remission- the virtual absence of depressive symptoms. (only 35-50% will achieve full remission)

3. Relapse- a return of the major depressive episode prior to recovery.

4. Recovery- a state of remission for ≥ 4 months.

5. Recurrence- the occurrence of a new major depressive episode after recovery.

Persistent Depressive Disorder (Dysthymia)

(Note: euthymia is the term for a normal mood)

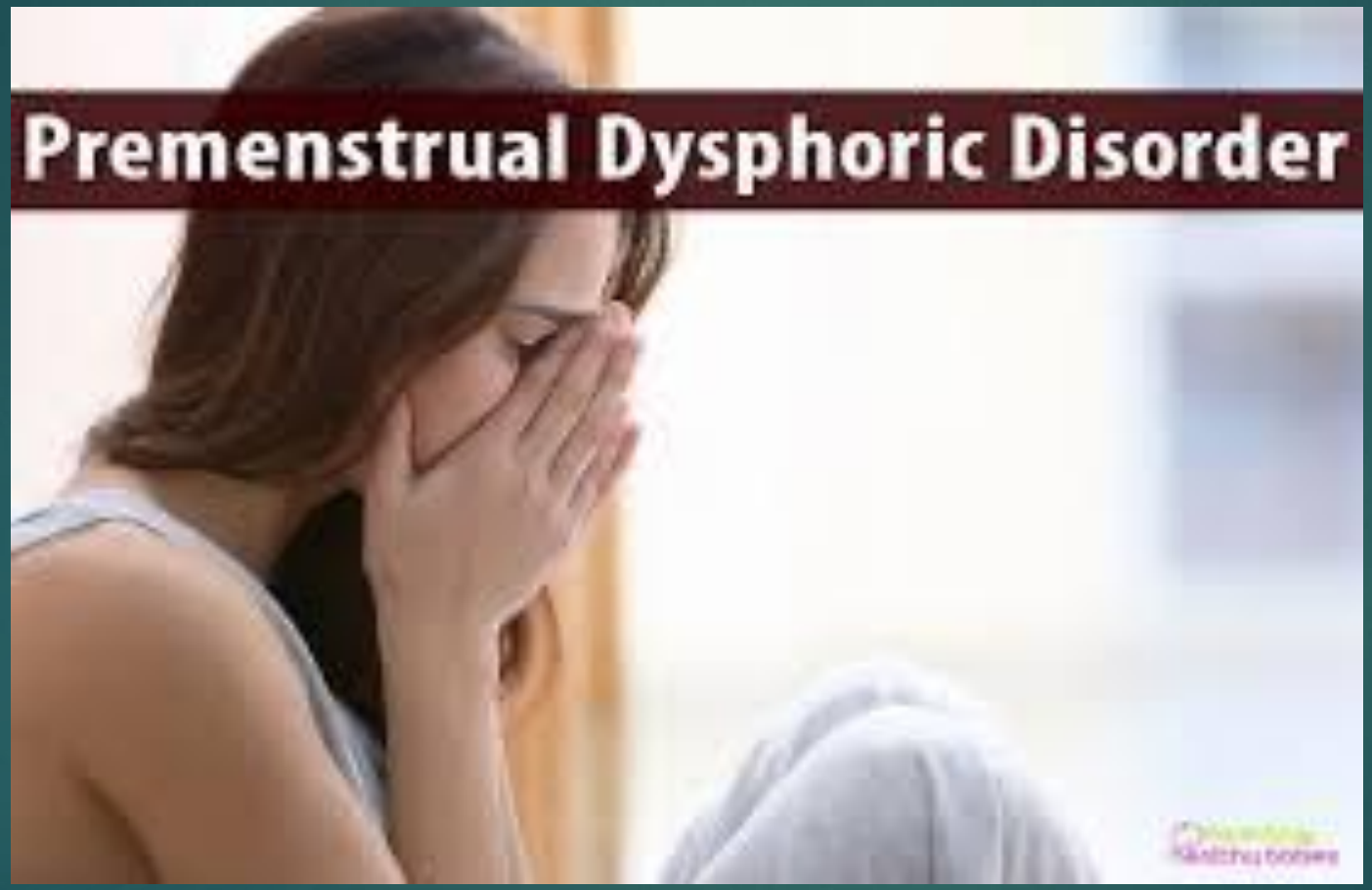
Persistent Depressive Disorder (Dysthymia)

- DSM -5-TR Criteria
- A. Depressed mood most of the day, more days than not, for **≥ 2 years**.
- B. Presence while depressed of ≥ **2/6** of following: (Note: in MDD it requires ≥5/9)
  - 1. Poor appetite or overeating
  - 2. Insomnia or hypersomnia
  - 3. Low energy or fatigue
  - 4. Low self-esteem
  - 5. Poor concentration or difficulty making decisions
  - 6. Feelings of hopelessness

Persistent Depressive Disorder (Dysthymia)

- DSM -5-TR Criteria (continued)
- C. During the 2 year period of the disturbance, the individual has NEVER been without symptoms in criteria A and B for > 2 months at a time.
- D. Criteria for a major depressive disorder may be continuously present for 2 years.
- E. Never been a manic or hypomanic episode and criteria for cyclothymic disorder was never met.
- F. Disturbance not better explained by schizoaffective disorder, schizophrenia spectrum and other psychotic disorder
- G. Symptoms not due to physiological effects of a substance(e.g., a drug of abuse a medication) or another medical condition
- H. Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Premenstrual Dysphoric Disorder



Premenstrual Dysphoric Disorder

DSM-5-TR Criteria (Was new in DSM-5)

A. In the majority of menstrual cycles, at least five **(5)** symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week post-menses.

Premenstrual Dysphoric Disorder, Diagnostic Criteria (Continued)

B. One or more of the following four symptoms must be present:

(1) Marked affective lability (e.g. mood swings; feeling suddenly sad or tearful; increased sensitivity to rejection).

(2) Marked irritability or anger or increased interpersonal conflicts.

(3) Marked depressed mood, feelings of hopelessness, or self-depreciating thoughts.

(4) Marked anxiety, tension, and/or feelings of being keyed up or on edge.

