Basics of Mental Health and Clinical Psychiatry
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Lecture 16
Mood Disorders - II

Hello, everyone. Let us begin lecture number 16.

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The topics which will be covered is bipolar disorder, etiology, its pathophysiology and its treatment, dysthymia, cyclothymia, seasonal affective disorders.

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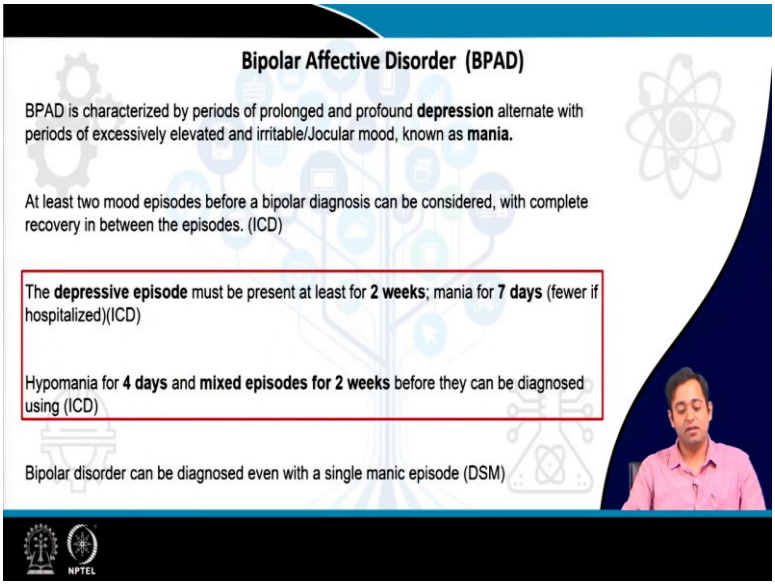

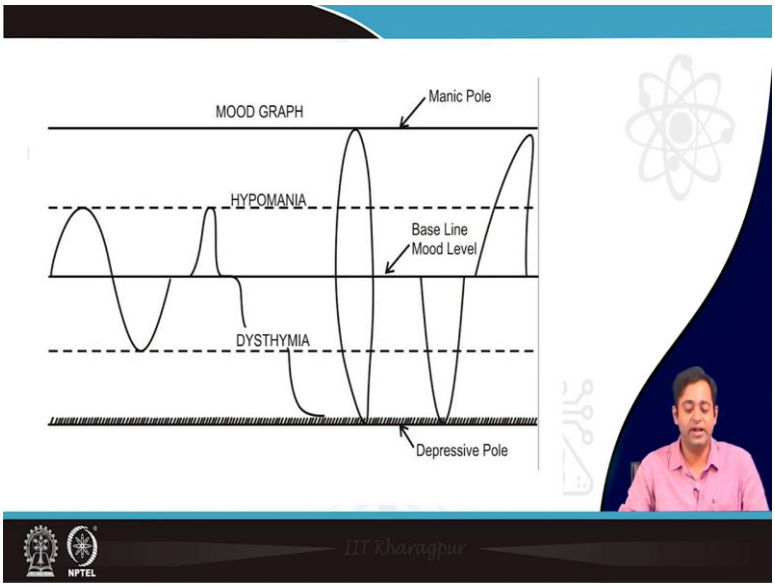

So, I will try to just give a recapitulation for the last lecture where we were discussing about the various sorts of mood disorders. And since we have begin with the bipolar affective disorder, let us just understand, in normal bipolar affective disorder, as the name sounds, we have two phases. One is a depressive phase, and the other is the manic phase, the upper phase.

So, in manic phase, you have elevated mood a person is excessively happy, you have grandiose ideation, the patient might think that I am king, I have lots of money, I have superhuman powers for which I can actually change the world, there is decreased need for sleep, there is excessive happiness. So, all these things are present in the manic phase of the illness.

What happens in depressive phase? It is similar to a major depressive episode or unipolar depression, but this is actually a bipolar phase. So, as the name suggests, bipolar, you have two phases, one is the depressive phase and you have a manic phase. Now, there are basically two types of bipolar disorders, type 1 and type 2.

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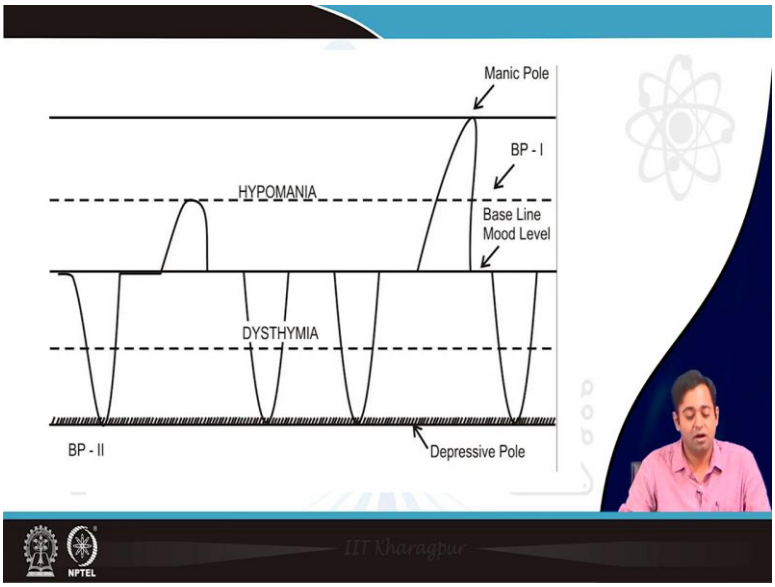

