Update on Mood Disorders
July 6, 2015

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Financial Disclosures

none
Update on Mood Disorders Outline

- Overview and Diagnostic criteria
- Trap of Meaning
- Premenstrual Dysphoric Disorder
- Disruptive Mood Dysregulation Disorder
- Bereavement/Grief
- Dementia (Major Neurocognitive Disorder)
- Bipolar Disorder
### Diagnosis of Depression

**Key issues**

1. Rule out Medical conditions causing psychiatric symptoms
2. Rule out Substance abuse or iatrogenic medications
3. Rule out Bipolar disorder (ie, screen for mania or hypomania)

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### The Three S’s of the Psychiatric Interview

1. **S** – Stressors/triggers
2. **S** – Suicidality
3. **S** – Substance Abuse
Physical Health Questionnaire-9, depression scale

- Nine (9) items
- Easy to score
- There are two components of the PHQ-9:
  - Diagnostic
  - Severity
- Google: “PHQ-9”

http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
Major Depressive Episode — Diagnostic Criteria

Criterion A. Five or more of the following...
MDE = ≥2wks of

- ↓’d mood
- anhedonia
- signif wt Δ (↓ or ↑)
- insomnia or hypersomnia
- ψmotor agitation/retardation (PMA/PMR)
- fatigue or anergia
- guilt/worthlessness (G/W)
- ↓’d concentration
- recurrent thoughts of death or SI

5 symptoms (with ≥1 sx in blue)
Major Depressive Episode
—Diagnostic Criteria (cont.)

*Criterion B.* The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Criterion C.* The episode is not attributable to the physiological effects of a substance or to another medical condition.

Criteria A-C represent a major depressive episode

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Major Depressive Disorder
—Diagnostic Criteria (cont.)

*Criterion D.* The occurrence of the MDE is not better explained by schizoaffective disorder, schizophrenia, etc.

*Criterion E.* There has never been a manic episode or a hypomanic episode.

*note: deletion of Bereavement exclusion in DSM 5*
Major Depressive Episode: SIG E CAPS criteria

Depressed mood (or anhedonia), plus:
S—sleep symptoms
I—lack of Interest.
G—feelings of Guilt
E—lack of Energy.
C—lack of Concentration.
A—lack of Appetite.
P—Psychomotor changes
S—thoughts of Suicide

Specifiers

- Atypical
- Catatonia
- Melancholic
- Mixed features
- Postpartum onset
- Psychotic features
Specifiers
(that are risk factors for bipolar disorder)

- Atypical
- Catatonia
- Melancholic
- Mixed features
- Postpartum onset
- Psychotic features

Other DSM-5 depressive disorders

- Persistent Depressive Disorder (dysthymia)
- Premenstrual Dysphoric Mood Disorder (PMDD)
- Disruptive Mood Dysregulation Disorder

N.B. DSM with diagnostic hierarchy:
Mood > Psychosis > other (anxiety, somatic, personality, etc.)
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http://well.blogs.nytimes.com/2013/08/12/a-glut-of-antidepressants/?_r=0

A Glut of Antidepressants
By RONI CARYN RABIN AUGUST 12, 2013 2:53 PM 529 Comments

Over the past two decades, the use of antidepressants has skyrocketed. One in 10 Americans now takes an antidepressant medication; among women in their 40s and 50s, the figure is one in four.

Experts have offered numerous reasons. Depression is common, and economic struggles have added to our stress and anxiety. Television ads promote antidepressants, and

Is there a glut of coffee, alcohol? http://psychcentral.com/blog/archives/2013/08/19/is-a-glut-of-antidepressants-really-so-bad/
Case vignette

28yo man, recently married 6m ago, appears well, but quickly breaks down: He says he’s made a terrible mistake for imposing himself on his wife. “I’m a terrible person who cheated on my wife and on my taxes.” He reports two months of depressed mood, crying spells, as well as oversleeping and not being able to get out of bed. In addition, his energy has been low, he has no appetite, and he can’t focus at work.

Would you diagnose him with Major Depressive Disorder? Would you prescribe an antidepressant?

Case vignette

“I cheated on my wife and on my taxes.”

Do we accept his reasons as the causes of his depression?

Even when confronted with an intuitively plausible set of reasons, we must look for objective causes.
The Trap of Meaning

“Finding an explanation that appears meaningful and adopting it as causal.”


"...humans are incredibly good at linking cause and effect—sometimes too good..."

"... it means that when you see something occur in a complex adaptive system, your mind is going to create a narrative to explain what happened—even though cause and effect are not comprehensible in that kind of system."


