Adjustment and mood disorders

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Adjustment Disorders

- **Definition**
- * The development of emotional or behavioral symptoms in the context of identified psychosocial stressors.
- * The resultant symptoms are clinically significant by virtue of either:
- a. impairment in function
- b. the subjective experience of excessive distress

Adjustment Disorders

- * The symptoms must occur within 1-3 months of the occurrence of the stressor, and must remit within 6 months following the cessation of the stressor.
- * The disturbance must not fulfill the criteria for another major psychiatric disorder.

Adjustment Disorders

Clinical Subtypes

- **1. Adjustment disorder with depressed mood**
- **2. Adjustment disorder with anxiety**
- **3. Adjustment disorder with disturbance of conduct**
- **4. Adjustment disorder with disturbance of emotion and conduct**

Adjustment Disorders

- **Epidemiology**
- * They are very common disorders.
- * In a study conducted in the United States, 10 % had adjustment disorder.
- * Male to female ratio is 1 to 2.

Adjustment Disorders

- **Treatment**
- * Symptomatic use of medication, e.g., antidepressants, anxiolytic agents.
- * Supportive psychotherapy
- * Family therapy to improve family support

Mood Disorders

- Mood Disorders are a group of psychiatric disorders where a disturbance of mood is the salient feature.
- The disturbance of mood may be in the form of low mood (depression) or high mood (elation).

Mood Disorders

The most common types are:

- Depressive Disorders
  - Major Depressive Disorder
  - Dysthymic Disorder
- Bipolar Disorders

1. Major Depressive Disorder (Unipolar depression)

Epidemiology

- **Sex:** Twice in women than in men.
- **Age:** Most commonly, its age at onset is 20-40 years.
- **Lifetime Prevalence:** 5-12 % in males, and 10-25 % in females.
- **Annual Incidence:** 1.5 % over the whole population.
- **Marital Status**
- **Socio-economic Status**

Etiology of depression

(A) Biological Factors:

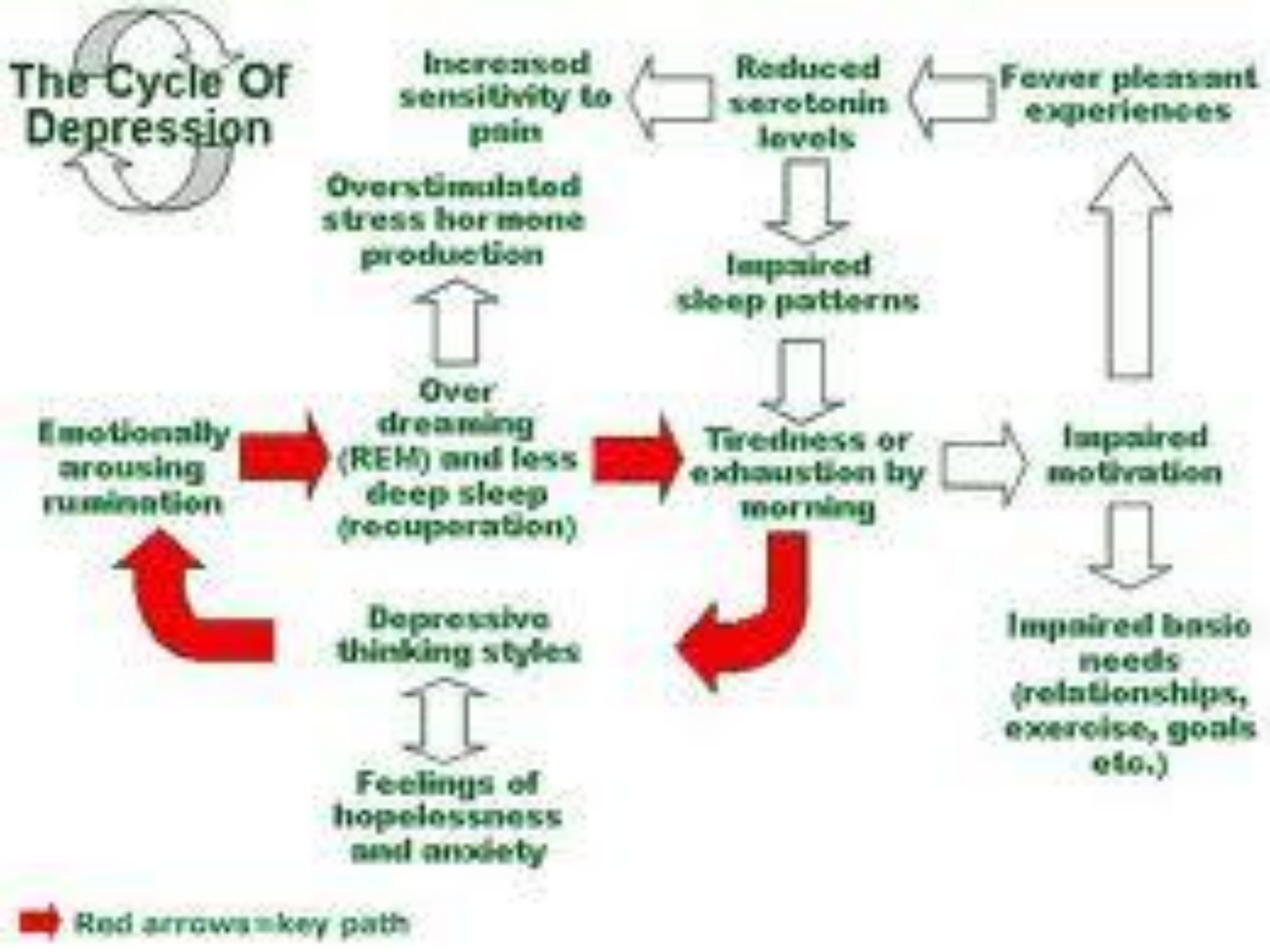
- **1. Genetic Factors:**
- **2. Neurochemical Factors:**
- **3. Hormonal Factors:**