Now, type 1 is when you have a manic phase, or you have you might be suffering from a depressive phase. So, in bipolar type 1, this is a normal baseline level of the person's mood, wherein the patient might be suffering from manic phase or he might be suffering from depressive phase. In bipolar type 2, this patient might have hypomania. He might not be having a classical manic episode, this is a manic episode, he might not have a manic episode, he might have a hypomania, or he might be associated with a depressive phase of the illness. This is actually bipolar type 2 and this is bipolar type 1.

Now, what is hypomania, as I was telling, hypomania is all those sorts of criterias symptomatology characteristic features which is present in which the severity of the manic illness is as compared to the manic illness is less and the social occupational dysfunction, which is present as presenting the manifest of the illness is not present in the hypomanic state.

So, what is the duration for which a mania can be categorized as this person is suffering from manic phase of the illness is minimum of one week, the symptomatology the symptoms, the characteristic features which are present for a minimum of 1 week, we call that mania. For a hypomania, the duration is 4 days. For a depression, the duration is 2 weeks.

So, there is a, this is dysthymia, where the normal baseline level and the depressive mood, it comes in between those things. So, this is actually a dysthymic phase where the normal baseline level dips, it does not goes and lands up in depressive phase, if this patient lands up in a depressive phase of the illness from dysthymia suffering from dysthymia, it is actually called double depression.

And when you have a manic phase and a depressive phase together in a single episode, the patient might be suffering from bipolar affective disorder, mixed phase. So, this will actually given in order to have a foundation of what is a mood disorder and what are the various types for it is clear conception.

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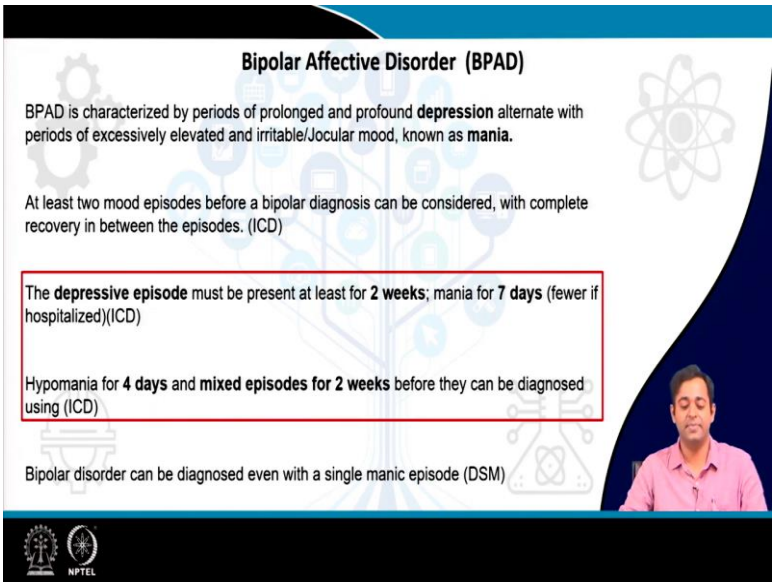

So, what is bipolar affective disorder? It is characterized by periods of prolonged and profound depressive phase which alternates with the manic depressive illness. At least two episodes before a bipolar diagnosis can be considered with complete recovery in between the episodes considered. The depressive episode multiple than for at least 2 weeks, mania for 7 days. And if the condition is so severe that the patient needs hospitalization, we are not considering the duration, the number of days according to the ICD.

For hypomania, it is 4 days the set of symptoms which is present should be for a minimum of 4 days. For mixed episodes, that is, wherein you might have the mania and the depressive phase simultaneously occurring together for a period of 2 weeks before they can be diagnosed. Bipolar disorder can be diagnosed even with a single manic episode. So, if the patient is suffering from only a manic episode first episode manic illness, he might also be diagnosed as bipolar affective disorder.

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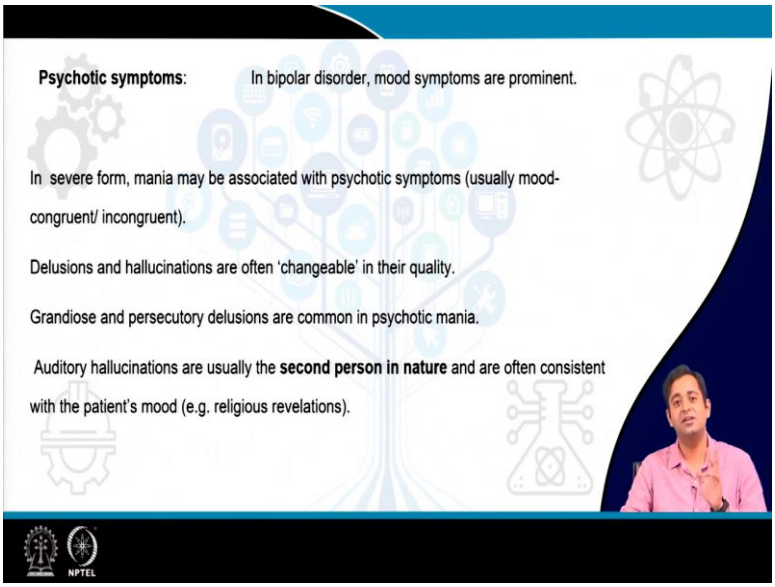

Now, he can also be suffering from psychotic symptoms wherein not only the mood is elevated, there can be delusions or hallucinations. In severe form mania may be associated that is mood congruent delusions and hallucinations. Now, what is mood congruent, where the if the patient is suffering from mania, he might have grandiose kind of delusions.