Embracing Complexity, An interview with Michael Mauboussin by Tim Sullivan
Harvard Business Review 2011
Reason vs. Cause

- “Reason" and "cause" are not contradictory, nor are they synonymous
- Confusion between them: delays mental health care for mood disorders much more than care for diabetes, heart disease, stroke and cancer (?)

Does the Trap of Meaning occur with mania or hypomania?

Yes!
Trap of Meaning references:


What are the Validated Risk Factors for Depression?

- Neuroticism
- h/o GAD
- h/o phobia
- h/o panic disorder
- age of onset of MDD
- parental warmth
- childhood sexual abuse
- parental loss
- maternal h/o MD
- paternal h/o MD
- h/o MD in cotwin
- prior episode of MD
Take Home Message

Be aware of "explaining away" mood episodes.


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Case Vignette

PMDD

How would you differentiate between PMDD and depression?

Normal PMS vs. PMDD

**Normal PMS (Premenstrual Syndrome):**
- 80% of women
- Mild to moderate emotional fluctuations

**PMDD (Premenstrual Dysphoric Disorder):**
- 3-8% of women
- Severe moods swings, depressed mood, irritability

Premenstrual dysphoric disorder

- Must begin in the week before menses and improve within a few days after onset of menses and then be absent in the week postmenses.
- Criteria must be confirmed by prospective daily ratings during at least 2 consecutive symptomatic menstrual cycles.
- Not simply premenstrual exacerbations of other psychiatric d/o’s

Menstrual Cycle Week and All Psychiatric Admissions

If random, admissions of women to psychiatric hospitals for all psychiatric diagnoses would be 25% on each week of the menstrual cycle.

Disorders with Premenstrual Exacerbation (PME)

Psychiatric
- Affective disorders
- Anxiety disorders
- Psychotic disorders
- Eating disorders
- Personality disorders
- Substance abuse

General Medical
- Migraine
- Allergies
- Asthma
- Seizures

Women and Depression

- More likely to present with atypical symptoms and anxiety
- More likely to respond to ssri’s (higher plasma levels of sertraline)
- Less likely to respond to TCAs (more likely to experience ADRs to TCAs)

Premenstrual Dysphoric Disorder Treatments

Two Main Treatments

• SSRI’s
• Hormones

"Be the you he likes. Good to be around, any day of the month."

This is so wrong!

A tangent on Midol (which is for PMS not PMDD)

https://www.midol.com/midol-products/
Accessed 6/13/15
### Midol Formulation

<table>
<thead>
<tr>
<th>formulation</th>
<th>Active ingredients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midol Complete</td>
<td>Acetaminophen 500 mg</td>
</tr>
<tr>
<td></td>
<td>Caffeine 60 mg</td>
</tr>
<tr>
<td></td>
<td>Pyrilamine Maleate 15 mg</td>
</tr>
<tr>
<td>Menstridol, formerly known as &quot;Extended Relief&quot;</td>
<td>Naproxen Sodium 220 mg</td>
</tr>
<tr>
<td>&quot;Teen&quot;</td>
<td>Acetaminophen 500 mg</td>
</tr>
<tr>
<td></td>
<td>Pamabrom 25 mg (8-bromotheophylline)</td>
</tr>
<tr>
<td>“PM”</td>
<td>Acetaminophen 500 mg</td>
</tr>
<tr>
<td></td>
<td>Diphenhydramine citrate 38 mg</td>
</tr>
</tbody>
</table>

### Possible PMDD Treatments

**Antidepressants**
- SSRI*
- SNRI*
  Clomipramine**

**Anxiolytics**
- Benzodiazepines**
- Buspar**

**Ovulation Suppression**
- OCPs*
- GnRH Agonists (leuprolide, nafarelin, goserein)**
- Danazol (inhibits LH/FSH)
- Oophorectomy

**Other**
- Exercise
- Vit B6
- Calcium**
- NSAIDS
- CBT*
- Diet
- Chasteberry (may reduce FSH or Prolactin)

**Studies for PMS**

**Studies for PMDD**
**SSRI’s in PMDD**

Fluoxetine, Sertraline and Paroxetine CR are FDA approved for PMDD

Intermittent dosing ok*


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**What about hormone therapy?**

**Lower progestin potency:**

- Ortho Evra patch
- Necon 1/35
- Ovcon 35
- Alesse
- Ortho-TriCyclen
- Levlite
- Othro-Cyclen
- Tri-Levlen
- Brevicon
- Triphasil
- Modicon
- Trivora

**Yaz:** Drospirenone 3.0mg, FDA approved for PMDD


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### Which hormones are good for mood?

