Mood Disorders

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Content

- Definition
- Common mood disorders
- Physiotherapy and mood disorders

Definition

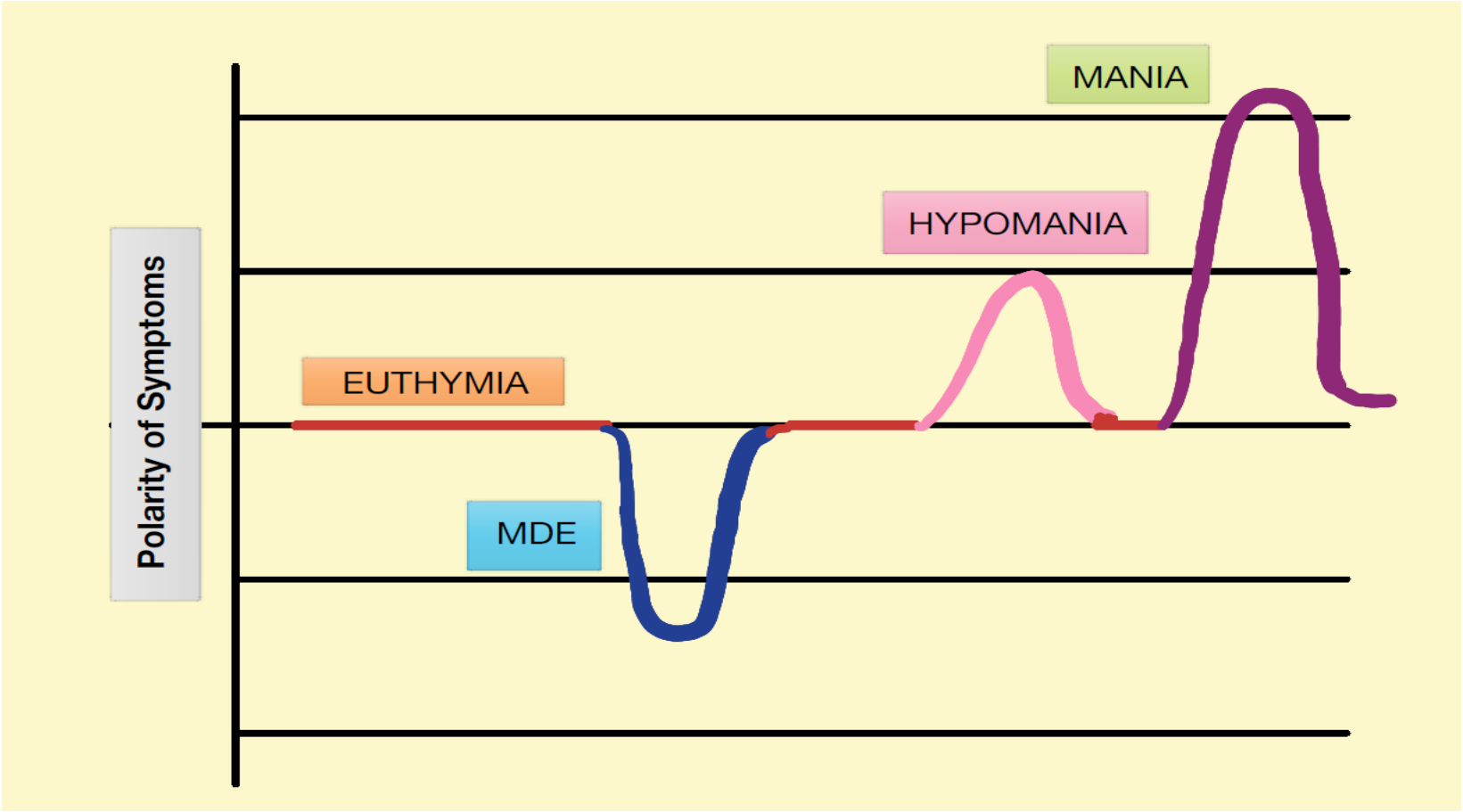
Mood

Pervasive & sustained feeling tone, that is experienced internally and influences a person's behavior