So, it is state dependent, that is why it is congruent to the mood. If you have a depressive phase of the illness for which the patient is suffering, you might be suffering from delusion of ill health, you might be suffering from depression of poverty, delusion of poverty. So, it is that is why it is called mood congruent. Auditory hallucinations are second person in nature.

Now, third person auditory hallucination is seen in schizophrenia that is why this is how it is differentiated with the depression with psychotic symptoms and a person who is suffering from schizophrenia who is having auditory hallucination. So, there is a clinching point here.

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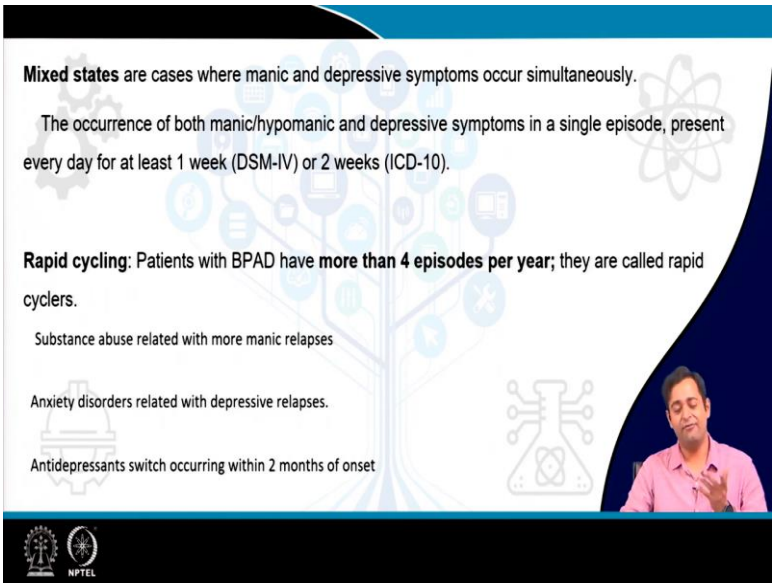

Now, mixed states are cases where manic and depressive cases they occur simultaneously. And the occurrence for both as we know is two weeks for depression and one week for mania. What are rapid cyclers? Where more than 4 episodes occur in 1 year, they are substance abusers, they are related more with manic relapses. Anxiety disorders, they are related with depressive relapses and the antidepressant switching which is seen they occur within the 2 months of onset of the various poles.

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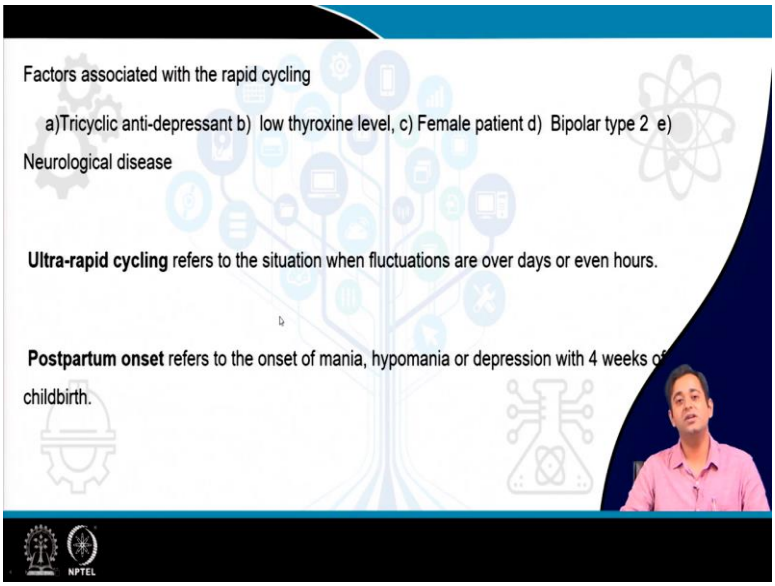

What are the factors which is associated with rapid cycling? It is tricyclic antidepressants. When we give tricyclic the class of antidepressants, which is commonly implicated in rapid cycling is tricyclic antidepressants like amoxicillin, amitriptyline, nortriptyline, other factor is

low thyroxin level, female patients, bipolar type 2 and neurological diseases. What is an ultra-rapid cyclers? They refer to the situation when the fluctuations they occur in days or even hours. There is a subtype postpartum onset they occur with the onset of mania, hypomania or depression, with 4 weeks of the childbirth.