(B) Psychosocial factors:

- **1. Early trauma in childhood**
- **2. Negative Life Events**
- **3. Chronic Stress**

Major Depressive Disorder

- **Clinical Picture:**
- 75 % of patients experience recurrences throughout life, with varying degrees of residual symptoms between episodes.
- **depressed mood** or **anhedonia** for two weeks. The patient is typically worse in the morning (diurnal variation).


The Cycle Of Depression
Increased sensitivity to pain
Reduced serotonin levels
Fewer pleasant experiences
Overstimulated stress hormone production
Impaired sleep patterns
Over dreaming (REM) and less deep sleep (recuperation)
Emotionally arousing rumination
Tiredness or exhaustion by morning
Impaired motivation
Depressive thinking styles
Impaired basic needs (relationships, exercise, goals etc.)
Feelings of hopelessness and anxiety
Red arrows = key path

Other symptoms of major depression include:

- 1. Sleep disturbances
- 2. change of appetite
- 3. Loss of libido, impotence in males.
- 4. Psychomotor retardation
- 5. Tendency to social withdrawal.
- 6. Decline in vocational functioning.
- 7. Fatigue or loss of energy.
- **Cognitive misinterpretations**
- 8. Diminished ability to think or concentrate.
- 9. Feeling of worthlessness
- 10. Excessive or inappropriate self-blame and guilt.
- 11. Recurrent thoughts about death
- 12. Diffuse bodily complaints,
- 13. Depersonalization and derealization.
- **psychotic features** in the form of delusions and hallucinations may be present

صلاح جاهين

- يا حزين يا قمقم تحت بحر الضياع

حزين أنا زيك و إيه مستطاع
الحزن ما بقالهوش جلال يا جدع
الحزن زي البرد ... زي الصداع
عجبي

صلاح جاهين

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- **انا شاب لكن عمرى الف *عام**
  وحيد لكن بين ضلوعى زحام