Affect

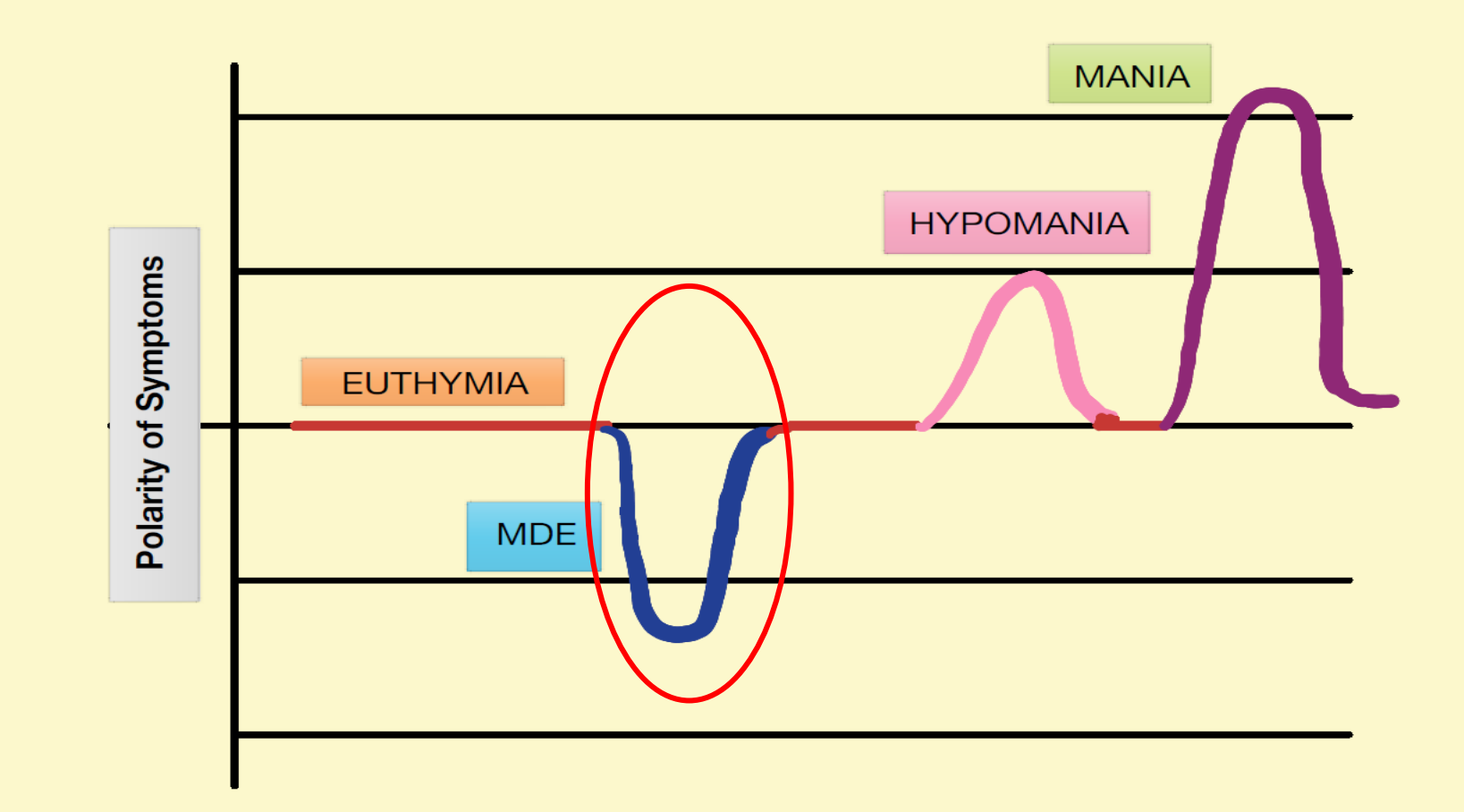
Observed expression of emotion

Major Episode



*MDE= Major depressive episode

Major Depressive Episode