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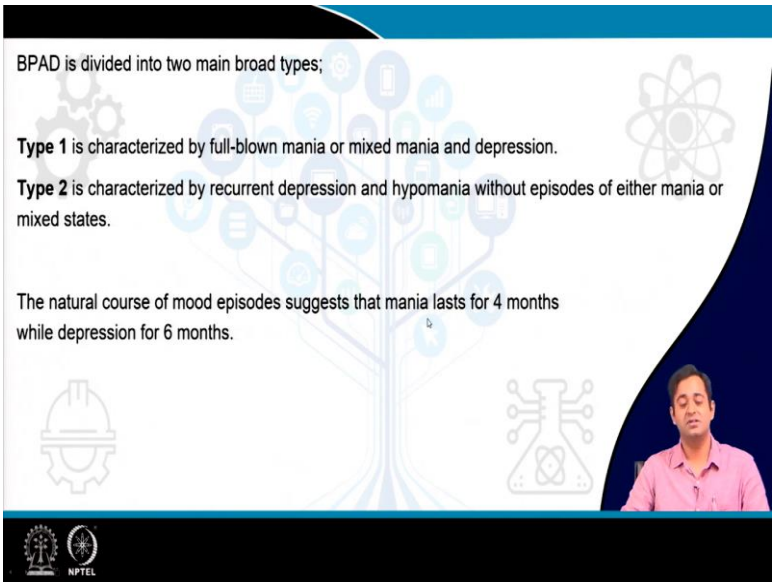

As we know bipolar is divided into basically two types. Type 1 in which you have full blown mania, or a mixed episode with depression and type 2 is depression with hypomania. The natural course of the mood suggests that the mania lasts for 4 months, while depression is for 6 months.

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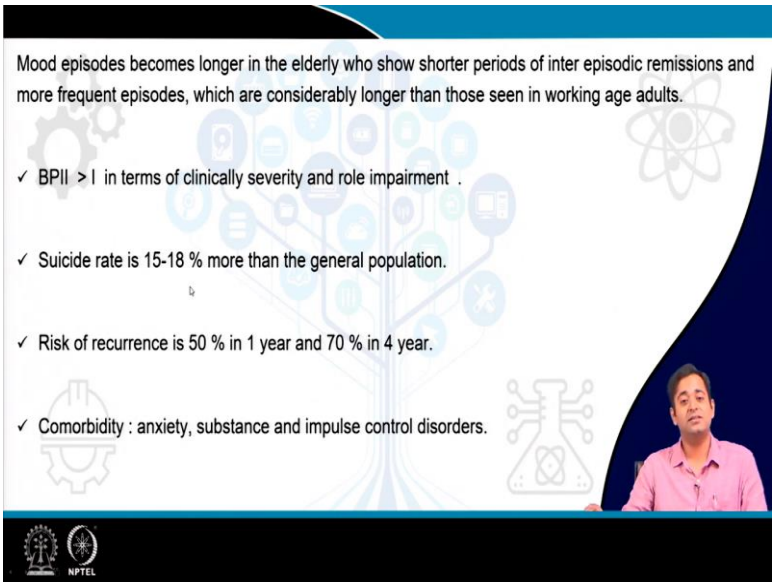

Mood episodes become longer in the elderly. So, as the disease progresses, and you have various episodes in your natural course of the history of the illness, where you have one episodes when the patient might be suffering from in the year 1990. And as the disease progresses, the next episode might be, he might be suffering is around somewhere around 2000. The next time the third episode when he suffers he might be around 2005.

So, as the disease progresses, the frequency of the episode it increases and the severity of the illness it increases and the inter episodic the duration it decreases. Bipolar type 2 in terms of civet clarity and role impairment is high as compared to bipolar type 1. Suicide rate is 15 to 18 percent, which is more than the general population. And the comorbid diseases associated psychiatric illness associated are anxiety disorders, substance abuse and impulse control disorders.

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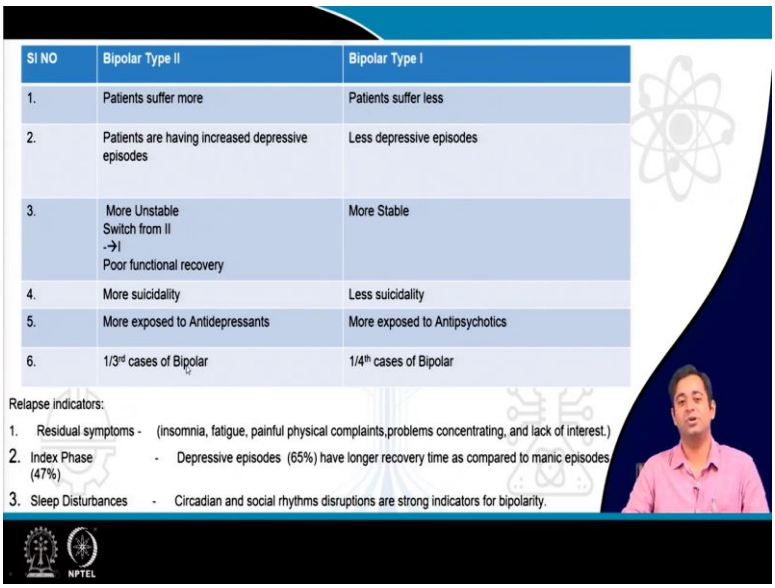

Now, how do you differentiate bipolar type 1 and type 2? Bipolar type 2 they actually suffer from more depressive phases of the illness. So, that is why they suffer more, there is more suicidality involved and they are more unstable. Whereas, the bipolar type 1, they are more stable, less depressive episodes are there and the patients suffer less. What are the relapse indicators wherein the patient actually there is reoccurrence of the symptoms after which the patient has suffered or if there is a relapse of the illness where the patient is actually on treatment and there is symptom relapse of the disease.