Premenstrual Dysphoric Disorder
(new in DSM-5)

- DSM -5-TR Criteria (continued)
- C. ≥ 1 of the following 7 symptoms must also be present to reach a total of 5 symptoms when combined with Criteria B symptoms above. (Thus B+C= ≥ 5 total symptoms

1. Decreased interest in usual activities (e.g., work, school, friends, hobbies)
2. Subjective difficulty in concentration
3. Lethargy, easy fatiguability or marked lack of interest.
4. Marked change in appetite; overeating or specific food cravings.
5. Hypersomnia or insomnia (Sleep issues)
6. Sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, as sensation of "bloating," or weight gain

Premenstrual Dysphoric Disorder
(new in DSM-5)

- DSM -5-TR Criteria (continued)
- D. Symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others
- E. The disturbance is not simply an exacerbation of the symptoms of another disorder , such as a major depressive disorder, panic disorder, persistent depressive disorder (dysthymia) or a personality disorder (although it may co-occur with any of these disorders.)
- F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles.
- G. Symptoms are not due to physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

Premenstrual Dysphoric Disorder,
(Continued)

- Onset and severity of symptoms increase with age.
- Mean age at onset of severe symptoms is in mid-20's.
- High incidence of major depression in first-degree relatives of women with PMDD.
- Heritability of premenstrual symptoms estimated to be 35%.
- SSRIs are considered first-line treatment for PMDD by some authorities.

Premenstrual Dysphoric Disorder

Features

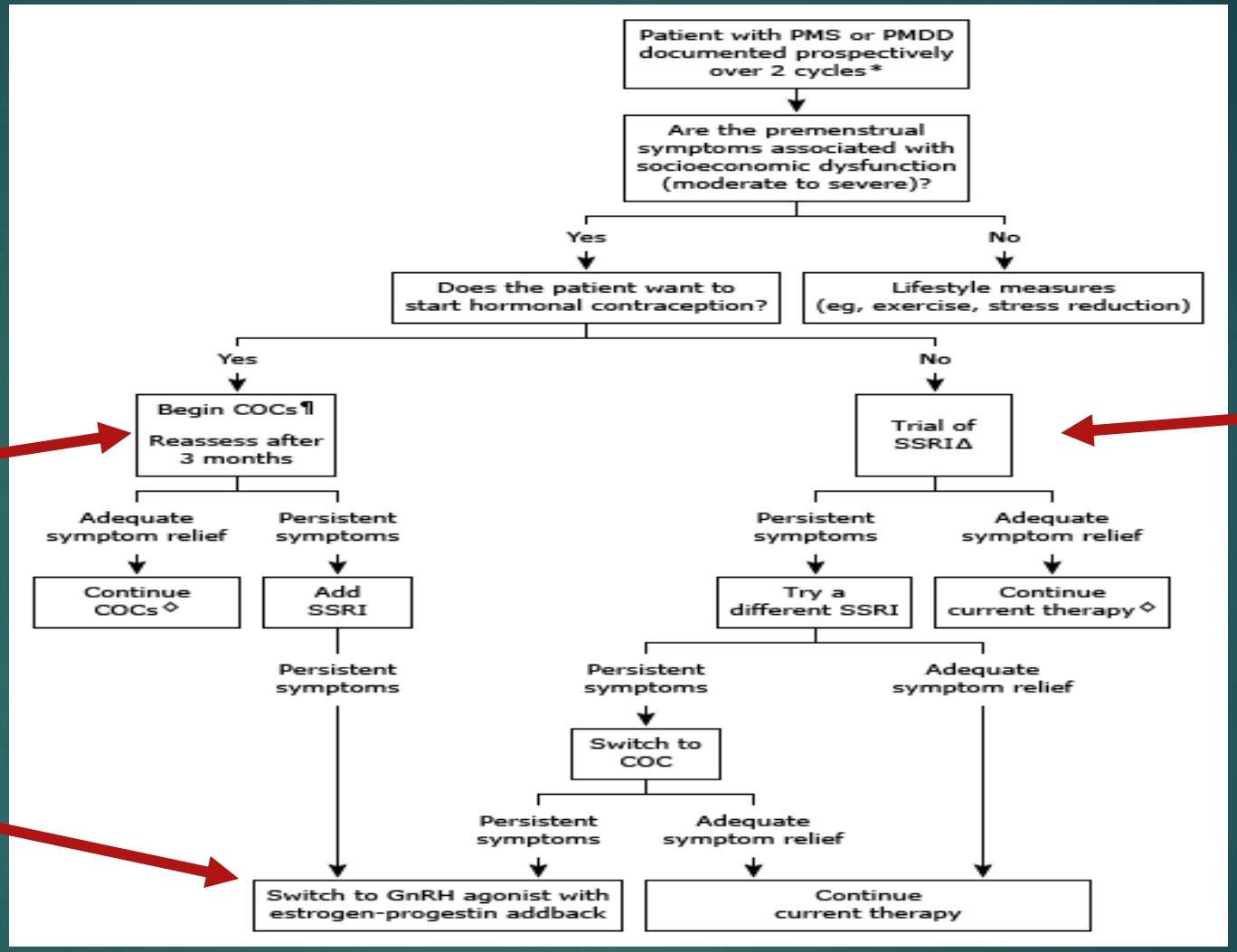
1. Symptoms occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter.
2. Symptoms may be accompanied by behavioral or physical symptoms
3. Symptom must have occurred in the majority of menstrual cycles during the past year.
4. Symptoms must have an adverse effect upon work or social functioning.
5. Symptoms peak around onset of menses but may continue into the first few days of the menses.
6. Symptoms MUST end during the follicular phase after the menstrual period begins
7. Important to note that one cannot make this diagnosis if physical or behavioral symptoms occurred in the absence of a mood or anxiety symptoms (B criteria)

Premenstrual Dysphoric Disorder

- Treatment: SSRIs are mainstay
- Symptoms during non-premenstrual intervals: Daily tx.
- With irregular menstrual cycles: Continuous tx.
- Unpredictable symptoms enduring > 1 week before onset of menses: Luteal phase regime
- Easily recognized symptom onset, last ≤ 1 week: Start SSRI at onset of symptoms

Note: Approximately 60-70% respond to an SSRI.