- **Progestin**, some to the amount and some to the hormonal fluctuation
- Monophasic OCP (e.g., Seasonale) taken continuously can stabilize mood
- Women who are sensitive to hormonal fluctuation should avoid triphasic OCP’s
- It takes about 2 cycles to see if a certain OCP will work
PMDD References


Freeman et al. An overview of four studies of a continuous oral contraceptive (levonorgestrel 90 mcg/ethinyl estradiol 20 mcg) on premenstrual dysphoric disorder and premenstrual syndrome. Contraception 2012 May;85(5):437-45.


PMDD In Summary

- PMDD: 3-8% of women
- Etiology: ?hypersensitivity to the change in estrogen and progesterone
- Not simply premenstrual exacerbations
- Treatments:
  - SSRIs daily or luteal phase dosing
  - Ovulation suppressing OCPs (more second line)
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_Growth Spurt_
Visits to physicians for antipsychotic treatment, annual rate per 100 children

- 4 per 100 population
- 3... 14- to 20-year-olds
- 1... Children 13 and under

Source: Archives of General Psychiatry
The Wall Street Journal
11-year-old Max.

- Since infancy, Max flew into a rage at the smallest of slights, such as being told "no."
- Sent one child to the hospital during a play session, and has drawn blood a few other times.

At age 4, Max was diagnosed with bipolar disorder.

60% or so of children who are likely candidates for the new diagnosis are currently diagnosed with bipolar disorder.
Disruptive Mood Dysregulation Disorder

Criteria

- Severe recurrent temper outbursts
  - not developmentally appropriate
- On average, outbursts are $\geq 3x/wk$
- Inter-episode mood is typically irritable, corroborated by others
- ages 6-18 only; onset must be before age 10
- no more than 1d of mania/hypomania

DMDD – Bottom Line

- Severe recurrent temper outbursts in children
- Previously diagnosed with bipolar disorder
- Still more information to come…
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Case Vignette

72yo man is depressed in the context of the death of his wife.

How would you differentiate between grief and depression?
No Bereavement in DSM-5

No Bereavement exclusion in DSM-5
Grief is still exists
Mild depressive episodes can be treated with psychotherapy alone

[Website Link]

<table>
<thead>
<tr>
<th>MDE</th>
<th>Grief</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predominant affect</strong></td>
<td>Emptiness and loss</td>
</tr>
<tr>
<td><strong>Affect</strong></td>
<td>Waves or “pangs of grief”</td>
</tr>
<tr>
<td><strong>Accompanied by</strong></td>
<td>Humor, positive emotions</td>
</tr>
<tr>
<td><strong>Thought content</strong></td>
<td>Preoccupied with thoughts/memories of deceased</td>
</tr>
<tr>
<td><strong>Feelings of worthlessness</strong></td>
<td>Absent</td>
</tr>
<tr>
<td><strong>Psychosis</strong></td>
<td>(except may hear voice of deceased)</td>
</tr>
<tr>
<td><strong>Suicidal ideation</strong></td>
<td>(except about “joining” the deceased)</td>
</tr>
</tbody>
</table>
Case Vignette

72yo man is depressed in the context of the death of his wife.

How long would you wait before diagnosing MDD?

a) Two weeks
b) One month
c) Two months
d) Four months
e) Six months
f) One year or more

Depression vs. Grief

• Beware the Trap of Meaning!

• Individuals who fulfill MDD criteria after loss of significant other have NOT been shown to recover at a greater rate than MDD alone
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Case Vignette

71yo man complains of poor memory and depressed mood.

How would you differentiate between dementia and depression?
Major Depressive Episode: SIG E CAPS criteria

Depressed mood (or anhedonia), plus:

S — Sleep symptoms
I — lack of Interest.
G — feelings of Guilt
E — lack of Energy.
C — lack of Concentration.
A — lack of Appetite.
P — Psychomotor changes
S — thoughts of Suicide

<table>
<thead>
<tr>
<th>Major Neurocognitive Disorder</th>
<th>Cognitive impairment due to depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insight</td>
<td>Not aware</td>
</tr>
<tr>
<td>Course</td>
<td>Slow, often subtle (onset over month/years)</td>
</tr>
<tr>
<td>Social skills</td>
<td>Maintained</td>
</tr>
<tr>
<td>Memory</td>
<td>Loss of recent, not remote memory.</td>
</tr>
<tr>
<td>Effort</td>
<td>Fair</td>
</tr>
</tbody>
</table>

*May not be distinguishable, or may be co-morbid*
Montreal Cognitive Assessment Test (MoCA)