So, what are those indicators? They can be due to this residual set of symptoms. What are those residual set of symptoms? Residual means the patient was actually treated for a certain period of time with some antidepressants, but there are some symptoms which is actually not

being relieved off. So, what are those? There is insomnia, fatigue, painful physical complaints, problems concentrating and lack of interest.

The first episode, the literature says that the index episode for the depressive phase have longer recovery time as compared to the manic episodes and the sleep disturbances as compared to when you are dealing with the relapse indicators, the circadian and the social rhythms disruptions are the stronger indicators for bipolarity.

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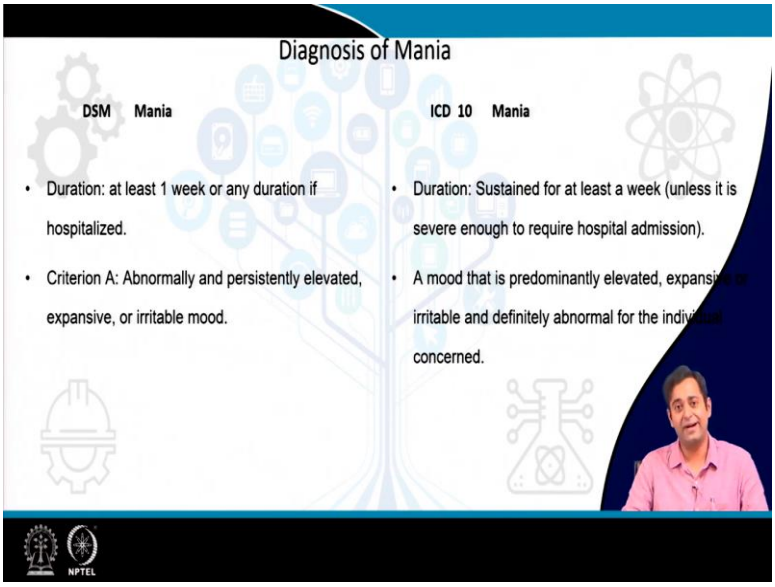

Now, as depression is present for minimum of 2 weeks. The diagnosis of mania in DSM and ICD is for a minimum of 1 week. As we have seen in depression you have low mood, fatigability, loss of interest. Here, we have elevated mood, increased energy, decreased need for sleep, grandiose ideas, these all are present, flight of ideas.

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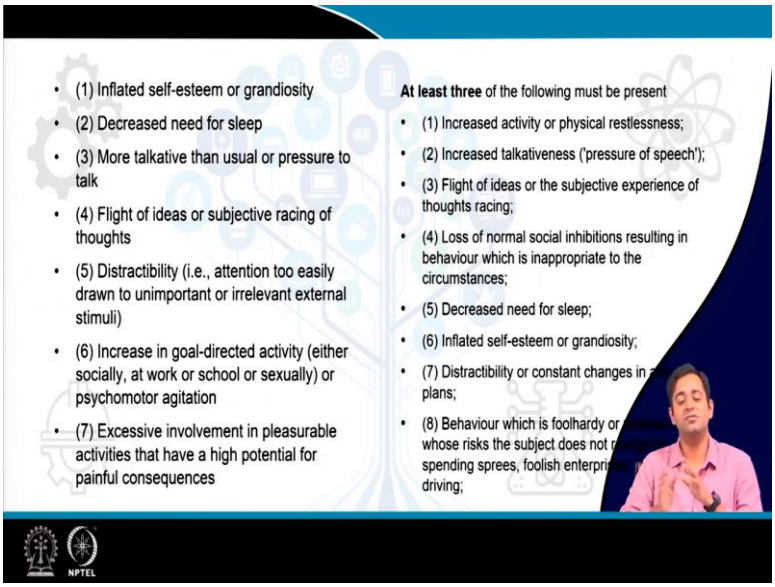

Increased activity, physical restlessness, loss of normal social inhibitions resulting to behavior which is inappropriate to the circumstances. Inflated self-esteem and the behavior which is foolhardy or whose risk to the subject does not recognize the spending that is he is on a spending free, there is grandiosity in the patient. Now this grandiosity can be defined more in terms of ability and potential. These are the two parameters in which the grandiosity is being defined.