PMDD Algorithm



COCs= combined estrogen-progestin oral contraceptives

GnRH= gonadotropin-releasing hormone agonists)

SSRI= Selective Serotonin Reuptake Inhibitor)

UpToDate: November 2019, 2024

Substance/Medication-Induced Depressive Disorder

DSM -5 Criteria

A. Prominent and persistent disturbance in mood predominates clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all activities.

B. There is evidence from the history, PE, or LAB findings of both (1) and (2)

   1. Symptoms in Criterion A began during or soon after substance intoxication or withdrawal or exposure to a medication

   2. Involved substance/medication is capable of producing the symptoms in Criterion

C. Disturbance is not better explained by a depressive disorder that is not substance /medication-induced.

D. Disturbance does not occur exclusively during a delirium

E. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of function.

Substance/Medication-Induced Depressive Disorder

- Keep in Mind:
- 1. Some medications (e.g., stimulants, steroids, L-dopa, antibiotics, CNS drugs , dermatologic agents, chemotherapeutic drugs, immunologic agents) can induce depressive mood disorders. (Hismanal)
- 2. It takes clinical judgment to decide if the depression is medication induced or not.
- 3. US lifetime prevalence of a substance/medication-induced depressive disorder is 0.26%

Depressive Disorder Due to Another Medical Condition

- DSM -5 Criteria
- A. Prominent and persistent period of depressed mood or markedly diminished interest or pleasure in all, or almost all activities that predominates in the clinical picture
- B. There is evidence from the history, PE, or LAB findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. Disturbance is not better explained by another mental disorder (e.g. adjustment disorder, with depressed mood, in which the stressor us a serious medical condition)
- D. Disturbance does not occur exclusively during a delirium
- E. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of function.

Depressive Disorder Due to Another Medical Condition

Keep in Mind:

There are clear associations, as well as neuroanatomical correlates of depression with:

1. Stroke
2. Huntington's disease
3. Parkinson's disease
4. Traumatic brain injury
5. Cushing's disease
6. Hypothyroidism
7. Multiple Sclerosis
8. Cancer

Depressive Disorder Due to Another Medical Condition

Be sure to screen for medical disorders that may cause symptoms similar to depression, such as:

1. Anemia – particularly B12 deficiency.
2. Cancer – pancreatic, "oat cell" carcinoma of the lung, ovarian, thyroid.
3. Endocrine – especially thyroid.
4. Cardiovascular – any cause of cardiac insufficiency.
5. Chronic pain – any type is associated with depression.
6. Drug induced – alcohol, narcotics, antihypertensives, oral contraceptives, chemotherapeutic drugs, glucocorticoids, etc., etc.
7. Infections – TB, HIV, mononucleosis, some viral syndromes.
8. Neurological – CVA, Parkinson's Disease, Alzheimer's Disease.

Depressive Disorder Due to Another Medical Condition

Always be sure a complete physical exam has recently been completed

Depression Disorder Specifiers

- Specifiers
- 1. Anxious distress
- 2. Mixed features
- 3. Rapid cycling
- 4. Melancholic features
- 5. Atypical features
- 6. Psychotic features
- 7. Catatonia
- 8. Peripartum onset
- 9. Seasonal pattern

Depressive Disorder Specifiers

- Mood disorders are further classified based on patterns of symptoms. The specifiers may indicate need for a specific treatment or describe a specific course and outcome.
- Specifiers
- 1. **Anxious distress**
  - The presence of at least two of the following symptoms during majority of the days of a major depressive episode or persistent depressive disorder (dysthymia)
  - A. Feeling keyed up or tense
  - B. Feeling unusually restless
  - C. Difficulty concentrating due to worry
  - D. Fear that something awful my happen
  - E Feeling that the individual might lose control of him or herself.

Specifiers for Depressive Disorders

2. With Mixed features :

A. At ≥ **3** of the following 7 manic /hypomanic symptoms are present nearly every day during most of the days of a depressive episode.

a. Elevated mood

b. Inflated self-esteem grandiosity

c. More talkative than usual or pressure to keep talking

d. Flight of ideas or subjective experience that thoughts are racing

e. Increase in energy or goal-directed activity (either socially, at work or school, or sexually) of energy

f. Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, foolish business investments)

g. Decreased need for sleep (feel rested despite sleeping less than usual; contrasted with insomnia.

Specifiers for Depressive Disorders

anhedonia - might be exam question

3. With Melancholic features :

A. One or more is present during the **most severe period** of the current episode.

   1. Loss of pleasure in all or almost all activities
   2. Lack of reactivity to usually pleasurable stimuli (Does not feel any better even temporally when something good occurs.)

B. Three or more of the following:

   1. Distinct quality of depressed mood with profound despondency, despair, /or moroseness or an "empty mood".
   2. Depression routinely worse in the morning
   3. Early morning awakening (EMA) (at least 2 hours before usual awakening)
   4. Marked psychomotor retardation or agitation)
   5. Significant anorexia or weight loss.
   6. Excessive or inappropriate guilt

positive/negative EMA common abbrev

Note: There is a near complete absence of capacity for pleasure, not simply a diminution.

More often seen in inpatients, more likely to occur if the patient is exhibiting psychotic features.

Specifiers for Depressive Disorders

4. With Atypical features

   A. Mood Reactivity (Mood brightens in response to actual or potential positive events.

   B. Two or more of the following:

      1. Significant weight gain or increase in appetite
      2. Hypersomnia
      3. Leaden paralysis (video)
      4. Long standing pattern of rejection sensitivity

Specifiers for Depressive Disorders

5. With Psychotic Features: : Presence of delusions or hallucinations.

   a. Mood-Congruent psychotic features:

      During depressive episodes the content of the delusions and hallucinations is consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism or deserved punishment.

   b. Mood Incongruent:

      During depressive episodes the content of the delusions and hallucinations is not consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism or deserved punishment.