Major Depressive Episode

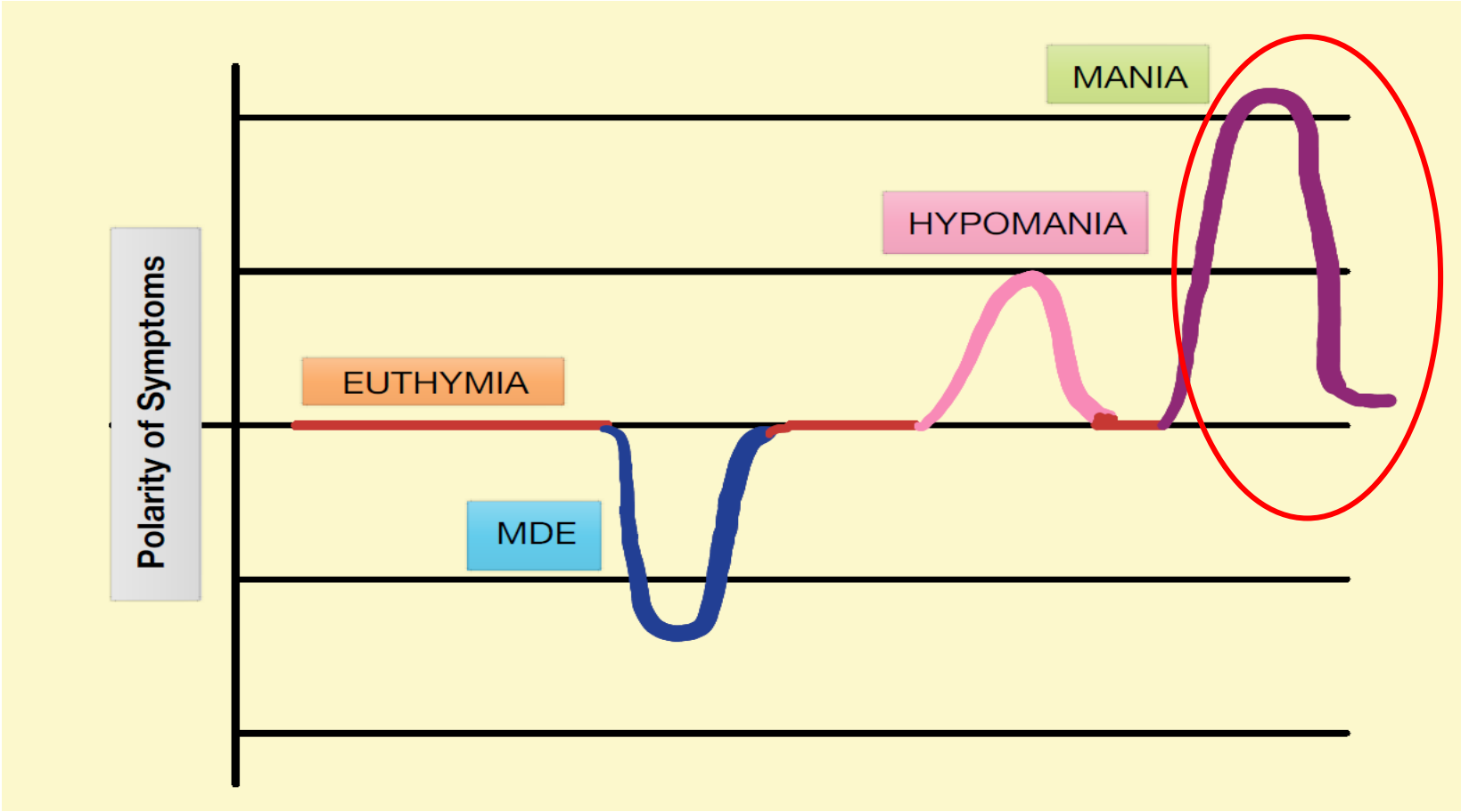
A. ≥ 5 symptoms during same 2 weeks at least 1 of depressed mood or loss of interest or pleasure