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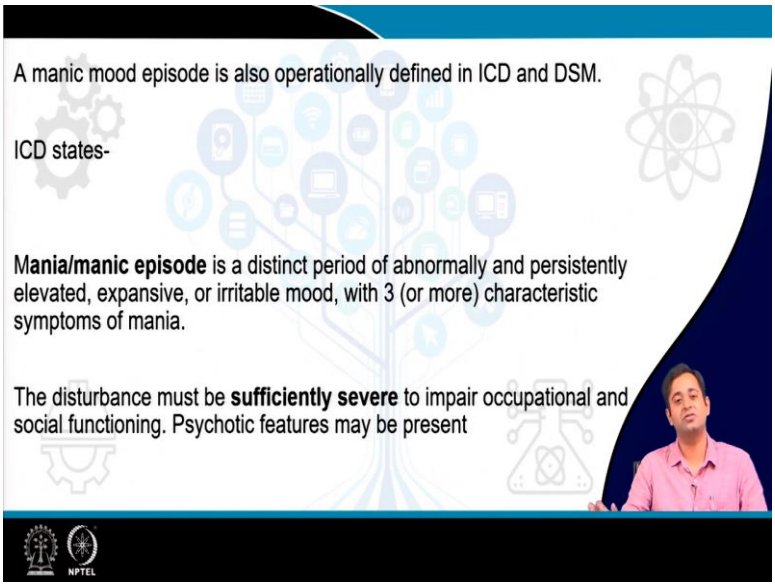

A manic episode is a distinct period of abnormally and persistently elevated, expansive and irritable mood with three or more characteristic symptoms of mania. Like whatever features whatever criteria is present, three or more has to be present, if you have to diagnose a patient

suffering from mania. And the disturbance must be sufficiently severe to impair the socio occupational functions of his or her life.

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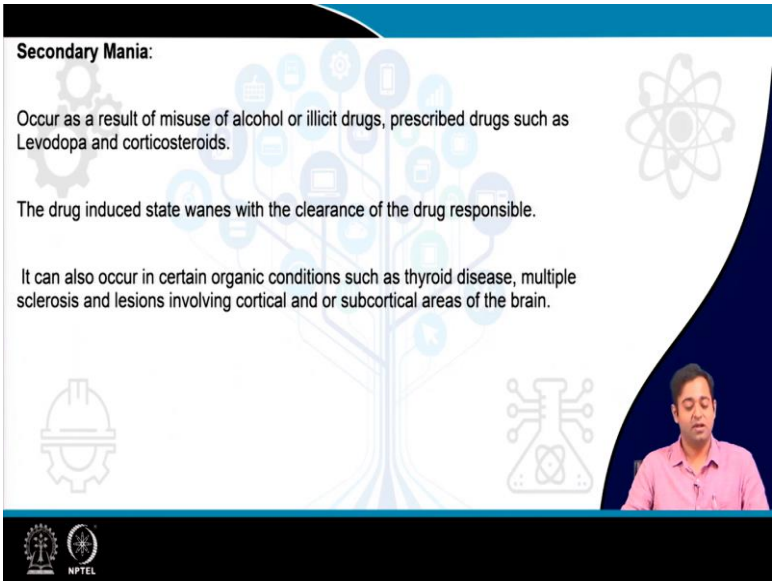

What is secondary mania? Secondary mania, it occurs as a result of misuse of alcohol that is substance or any drugs. The drug induced state veins with the clearance of the drug responsible we can see that and it can also occur due to certain organic conditions such as thyroid, multiple sclerosis, or lesions involving cortical or subcortical area of the brain.

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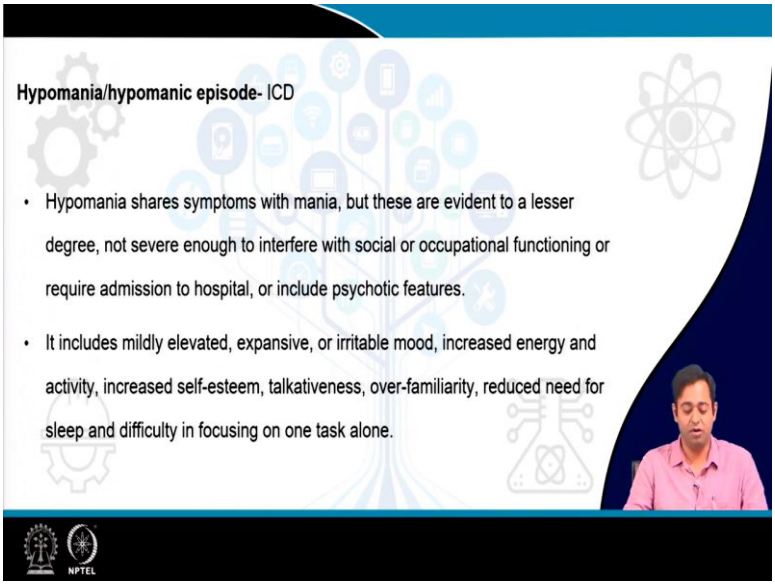

Hypomania as we have seen, the duration has to be a 4 days and the severity of the illness is not that much high as compared to the mania, there is no socio-occupational dysfunction, as

compared to mania. Otherwise, all the symptoms of inflated self-esteem, increased energy decreased need for sleep, all those symptoms are present in hypomania also.