Specifiers for Depressive Disorders

6. With Catatonia:

Note: This topic will also be addressed in the lecture on Schizophrenia and other Psychotic Disorders

Catatonia Associated with a Depressive Disorder

- DSM -5:
- A. Clinical picture dominated by ≥ 3 of following symptoms

  1. Stupor (Extreme hypoactivity and immobility. Absence of movement or reaction when awake; not actively relating to the environment, yet fully conscious.)
- 2. Catalepsy: (Maintenance of fixed sitting or standing position against gravity that appears uncomfortable with minimal movement with response to external stimuli, including pain.)
- 3. Waxy flexibility (Patient can be positioned in uncomfortable positions that the patient maintains for long periods with slight resistance to examiner.)
- 4. Mutism (Extreme verbal unresponsiveness in the absence of aphasia.)
- 5. Negativism (opposition to instructions or external stimuli)

Catatonia Associated with a Depressive Disorder

- DSM V: A. ≥ 3 of following symptoms (continued)
- 6. Posturing (spontaneous and active maintenance of rigid positions against gravity)
- 7. Mannerism (odd caricature of normal actions, seem out of context such as suddenly grimacing or using hands when talking.)
- 8. Stereotypy: (repetitive, abnormal frequent, non-goal directed movements) (ex. Rocking, chewing, grimacing, shrugging, hand waving, etc.)
- 9. Agitation (Purposeless hyperactivity, not influenced by external stimuli)
- 10. Grimacing (Contortion of facial features)
- 11. Echolalia (mimicking another's speech)
- 12. Echopraxia (mimicking another's movements)

Examples: Catatonia associated with schizophrenia, MDD, etc.

Waxy Flexibility

Specifiers for Depressive Disorders

7. With Peripartum onset:

Peripartum/
Postpartum Depression

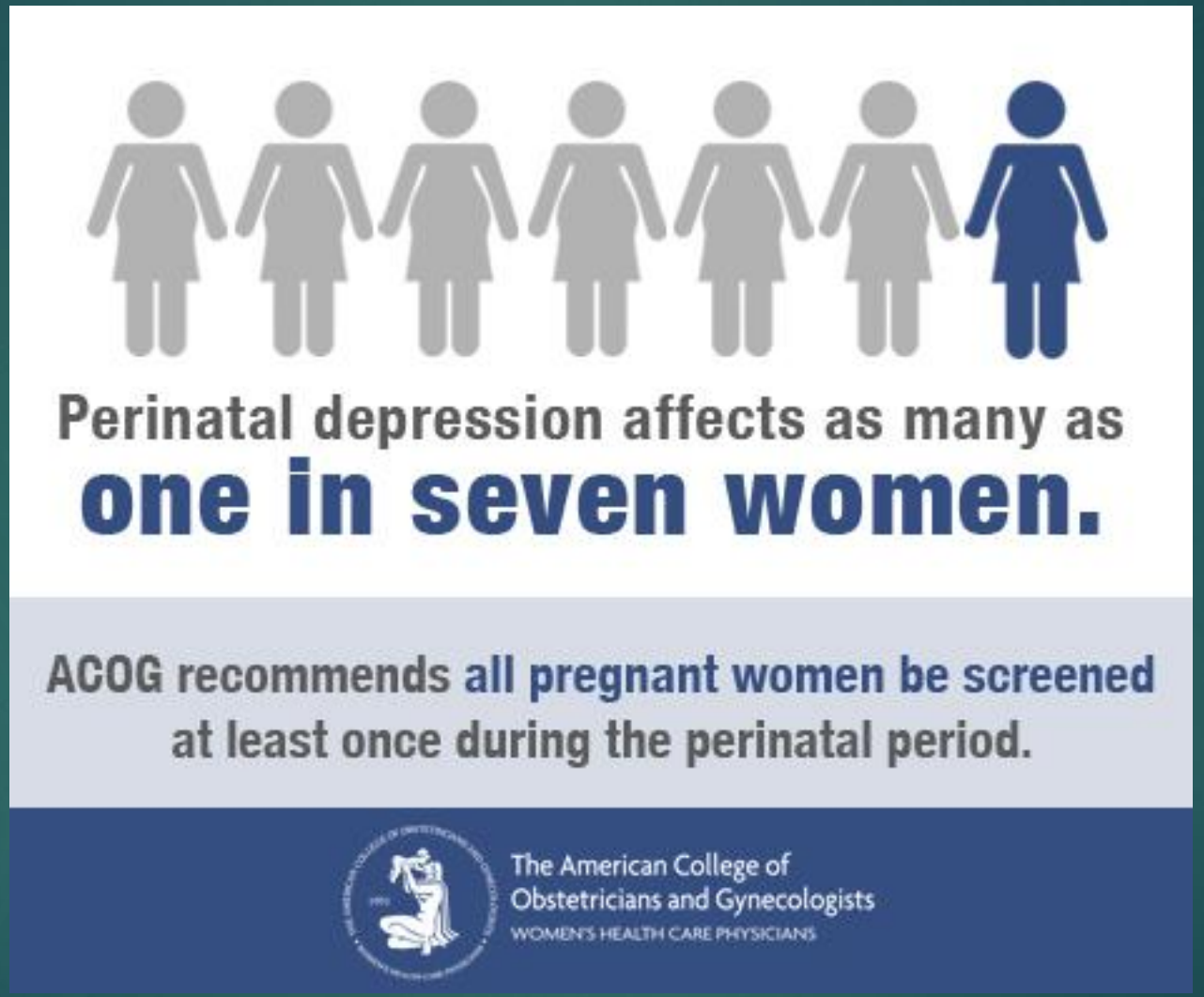
Mood Disorder Specifiers

- **Peripartum onset:**
  - **depressive, manic, or hypomanic during pregnancy or within 1st 4 weeks postpartum**
    - Requires treatment
    - 3-6% develop major depressive episode during this period
    - 50% of "postpartum depression begins prior to delivery
    - Mood and anxiety symptoms as well as "baby blues" during pregnancy increase risk for postpartum major depressive episode.
    - Most severe form can be life threatening to mother or child

Postpartum Depression

- "Postpartum blues" occur in 50-80% of women after giving birth and typically last 3-7 days, but can normally last a bit longer.
- Postpartum depression is diagnosed using the same DSM criteria for a MDD. It can affect 10-20% of mothers depending on the study.
- A prior psychiatric history is a risk factor; risk for postpartum depression in women with no prior psychiatric history has been estimated to be 2-5%.
- Women may feel guilty about having depressive feelings at a time they think they should be happy, and be reluctant to bring up their symptoms or negative feelings toward the child.