1. Depressed mood
2. Loss of interest or pleasure
3. Significant weight loss or weight gain/ change of appetite
4. Insomnia/hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue
7. Feeling of worthlessness
8. Diminished ability to think/concentrate
9. Recurrent thought of death

B. Clinically significant distress/ impairment

C. Not due to substances or medical condition

Manic Episode



Manic Episode

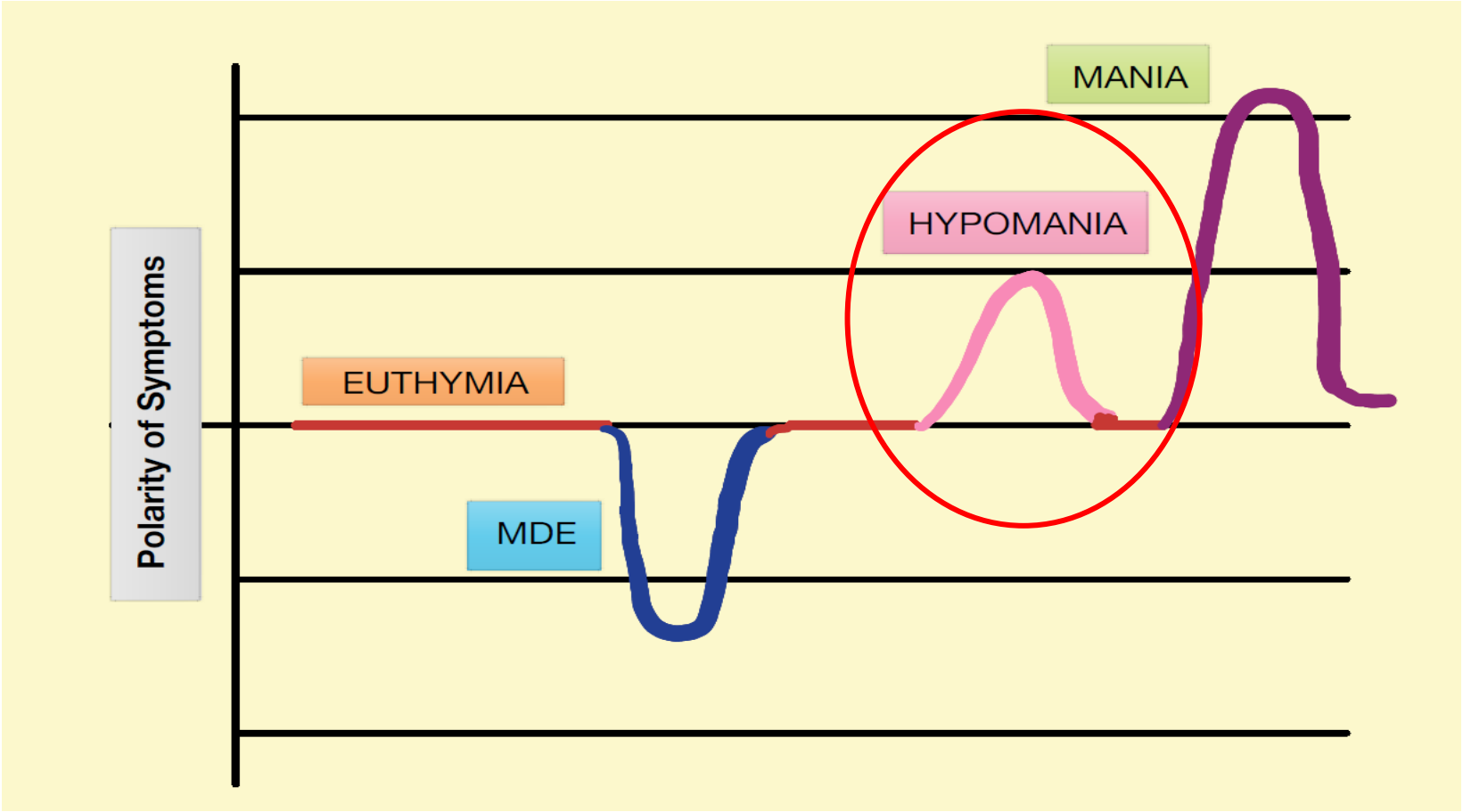
A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and persistently increased goal-directed activity or energy ≥ 1 week