  خايف لكن خوفى منى انا

  أخرس لكن قلبى مليان كلام

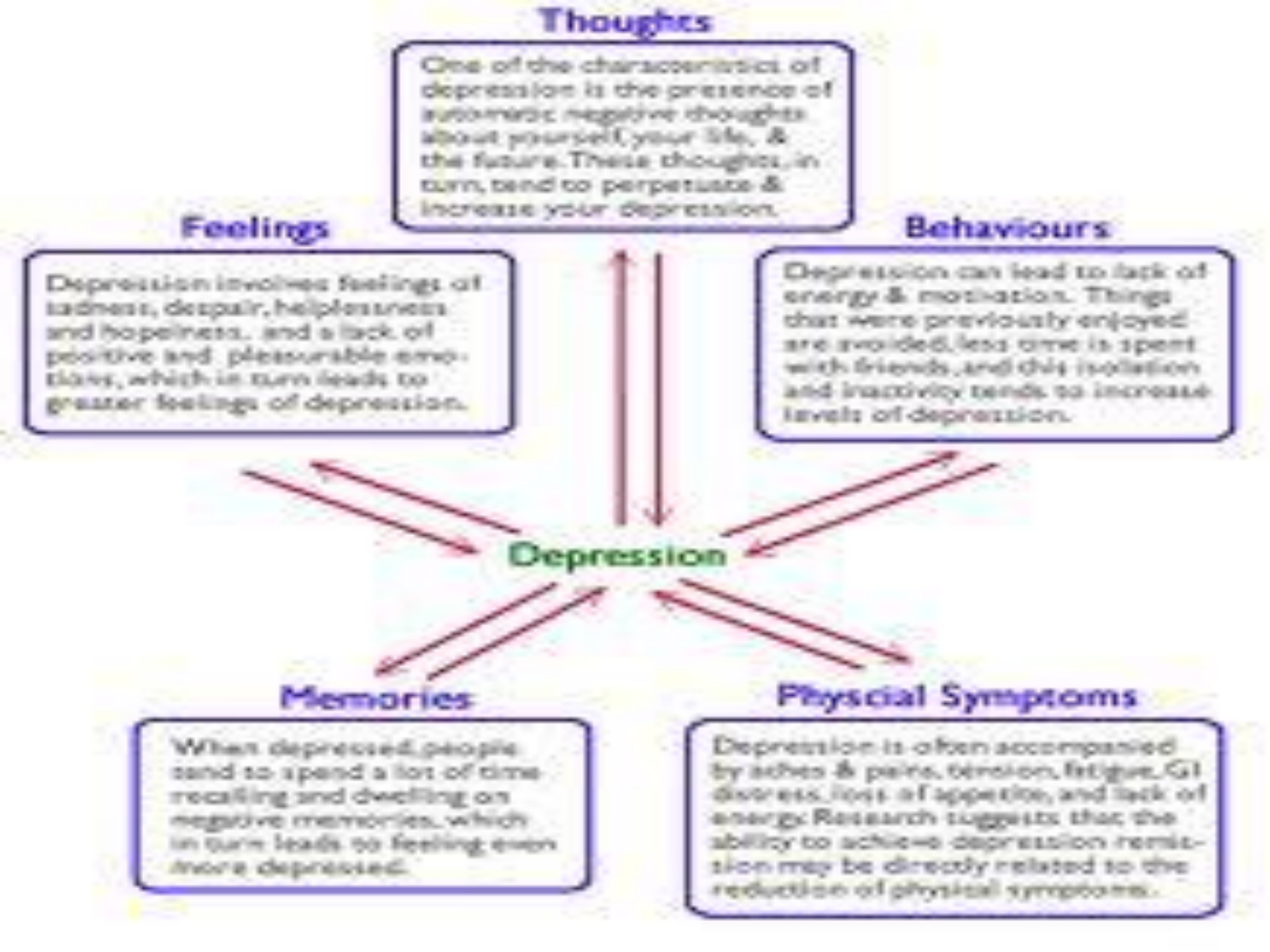
  !!!عجبى

Depression is a systemic illness

- multiple disorders related to the immune system, (malignancies, susceptibility to infections)
- Control of diabetes becomes difficult.
- platelet aggregation and blood vessels (coronary ischemia).

The Economic and Social impact of Major Depression

- Unipolar Depression was the **"leading cause of disability"** all over the world in the age range of 15-44 years (WHO, 2001).
- It was ***the fourth leading cause of death*** in the same age range.
- By the year 2020, with the increasing number of depressed patients, it will rank second on the list of causes of death after ischaemic heart disease.


Thoughts
One of the characteristics of depression is the presence of automatic negative thoughts about yourself, your life, & the future. These thoughts, in turn, tend to perpetuate & increase your depression.
Feelings
Depression involves feelings of sadness, despair, helplessness and hopelessness, and a lack of positive and pleasurable emotions, which in turn leads to greater feelings of depression.
Behaviours
Depression can lead to lack of energy & motivation. Things that were previously enjoyed are avoided, less time is spent with friends, and this isolation and inactivity tends to increase levels of depression.
Depression
Memories
When depressed, people tend to spend a lot of time recalling and dwelling on negative memories, which in turn leads to feeling even more depressed.
Physcial Symptoms
Depression is often accompanied by aches & pains, tension, fatigue, GI distress, loss of appetite, and lack of energy. Research suggests that the ability to achieve depression remission may be directly related to the reduction of physical symptoms.