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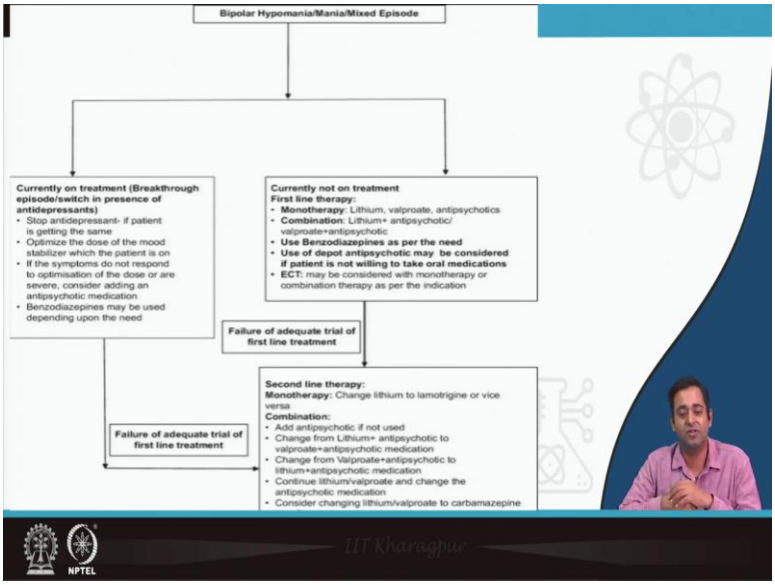

So, let us talk about the management of bipolar disorders. So, the benefit of bipolar disorder is basically depends upon which stage of the illness patient is presenting with. So, they can have four different stages. And the priority of the patient is as you all know to return back to the normal mood state levels, that is called euthymia. So, what are the first those four conditions where we should be looking for which can the patient presents with?

First is mania or hyper manic or mixed episodes of first episode mania, a bipolar depression or a switch or antidepressant switch. So, these are the four basic most common conditions in which the patients might come up in bipolar disorder. So, let us discuss about the manic phase of the illness.

So, in manic phase of the illness, the primary aim is to maintain the counteract the agitation, the irritability of the patient, the psychotic process, if at all it is involved or present such as grandiose ideation, the ability and the potential of that I am king, I can do this I have superhuman powers, which is actually destructing his life. So, the main idea is to counteract those.

So, how it is been done, it is done with the help of mood stabilizers. So, primarily the first line mood stabilizers in psychiatry is Valproic lithium carbamazepine oxcarbazepine. So, this is given in conjunction with antipsychotics. Among antipsychotics we have to decide if the irritability on the part of patient is very high. So, typical antipsychotics can be preferred, or if

they admit is not that much high and patient is having those psychotic processes along with elevated mood atypical antipsychotics can be considered like mainly risperidone, olanzapine, quetiapine. These all are having good evidences to counteract the psychotic phenomena associated with mania.

So, benzodiazepines are given in order to counteract the agitation, irritability, the subjective restlessness, and decreased need for sleep. So, there are special hierarchies that has to maintain. So, you go according to the levels first line, second line, third line, fourth line levels of drugs. So, next is the bipolar depression.

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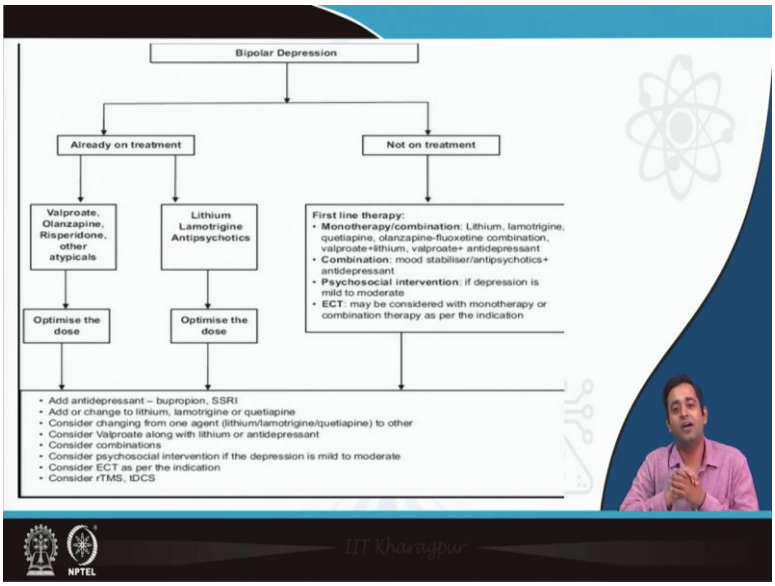

So, bipolar depression is when your patient is having episodes of depression as well as hypomania. So, in bipolar depression, the main idea is to stop going towards the manifest or sorry, stop going towards the dip, further dip. Now, in bipolar depression in bipolar phases, mostly the depressive phases are more and hypomanic phases are less.

So, the main idea is to see that if the patient is on any kind of mood stabilizers, which is acting from below, like lamotrigine what is acting from above like lithium or valproate, that has to be seen a rationalize judiciously. We need to see the drug levels of the mood stabilizers basically, valproate and lithium that has to be thoroughly maintained or assessed.

And if possible, optimization of the mood stabilizers has to be done for maintenance of the euthenics levels that normal mood levels. So, if at all it is found that there is a breakthrough episode, which can also happen, that patient is on any kind any mood stabilizer for a particular dose for a particular period of time, but even though episode of mania or

hypomania or depression comes, so there you need to see that the dose is adequate for that be it and all for that particular kind of stage of the illness. So, there we need to optimize increase the dosage further.