B. During A. : ≥ 3 (or ≥ 4 if irritable) of the following are present with significant degree
   1. Inflated self esteem/grandiosity
   2. Decreased need for sleep
   3. Talkative
   4. Flight of idea/thought racing
   5. Distractibility
   6. Increased goal directed activity/psychomotor agitation
   7. Excessive involvement in activities with high potential for painful consequence

C. Marked impairment (or required hospitalization/psychosis)

D. Not due to substances/ medical conditions

Hypomanic Episode



Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood and persistently increased goal-directed activity or energy ≥ 4 consecutive days

B. During A. : ≥ 3 (or ≥ 4 if irritable) of the following are present with significant degree
   1. Inflated self esteem/grandiosity
   2. Decreased need for sleep
   3. Talkative
   4. Flight of idea/thought racing
   5. Distractibility
   6. Increased goal directed activity/psychomotor agitation
   7. Excessive involvement in activities with high potential for painful consequence

C. Associated with unequivocal change in functioning

D. Mood disturbance and a change in functioning are observed by others

E. Not severe to cause marked impairment

F. Not due to substances/ medical conditions

Mnemonic

Depressed mood

+

- **S:** Sleep disturbance
- **I:** Interest decreased in pleasurable activities
- **G:** Guilty feeling
- **E:** Energy decreased
- **C:** Concentration decreased
- **A:** Appetite change
- **P:** Psychomotor
- **S:** Suicidal ideation

MDE

- **D**: Distractibility
- **I:** Insomnia (decreased need for sleep)
- **G:** Grandiosity
- **F:** Flight of ideas
- **A:** Activities
- **S:** Speech
- **T:** Thoughtlessness

Mania/ hypomania

Depressive Disorders

- Major depressive disorder
- Persistent depressive disorder

Major Depressive Disorder

Epidemiology

- Life time prevalence 5-17%
- F>M
- Mean age onset =40 years (20-50 years of age)
- Divorced or separated
- No correlation between socioeconomic status and major depressive disorder

Etiology

Biological	Psychosocial
Neurotransmitters dysregulation	Insecure attachment
Brain structure and activity alterations	Loss
Stress hormones	Life event
Inflammation	Personality
Genetic	Cognitive distortions

Major Depressive Disorder

Diagnosis

A-C major depressive episode

D. Not better explained by schizoaffective disorder, schizophrenia,…..

E. Never been a manic episode or a hypomanic episode

Treatment

Biological:	Antidepressants
	ECT, rTMS, Phototherapy / light therapy
Psychosocial:	Supportive psychotherapy
	Cognitive behavior therapy
	Psychoanalytically oriented therapy
	Family therapy

Major Depressive Disorder

Phases	Duration	Goals	Activities
Acute	8-12 weeks	-Remission of symptoms -Restore function	-Establish therapeutic alliance -Educate -Treatment -Monitor progress
Maintenance	≥ 6-24 months	-Return to full function and QoL -Prevention of recurrence	-Educate -Rehabilitate -Treat comorbidities -Monitor for recurrence

CANMAT Depression Guideline 2016

Persistent Depressive Disorder

- Dysthymic disorder or dysthymia
- Low-grade chronicity for at ≥2 years
- Insidious onset, with origin often in childhood or adolescence

Epidemiology

- 5-6%
- F>M
- Young (beginning in childhood or adolescence)
- Low incomes

Persistent Depressive Disorder

Etiology

- Bio: Same as MDD
- Psychosocial:

  Parental loss or separation

  Deprivation of affection and care

  Interpersonal disappointment

Persistent Depressive Disorder

Diagnosis

A. Depressed mood most of the day, for more days than not, for ≥ 2 years
(children+adolescents = 1 year)

B. ≥ 2 of the followings;

1. Poor appetite or over eating
2. Insomnia or hypersomnia
3. Low energy/ fatigue
4. Low self-esteem
5. Poor concentration/ difficulty making decisions
6. Feelings of hopelessness