Use instructions
**MOCA (vs. MMSE)**

- Both are **screening** tools
- Slightly more difficult, about 10min
- More sensitive, particularly for early AD, and neurological disorders (eg, Parkinson’s)
- Includes tasks such as a clock-drawing test and a trail test
- Three versions
- Free

*Reference: Nassreddine et al, 2005*

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**Dementia vs. Depression**

- Depression requires either sad mood or anhedonia
- Depression may be the “prodrome” of dementia
- Depression, even the context of dementia, may respond well to antidepressants or behavioral activation/socialization
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**Bipolar Disorder**

Case Vignette

35yo man

- Presents to your outpatient clinic with depressed mood, anhedonia, low energy, sleeping 12-14 hours per day, for the past four weeks

- How would you rule out bipolar disorder?
List DSM criteria for Mania/hypomania
Reminder for Bipolar Disorder: DIG FAST Mnemonic*

D – Distractibility
I – Insomnia
G – Grandiosity (or inflated self esteem)

F – Flight of Ideas (or racing/crowded thoughts)
A – Activities (increased goal directed activities)
S – Speech (pressured)
T – Thoughtlessness (impulsivity, ie, increased pleasurable activities with potential for negative consequences: sex, money, traveling, driving)

*need 3 for elevated mood, 4 if mood is only irritable

Subtypes of Bipolar Disorder

Bipolar I: Depressive episodes plus **manic episodes**

Bipolar II: Depressive episodes plus **hypomanic episodes**

“Bipolar III”: Antidepressant Associated Mania/Hypomania
Typical (MINI) screening question

“Have you ever in your life ever felt unusually elevated or irritable?”
Obstacles to correct assessment and diagnosis of bipolar disorder

- clinician lack of familiarity with bipolar disorder
- relative rarity of mania
- disinclination to see doctor when manic or hypomanic
- phenomenon of Trap of Meaning
- poor recall by patients
- absence of collateral information

We need lots of information:

Several risk factors are associated with conversion:
- Age of onset (ie, <25yo)
- Family history of bipolar disorder
- Number of depressive episodes (ie, > six)
- Post-partum onset
- Psychotic features
- Severity (eg, hospital admission)

Other important information:
- Triggering events
- Prodrome
- Treatments: efficacy and adherence
- Number of episodes
- Course
- Baseline functioning
Problem:

The database is Gi-Normous, how do we cover it all?

Life Course Method:  
Get a Story

Start from the beginning of patient’s history of mood/psychiatric problems.
Using life events, divide history into epochs of time
Go chronologically forward with each epoch, with special attention to mood episodes and significant life events
For each mood episode, obtain prodromal symptoms, medications tried and their efficacy, adherence to medications.
Obtain collateral information
Diagnostic Criteria Compared

<table>
<thead>
<tr>
<th>Hypomanic Episode:</th>
<th>Manic Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>at least 4 days.</td>
<td>at least 1 week</td>
</tr>
<tr>
<td>B.</td>
<td></td>
</tr>
<tr>
<td>See DIGFAST</td>
<td>same</td>
</tr>
<tr>
<td>C.</td>
<td></td>
</tr>
<tr>
<td>unequivocal change</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
</tr>
<tr>
<td>observable by others.</td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
</tr>
<tr>
<td>not severe enough to cause marked impairment</td>
<td>marked impairment or hospitalization or psychosis</td>
</tr>
<tr>
<td>F.</td>
<td></td>
</tr>
<tr>
<td>are not due to ... a substance ... or a general medical condition</td>
<td>are not due to ... a substance ... or a general medical condition</td>
</tr>
</tbody>
</table>

Key point:

Marked impairment is enough to qualify for a diagnosis of mania

Bipolar Disorder Symptoms Are Chronic and Predominantly Depressive

146 Bipolar I Patients followed 12.8 yrs

- 53% Depressed
- 32% Hypo/manic
- 6% Cycling/mixed
- 9% Asymptomatic

86 Bipolar II Patients followed 13.4 yrs

- 50% Depressed
- 46% Asymptomatic

Study 1

Study 2

Tip#1: Focus on Prodrome

If multiple episodes, obtain:
- Overall number
- Frequency
- Typical course
- Most recent episode

Keep interview moving, don’t get bogged down!

Tip#2: Obtain only as much info as you need.
Advanced tip#3: Quote the patient

Tip#4: Find the kryptonite!
Tip#5: Practice!


Bipolar Depression Treatment

- Typical pattern is M-D-E:
  - Prevent Mania
- Avoid antidepressants
- Prevent Mania
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