Boards will have questions where a patient presents with symptoms for the past X time and you need to know the diagnostic criteria so you can accurately diagnose them before moving on with the rest of the question which might ask about treatment/drug/other symptoms - IMPORTANT TO KNOW DIAGNOSTIC CRITERIA!



Postpartum Depression

- Severely ill patients
  - often report suicidal ideation and behavior,
  - typically demonstrate obvious impairment of functioning, and
  - often manifest poor judgement that could lead to imminent harm.
  - Places the patient and others (including children) at risk patients are more likely to develop complications such as psychotic and catatonic features and have a history of severe or recurrent episodes.
  - Patients with severe major depression should be referred to a psychiatrist for management and often require hospitalization

Postpartum Depression With Psychotic Features

- Postpartum mood disorders with psychotic features occur in roughly 1-2 cases per 1000 deliveries. In such cases hospitalization may be necessary to protect the infant and mother. **(Involuntary hospitalization 5150)**
- If a women has had a postpartum episode with psychotic features the risk for recurrence is 30-50% at subsequent deliveries.
- A good rule of thumb is to **treat depressive symptoms lasting more than two weeks.**

Postpartum Depression Treatment

- Antidepressants
  - SSRIs are safest and low risk for child if breastfeeding
- ECT: If no response after 4 trials of an SSRI or other antidepressant(s)

PPD-Specific Treatment

- An IV formulation of Allopegnanolone (Brexanolone), which is a metabolite of progesterone, was FDA-approved for treatment of PPD in March 2019. It's administered as a continuous IV infusion over 60 hours.
- In the United States, brexanolone is dispensed only to certified health care facilities and patients who enroll in a Risk Evaluation and Mitigation Strategy program. The program requires on site clinicians to monitor patients for excessive sedation and sudden loss of consciousness during the intravenous infusion, and also requires continuous pulse oximetry to monitor for hypoxia.
- Side effects > 5%: Dry mouth; Flushing/hot flash; Loss of consciousness; sedation/somnolence
- Another problem: One infusion costs **$34,000**
- The drug binds to synaptic and extra-synaptic GABA A receptors.
- GABA is the primary CNS neuroinhibitory mechanism and the working theory is inflammation and hormonal fluctuations post-delivery can cause GABA hypofunction in some patients.

may ask about name of drug but won't ask about AE
just know that there are out there and are very useful

PPD-Specific Treatment An Oral Medication

Zuranolone

1. In 2023 this drug received FDA approval for oral treatment of Post Partum Depression.
2. It is a positive allosteric modulator of synaptic and extra-synaptic GABAa receptors and neuroactive steroid. It is give once daily orally for 14 days for patients with severe PPD.
3. Most common adverse effects (>10%) were:
   a. somnolence, dizziness and sedation.
   b. No loss of consciousness, withdrawal symptoms or increased suicidal ideation were noted.
4. Studies support the potential of zuranolone as a novel rapid acting treatment for PPD.

Am. J. Psychiatry 9/2023

Specifiers for Depressive Disorders

8. With Seasonal Pattern:

Seasonal Affective Disorder (SAD)

Seasonal Affective Disorder (SAD)

- Definition: Recurrent episodes of major depression, mania, or hypomania with seasonal onset and remission. It is NOT considered a separate mood disorder but rather SAD is a subtype of the following mood disorders:
  - Unipolar major depressive disorder (MDD) (Most common type)
  - Bipolar I disorder
  - Bipolar II disorder

Seasonal Affective Disorder (SAD)

What are the facts?

1. Typically patients will experience depression as the photo period decreases with advancing winter
2. Women compromise ~75% of those affected
3. Median age of presentation is 40
4. SAD is rare after 55

Seasonal Affective Disorder (SAD)

Seasonal patterns: (Major depression)

- ✓ Fall-winter onset: Also known as **winter depression**
  - ✓ If left untreated will typically remit in the spring-summer
  - ✓ Increased sleep, increased appetite, carbohydrate craving and weight gain. (Symptoms often seen in atypical depression)
- ✓ Spring-summer onset (Also known as summer depression);
  - ✓ Major depressive episodes begin in spring-summer and, if left untreated, remit during the following fall-winter
  - ✓ Symptoms: insomnia, decreased sleep, decreased appetite with weight loss. (typical symptoms of depression)

Seasonal Affective Disorder (SAD)

Treatment recommendations

1. Antidepressants (SSRIs)

   FDA approved extended form of bupropion as a preventative treatment

2. Light Therapy

   Invented in 1984

   Typically 1500-10,000 LUX

   Sit in front of light source for 1- 2 hours before dawn, and some will benefit if also used at dusk

   Usually well tolerated

3. Psychotherapy
4. ECT (If poor response to 1,2,3)

Light Therapy

Treatment of Mood Disorders

Treatment of Mania

Treatment of Mood Disorders

- I. Bipolar Disorders
  - A. **Mania and Hypomania**
    - 1. Despite clinical differences between mania and hypomania (e.g., hypomania is less severe) for purposes of treatment they are considered similar and thus treated with the same medications.
      - a. Antipsychotics
      - b. Lithium
      - c. Anticonvulsants
      - (Note: a, b, & c can be used alone or in combination)

Treatment of Acute Mania

- Lithium, Valproate and Carbamazepine are FDA approved for Treatment of acute mania by the FDA.
- Use of a second-generation antipsychotic (SGA) is used in the treatment of acute mania (except Clozapine)
- Most recommend the use of an antipsychotic in conjunction with Lithium, Valproate or Carbamazepine.
- If Carbamazepine is used with an antipsychotic it will lower the level of antipsychotic by up to 40%.
- Non-Responsive Patients: Electroconvulsive Therapy (Last resort as most do respond to appropriate psychopharmacologic treatment)

Lithium

Things to keep In mind:

1. Clinically is very effective for many patients in both acute and maintenance phase.
2. Must be kept within it's therapeutic range, 0.6-1.2 meq/l. (Some experts recommend 0.6-.8 as it may have kidney sparing effect under 1.0)
3. Serum level should be monitored intermittently. (More frequently at the start of its use) get a trough level first

   (might take a few weeks for beneficial effects to become evident.)
4. Goal is to get on a once nightly dose
5. Can be lethal in overdose.
6. Can cause long-term adverse effects on the thyroid and less frequently on the kidney.
7. Use of various diuretics, antihypertensives and NSAIDS can raise lithium levels.
8. Manic states as well as Pregnancy can reduce lithium levels,
9. Caffeine can reduce lithium levels if consumed in large quantities
10. Can increase WBC levels (Not a concern if rest of PE is WNL)
11. If patient is ill/feverish may be prudent to hold dose.
12. Get lithium level in the AM (trough level).
13. Note : Nausea is early sign of possibly developing lithium toxicity..(I made sure all my patients informed me if they developed nausea.)Then held a dose or two and got lithium level in AM.