Diagnosis

C. During 2 years, individual has never been without A, B for > 2 months

D. MDD may be continuously for 2 years

E. Never been a manic episode or a hypomanic episode or cyclothymic disorder

F. Not better explained by schizoaffective disorder, schizophrenia,…..

G. Not due to substances or medical condition

H. Clinically significant distress/impairment

Persistent Depressive Disorder

Treatment

"Long term"

Biological: Antidepressants

Psychosocial :

Supportive psychotherapy

Cognitive behavior therapy

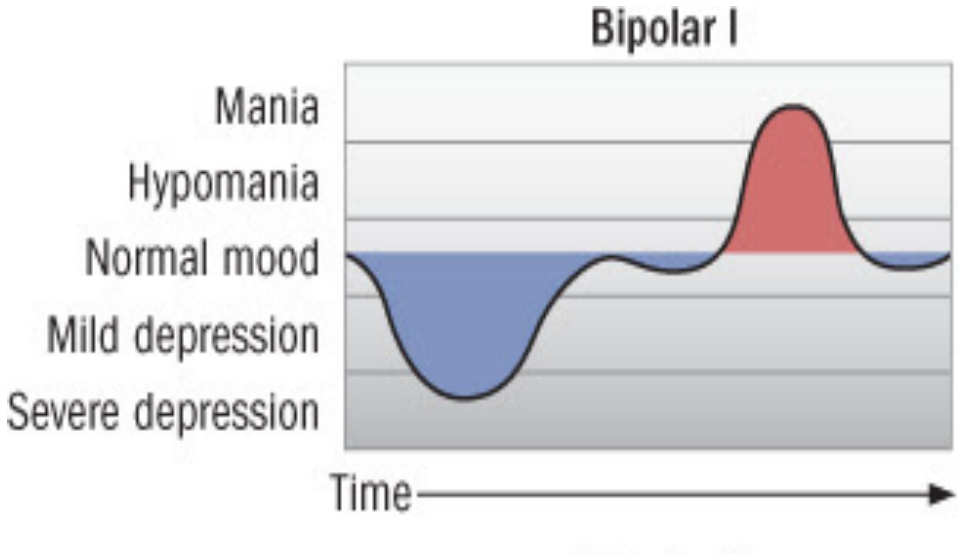
Psychoanalytically oriented therapy

Family therapy

Bipolar Disorders

- Bipolar I disorder
- Bipolar II disorder

Bipolar I Disorder



Epidemiology

- Life time prevalence 0.6-2.4%
- F=M (M: more mania, F: more depressive)
- Age of onset in late adolescence and young adulthood (average=25)
- Single or divorced
- Upper socioeconomic groups

Bipolar I Disorder

Etiology

- Bio:
  - Mania: Dopamine, norepinephrine, serotonin **hyperactivity**
  - Depress: Dopamine, norepinephrine, serotonin **hypoactivity**
  - Genetic
- Psychosocial:
  - A defense against underlying depression (omnipotence)