And antidepressants later on can be added in undercover of mood stabilizers. On the first line agent for bipolar depression is the evidence most evidences for Olanzapine-Fluoxetine, next is the Lamotrigine and third is the Quetiapine. So, these are the drugs which is given for bipolar depression. Now, you have some special conditions also where you need to be like very cautious by giving medicines to the bipolar patients suffering from those special conditions.

These are suicidality, we need to be very aware of the conditions of suicide, patient has those component of can do and like commit suicide kill their lives, end their lives wherever they are alone, then you have a special condition of young age, elderly age where you need to go slow act start low, like the dosage where you are given for normal manic or depressed patient for like normal age group adult normal adult.

You should be going very in a very slow titrated manner like the dosage should be given in very lowest possible dosage. And it should be tatted very slowly like in a week or 10 days or 2 weeks. So, the capability the metabolizing power of the pediatric age group and the elderly age group is less as compared to the normal that has to be kept in mind.

In terms of pregnancy, you need to be aware of the side effects valproate lithium can cause, the various Epstein, Annamarie in lithium first trimester, valproate you have cognitive those, congenital manifestations, neural tube defects in the first trimester, those all those kinds of things has to be analyzed before prescribing the in those special circumstances. So, these are the conditions that has to look for.

There are some factors which actually makes the treatment more efficacious. There are some past treatment responders those who have responded in the past with a specific molecule or there has been episodes of more frequency or there has been familiar like familiarity the familiar disposition, so that has to be taken into account. So, while the patient is being assessed for the treatment plan, these areas need to be more stressly looked out for more carefully that can actually help in the management of the patient of bipolar.

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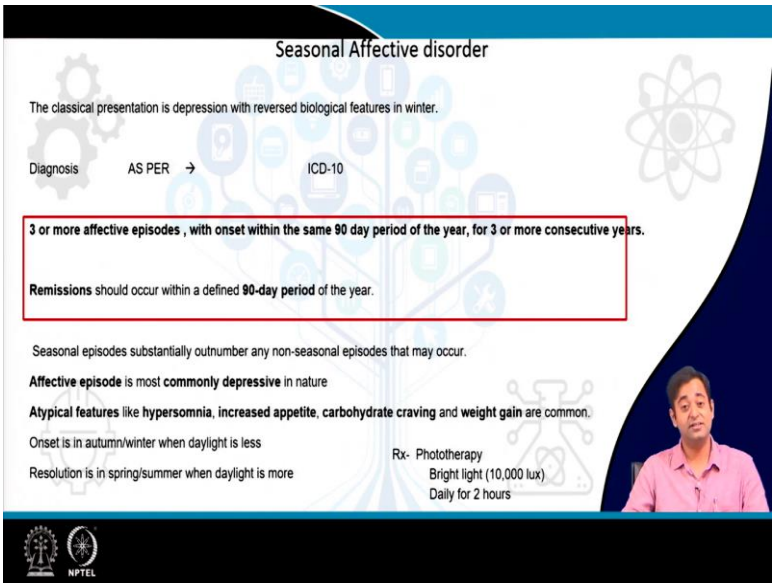

So, next is seasonal affective disorder. It is a classical presentation of the depressive phase with refers biological features happening in winter season. Three or more effective episodes occurs with onset within the same 90-day period of the year for three or more consecutive years. So, it is happening for three consecutive years, and in every year, you have 90-day period for which the patient feels low that is depressed, remission should occur within that 90-day period.

Seasonal episodes usually outnumber any non-single episode and as you can see, the effective response is most commonly depressive. It is seen in the autumn or winter phase when the delight is less and resolution is seen with the as a delight improved that is in summer, treatment is mostly phototherapy daily for 2 hours.

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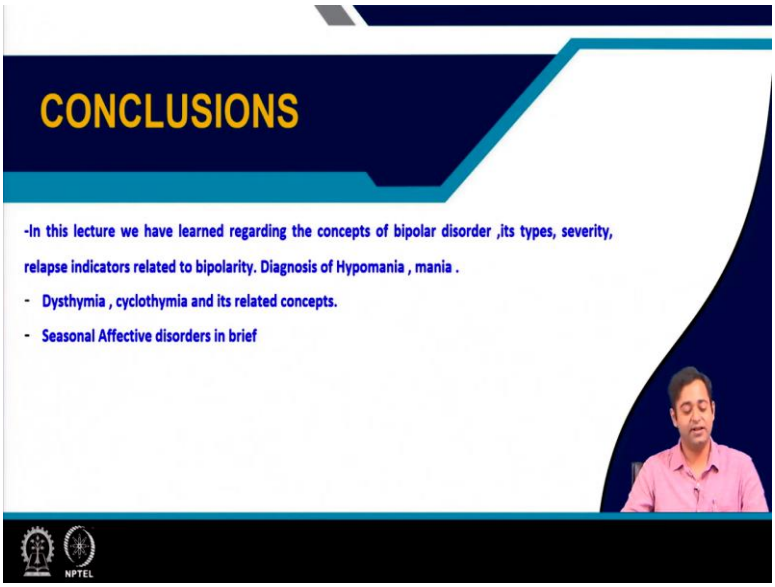

So, in this lecture we have learned regarding the concepts of bipolar, its type, severity, relapse indicators to bipolarity, the diagnosis of hypomania, mania, and the various other related terminologies to it with the treatment of bipolar disorder and seasonal affective disorder.

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Thank you.