Anticonvulsants

1. Carbamazepine and Valproic Acid are commonly used, but other anticonvulsants are also effective, e.g., Lamotrigine.
2. Carbamazepine and Valproate can be very effective, particularly if there is an irritable component to mania. They are used for both acute and maintenance treatment. Lamotrigine is more effective for the depressed phase of Bipolar Disorder.
3. They are potentially less toxic than Lithium, but require monitoring for hepatic, hematologic, and dermatologic adverse effects.

Treatment of Mood Disorders

- **I. Bipolar Disorders (continued)**
  - B. Treatment duration.
    - 1. Allow about 14-21 days for a treatment trial.
      - Most will show improvement in about a week.
  - C. Poor response
    - 1. Try different medication combinations
  - D. Refractory patients
    - 1. ECT

Maintenance Treatment in Bipolar Disorder

1. In general, efforts should be made when possible to make any medication decreases very gradual once a patient is stable.

2. Rapid decreases in mood stabilizing medications in a stable patient with Bipolar Disorder can precipitate a manic episode.

3. Psychotherapy therapy can be very helpful in Bipolar Disorder in assisting patients to better manage their lives by avoiding certain behaviors and in the early recognition of the reoccurrence of symptoms, but is should virtually always used in conjunction with medications.

Treatment of Mood Disorders

II. Major Depresisve Disorder

1. Length of medication treatment should be ≥ 4 months once the patient remits (no symptoms of MDD), but 6 months is not unusual.
2. Studies show that 50% with a MDD episode will have a second episode.
3. Not treating until full remission is obtained will increase likelihood of a recurrence
4. Patients with ≥ 3 episodes are candidates for continuous treatment.

Treatment of Mood Disorders

II. Major Depresisve Disorder

1. Psychotherapy:
   a. Cognitive-Behavioral Therapy has the most outcome data for being effective for Major Depression It may also be valuable in preventing relapse.
   b. Intensive Interpersonal Therapy has also demonstrated effectiveness.
   c. Healthy lifestyle choices, e.g., exercise, diet, and social outlets are also an important component of psychological treatment.
2. Antidepressant therapy: multiple medications are FDA approved for the treatment of major depression in placebo-controlled studies.
3. Electroconvulsive Therapy: an electrical current induces a generalized seizure. (Will be discussed in detail in our ECT lecture)
4. Transcranial Magnetic Stimulation: modulates neurocircuits felt to be dysregulated in their functional connectivity with each other.
   (Covered in the ECT lecture)
5. . Combination approaches- combining aspects of the above into a treatment plan.

Major Depressive Disorder

Antidepressant Treatment

- All effective FDA approved antidepressants have an effect of increasing norepinephrine, serotonin, and/or dopamine.
- No single antidepressant is clearly more effective than another for everyone.
- No single antidepressant results in remission for all patients.
- There is no antidepressant that is without the potential for causing some side effects.
  - Some side effects may be useful at times (i.e.; sedation)
  - Always do a thorough drug history: Prior successes/failures, family members who did well on a particular antidepressant medication.
  - Take note of medications that can be problematic with certain antidepressants
- Recently an intranasal form of esketamine was approved by the FDA for treatment resistant depression.

Major Depressive Disorder

Common Adverse Effects of SSRIs

1. Nausea
2. Drowsiness, fatigue
3. Nervousness, tremors
4. Insomnia
5. Anorexia
6. Diarrhea
7. Sexual dysfunction (best available data suggests all SSRIs cause sexual dysfunction in approximately 30% of patients, usually delayed ejaculation (men), decreased libido, and anorgasmia (women).

FDA Black Box Warning on all antidepressants

- The FDA mandated a BB warning in 2004 that antidepressants used in children, adolescents, and young adults less than 26 years of age can show an increase in suicidal thinking and "behaviors" of 4%, twice the placebo rate of 2%. This was not found in adults over 26 years of age.
- There were no suicides in the initial pooled studies; a larger sample size would be needed to demonstrate increased risk of actual suicide.
- An FDA approved medication guide concerning use of antidepressants in this age group must be distributed to parents/guardians for any outpatient prescription.
- Antidepressant use in children and adolescents has decreased since 2004, however there are some concerns that has resulted in less effective treatment for depression in that age group.
- Current recommendations are that adverse effects will most likely occur in the first 2 months and decrease thereafter. Follow-up should be weekly the first month and bi-weekly the second month.

Major Depressive Disorder

insomnia

Antidepressant Treatment

Determine if the patient meets criteria for antidepressant treatment:

- -moderate to severe depression that has persisted for one month or longer.
- -mild to moderate depression that is chronic and significantly interferes with routine functioning in social or occupational roles.
- -patients with multiple episodes of major depressive disorder; any patient with three or more episodes of MDD is a candidate for continuous treatment.
- Note: most patients with suicidal or psychotic symptoms will likely need continuous antidepressant medication

Major Depressive Disorder

Antidepressant and Supportive Treatment

1. Give adequate dosage for adequate duration, usually at least 3-4 weeks and up to 6 weeks is recommended, to determine if there is a response to that oral medication; sometimes a change to a different medication is indicated.
   a. The # 1 reason for a drug failure is too low a dose or an adequate dose not given long enough.
2. Brief, practical supportive counseling is appropriate, helpful, and should be part of treatment with medications. For example recommendations about communication styles, social networks, lifestyle changes, sleep, alcohol use, and exercise can be very helpful.
3. Monitor progress; a self-rating scale can be used but should ALWAYS be augmented by a clinical interview.
4. Special attention must be directed to issues around suicide if that has been a concern.

Major Depressive Disorder

Antidepressant Treatment (continued)

- An empiric trial and careful evaluation of response is recommended, with changes in dosage or medication if the response is insufficient.