Bipolar I Disorder

Diagnosis

A. ≥1 Manic episode (A-D manic episode)

B. Not better explained by schizoaffective disorder, schizophrenia…and other psychotic disorders

Treatment

Biological: Antimanics/ mood stabilizers

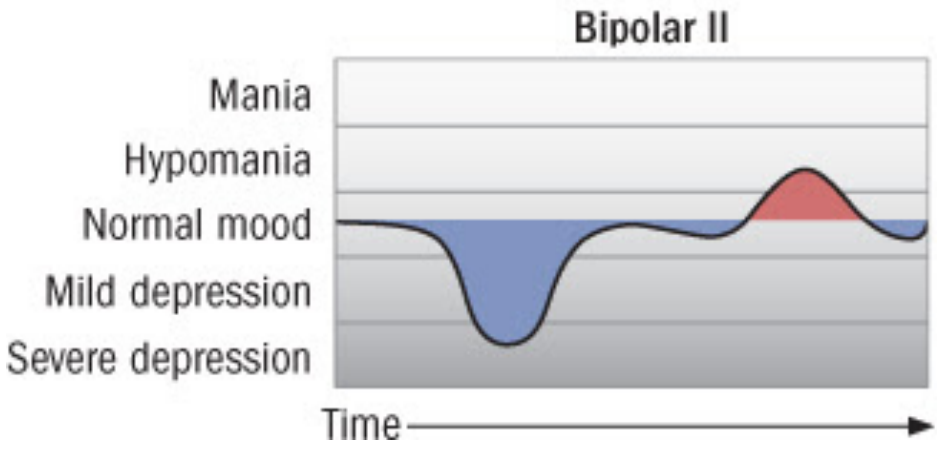
- Lithium
- Anticonvulsants: Valproate, Carbamazepine, Lamotrigine
- Atypical antipsychotics: Quetiapine, Risperidone, Aripiprazole etc.
- ECT

Treatment

Psychosocial:

- Supportive psychotherapy (Psychoeducation)
- Cognitive behavior therapy
- Psychoanalytically oriented therapy
- Family therapy

Bipolar II Disorder



Diagnosis

A. ≥ 1 hypomanic episode and ≥ 1 major depressive episode
B. Never been a manic episode
C. Not better explained by schizoaffective disorder, schizophrenia…and other psychotic disorders
D. Clinically significant distress/impairment

Bipolar II Disorder

Treatment

Similar to bipolar I disorder

- Biological: Antimanics/ mood stabilizers
  - Lithium
  - Anticonvulsants: Valproate, Lamotrigine
  - Atypical antipsychotics: Quetiapine
  - ECT
- Psychosocial

Physiotherapy and Mood Disorders

Health Benefits of Regular Exercise

- Improved sleep
- Better endurance
- Stress relief
- Improvement in mood
- Increased energy and stamina
- Reduced tiredness that can increase mental alertness
- Weight reduction
- Reduced cholesterol and improved cardiovascular fitness

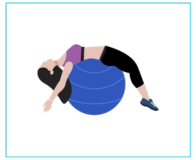
Goals of Physiotherapy

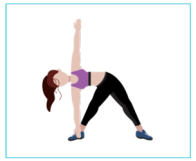
- **Physical goals**
- **Psychological goals**
  - To raise self-esteem and confidence
  - To improve mood and promote wellbeing through a structured exercise program
  - To motivate the patients and promote self management in mental and physical health issues
  - To promote a more positive body image
  - To reduce social isolation

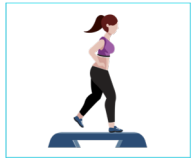
Role of Physiotherapist

- Encourage the patient to participate in exercise program.

Physical Activity Program







- American College of Sports Medicine
  - 3 x 20-60 minutes/week

-Relaxed deep breathing
-Muscle flexibility exercises
-Relaxation techniques
-Endurance training
-Hydrotherapy
-Biofeedback
-Ergonomics

-Cycle ergometry
-Muscle strengthening
-General mobility exercises
-Multi sensorial stimulation
-Balance and equilibrium training

Physical Activity Program

- Guszkowska (2004)
  - Rhythmic aerobic exercise
  - Low-moderate intensity
  - Large muscle groups
    - Jogging
    - Swimming
    - Cycling
    - Walking

Endorphin
Blood circulation
Self efficacy
Distraction

Physical Activity Program

- Meta-analysis shows
  - Physical activity decreases risk of developing clinical depression.
  - Aerobic and resistance exercises are effective in treating depression.
  - The effect is of the same magnitude as psychotherapeutic interventions.
    - Improve self-perceptions and self esteem

Conclusion

- Definition
- Common mood disorders
- Physiotherapy and mood disorders

Reference

- Synopsis of Psychiatry ,eleventh edition
- Jaswinder Kaur et al., role of physiotherapy in mental disorders, delhi psychiatric journal, Oct 2013