- Patients **must** be asked about side effects.
  - Minimizing any long-term side effects are critical to maximizing compliance, especially in cases where the patient is a candidate for maintenance treatment.

- The relatively newer antidepressants:
  - much fewer long-term side effects than the older tricyclic medications, and
  - much safer in an overdose.

Antidepressant Medications (not an inclusive list)

SSRI'S: FLUOXETINE, SERTRALINE, PAROXETINE, CITALOPRAM, FLUVOXAMINE, ETC.

MECHANISM OF ANTIDEPRESSANT ACTION IS ESSENTIALLY THE SAME BUT THERE ARE DIFFERENCES BETWEEN THE DIFFERENT MEDICATIONS.

TRICYCLIC ANTIDEPRESSANTS: AMITRIPTYLINE, DESIPRAMINE, NORTRIPTYLINE, DOXEPIN, ETC.

OLDER MEDICATIONS, JUST AS EFFECTIVE FOR DEPRESSION, ASSOCIATED WITH MORE SIDE EFFECTS, AND CAN BE FATAL IN OVERDOSE.

HETEROCYCLIC ANTIDEPRESSANTS: AMOXAPINE, BUPROPION, TRAZODONE, ETC.

BUPROPION HAS A LOWER INCIDENCE OF SEXUAL SIDE EFFECTS RELATIVE TO THE SSRI'S.

TRAZODONE IS USED WIDELY AS A SLEEP AID BECAUSE IT'S SEDATING. IT HAS CAUSED CASES OF PRIAPISM, A PROLONGED, ABNORMAL ERECTION OF THE PENIS, WHICH IS A UROLOGIC EMERGENCY WHEN IT OCCURS.

NOVEL ANTIDEPRESSANTS: VENLAFAXINE, DULOXETINE, REMERON, ETC.

REMERON ALSO HAS A LOWER INCIDENCE TO SEXUAL SIDE EFFECTS COMPARED TO SSRI'S, BUT HAS BEEN ASSOCIATED WITH WEIGHT GAIN.

MONOAMINE OXIDASE INHIBITORS: PHENELZINE AND PARNATE ARE MOST COMMON.

THEY INHIBIT THE ENZYME MONOAMINE OXIDASE. DIETARY RESTRICTIONS ARE NECESSARY TO AVOID HYPERTENSIVE EPISODES.

ketamine comes in a nasal spray - first approved version
physician needs to undergo additional training
patient needs to have it administered din a clinical setting for at least 2 hours

Ketamine and Esketamine

- The use of ketamine to treat depression has increased.
- Ketamine can rapidly and transiently alleviate treatment-resistant unipolar major depression, including suicidal ideation, but effects only last about a week.
- Studies have not shown as good a response for suicidal patients using esketamine
- Per APA guidelines clinicians should prescribe ketamine or esketamine cautiously for this indication, and only after exhausting all other recommended non-electroconvulsive therapy treatments for resistant depression.
- Esketamine is the s-enantiomer of ketamine in a nasal spray. Ketamine is a mixture of two enantiomers (mirror image molecules). This is the first FDA approval of esketamine for any use.
- Clinicians will need to undergo additional training on the risks of the medication and patients require monitoring after their doses have been administered.
- Monitoring must be for at least 2 hours because of concerns about sedation and dissociation.
- Patients cannot take the medication home with them because of the above concerns as well as possible misuse.

Patient Referrals

When should a PCP refer? (A partial list)

1. To obtain a consultation
2. Suicidal ideation and behavior
3. Psychotic features (delusions, hallucinations)
4. Impulsive Impulsive dangerous behavior
5. Functional impairment
6. Comorbid psychopathology (anxiety & substance abuse disorders)
7. Multiple medication failures (2-4)
8. Need for psychotherapy
9. Recurrence of mood disorders

Psychological Tests

The following tests, the Beck Depression Inventory and the Zung Self-Rating Depression scale are easily administered. They, as well as other psychological tests are a nice way to follow a patient's course over time. However, they are not a substitute for a thorough Mental Status Examination!!

Zung Self-Rating Depression Scale

Patient's Initials: _____ Date of Assessment: _____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Normal: ≤ 34 **Depressed: ≥ 50**

BECK DEPRESSION INVENTORY

Roche

V 0477

Beck Depression Inventory

CRTN: _____ CRF number: _____ Page 14 patient inits: _____

Baseline

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

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

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

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Beck Depression Inventory

CRTN: _____ CRF number: _____ Page 15 patient inits: _____

Baseline

11. Agitation
- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest
- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

13. Indecisiveness
- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

14. Worthlessness
- 0 I do not feel I am worthless.
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

15. Loss of Energy
- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern
- 0 I have not experienced any change in my sleeping pattern.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability
- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

18. Changes in Appetite
- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty
- 0 I can concentrate as well as ever.
- 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue
- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

Subtotal Page 2

Subtotal Page 1

Total Score

NR15645

BECK DEPRESSION INVENTORY SCORING

Classification	Total Score	Level of Depression
Low	1-10	Normal ups and downs
	11-16	Mild mood disturbance
Moderate	17-20	Borderline clinical depression
	21-30	Moderate depression
Significant	31-40	Severe depression
	Over 40	Extreme depression

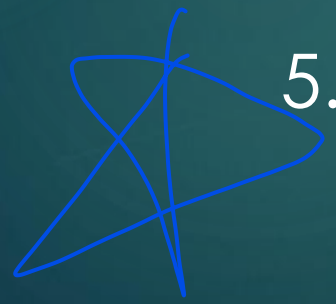
Final Thoughts

Clinical points for Depression

1. A hopeful optimistic tone should be established at the initial interview.
   a. The severity of the depressive syndrome should be assessed
   b. Extensive psychological probing should not be attempted when the patient is deeply depressed.
   c. **Suicidal risk** should be determined initially and reassessed frequently
2. Moderate to severe depression should be treated **aggressively** with somatic therapy.

Clinical points for depression

3. The clinician should determine whether psychosocial stressors are present that are contributing to the depressed mood and should counsel the patient on ways to cope with them.
4. Depressed patients tend to "get down" on themselves because they have been depressed; the clinician should help the patient to abandon negative or self-deprecating attitudes through CBT or other psychotherapeutic techniques.
5. Those patients who are acutely suicidal should be involuntarily admitted to an inpatient psychiatry unit for their safety as well as the safety of others.



Clinical Points for Mania

1. Somatic therapies should be used aggressively to treat symptoms as rapidly as possible
2. The patient should be followed up closely as the mania "breaks" to determine if a subsequent depression is emerging.
3. After an episode of mania, patients should receive maintenance medication; typically they will continue to take mood stabilizers for several years, and perhaps for the remainder of their lives, to prevent subsequent relapses.
4. Patients should be advised to get adequate sleep.

Clinical points for Mania

5. Even when stable, patients should be followed up regularly to ensure continued compliance with medication and to monitor blood levels (if applicable)

6. Manic episodes can have devastating personal, social and economic consequences;

at a minimum patients will require supportive psychotherapy, to help them cope with these consequences and maintain self-esteem.

7. Family members should receive support as needed

8. Patients with bipolar illness usually appreciate being told of the "good side" of their illness: its association with creativity and high achievement

Clinical points for Mania

9. Treatment setting (Depends on symptom severity)

   A. Inpatient:

      To mange safety due to suicidal attempt/ideation, delusions, hallucinations, poor judgment that poses risk to the patient or others

   B. Partial Hospital (day) Treatment:

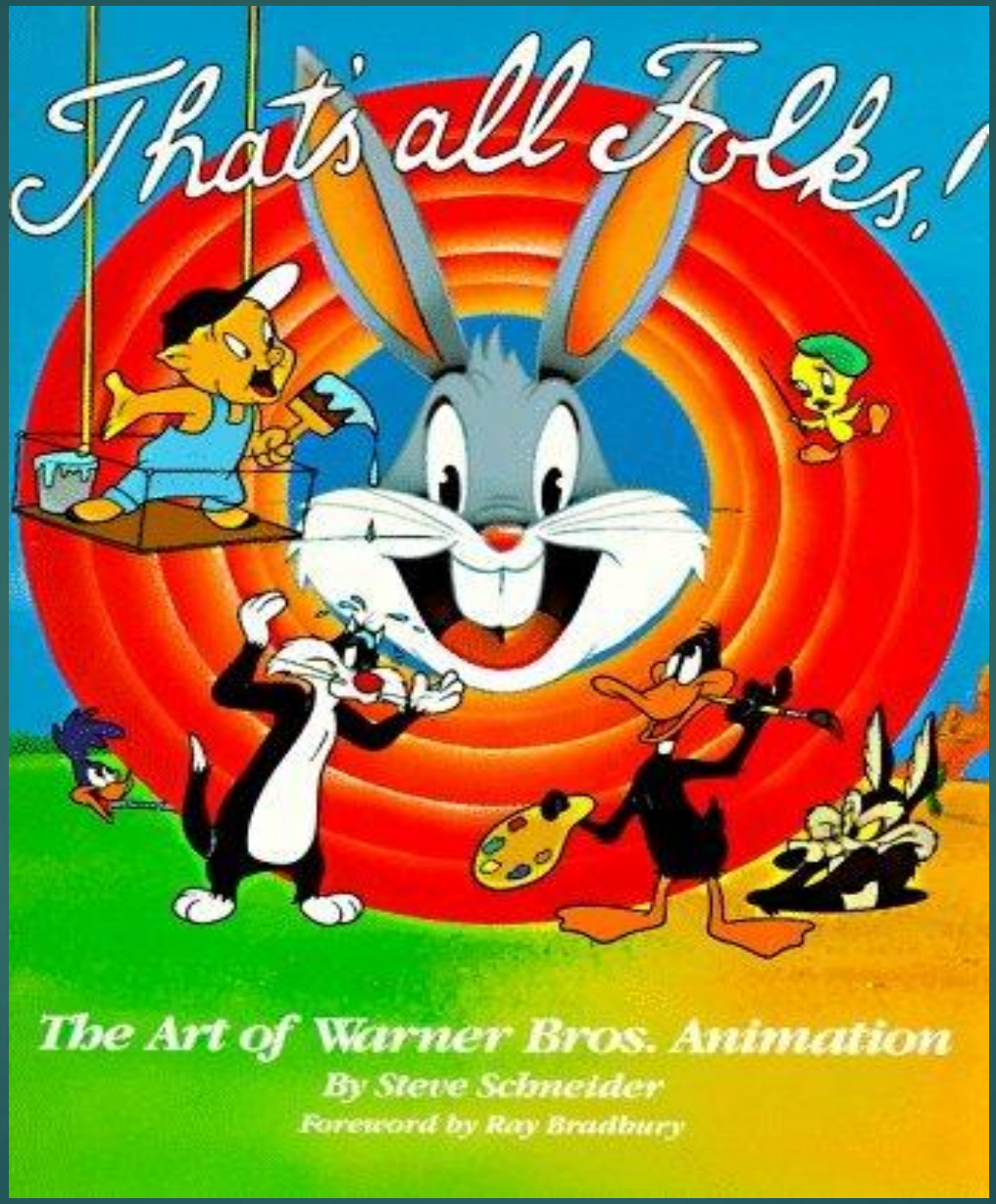
      For patients moderately ill with non-imminent suicidal thoughts do not pose imminent risk to self/others

   C. Outpatient: For less acutely ill patients i.e., feel family better off without them, but no plan or intent to commit suicide.

A Video MDD

A few of many items to watch/listen for.

1. Criteria/signs of major depression that are elicited.
2. What is her purpose in life?
3. Seriousness or lack thereof regarding her plan for suicide.
4. What if anything concerns you about the action of her children?
5. Is she currently an inpatient or outpatient?
6. Does she display any psychotic thinking.?
7. What are some differential diagnoses to consider in this case?
8. Describe her affect.
9. How does she describe her mood?
10. Should she be on an antidepressant?
11. She has cut off seeing her friends. What do you think about that action?
12. Have there been times she functioned well and been free of depressive symptoms? What does this mean in regards to her diagnosis?
13. Why did the psychiatrist ask when during the year her depression occurred?
14. How did she describe her arms as feeling when she was very depressed?


That's all Folks!
The Art of Warner Bros. Animation
By Steve Schneider
Foreword by Ray Bradbury