2. Dysthymic disorder (Depressive Neurosis)

- It is a chronic depressive illness less severe than Major Depressive.
- The onset is insidious and the course is chronic (more than 2 years). Its lifetime prevalence is 6 % of all people.
- Age of onset is usually younger than in major depression.

2. Dysthymic disorder

- Those with onset during childhood or adolescence have a greater risk to develop major depression later in life (Double Depression).
- It is more common among the first degree relatives with major depression.

Clinical picture of Dysthymia

- A persistent depressed mood for more than two years.

In addition, there are at least two of the following symptoms:

- Poor appetite or overeating.
- Sleep problems.
- Fatigue.
- Feeling of hopelessness and low self esteem.
- Poor concentration or difficulty making decisions.


Change your appetite
Feel hopeless
Sleep more
Dysthymia affects
Can't focus
Reduce your energy
Can't make decisions

Treatment of Depressive disorders

- **1. Hospitalization**
- **2. Pharmacotherapy:**
- **3. Electro-Convulsive Therapy (ECT)**
- **4. Psychotherapy**

Pharmacotherapy:

- * Tricyclic and tetracyclic antidepressants
- * SSRIs and other more recent antidepressants
- * Maintenance treatment should be continued for at least 6 month to prevent relapse.
- * Long treatment is needed with chronic or recurrent major depression
- * Lithium, Antipsychotics in small dose and Antiepileptics.

Electro-Convulsive Therapy (ECT)

is indicated in:

- * Refractory Depression
- * If it is associated with psychotic features
- * Suicidal patients

Psychotherapy:

- * Psychotherapy in conjunction with antidepressants
- * Cognitive Therapy: Short term treatment aiming to correct the negative cognitive symptoms of depression.
- * Supportive Psychotherapy: For emotional support, ventilation and reinforcement
- * Family therapy: Indicated when patient's depression is disrupting family stability or related to family events.


Situations
• Loss
• Isolation
• Conflict
• Stress
Thoughts
• Negative thinking habits
• Harsh self-criticism
• Unfair & unrealistic thoughts
Emotions
• Discouragement
• Sadness
• Irritability/anger
• Numbness
• Anxiety
Physical State
• Altered sleep
• Low energy / fatigue
• Agitation
• Changes in brain chemistry
Actions
• Social withdrawal
• Reduced activity level
• Poor self-care

Bipolar Disorders

- characterized by the recurr
  either manic or hypomanic episodes, with or without history of a major depressive episode.
- There may be a mixed episode.
- Bipolar Disorders occupy the 9th position in the list of "causes of disability" according to the WHO report in 2001.

A MANIC EPISODE

- consists of a distinct period of persistently
- elevated, expansive, or irritable mood.
- grandiose thinking,
- decreased need for sleep,
- flight of ideas,
- distractibility
- increase in goal-directed activities.
- hyperactive.
- Excitement and aggressive behavior
- There may be psychotic features

صلاح جاهين

- **إنشد يا قلبي غنوتك *للجمـــــــــــال**

و ارقص في صدري من اليمين للشمال

ما هوش بعيد تفضل لبكره سعيـــــــد

ده كل يوم فيه الف الف احتمـــــــال

عجبي !!

صلاح جاهين

- مرحب ربيع مرحب ربيع
مرحبـــــــــه
يا طفل يا للي ف دمي ناغا وحبـــــــا
علشان عيونك يا صغنن
هويـــــــــت
حتي ديدان الأرض و
الأغربـــــــــة
!!!! !!! عجبي

A HYPOMANIC EPISODE

- is similar to a manic episode, but the symptoms are not severe enough to cause marked deterioration in either social or occupational functioning.
- Hospitalization is not required, and there are no psychotic features.

Epidemiology of Bipolar affective disorder

- **Lifetime Prevalence:** 1 %
- **Sex**: No difference between males and females.
- **Age at onset:** Bipolar disorder occurs at any age, starting from childhood.
- It typically has an earlier age of onset than major depression, with an average of 30 years.

Etiology of BAD

- **Genetics:** First-degree relatives of bipolar disorder are 8-18 more likely to have the disease compared to controls.
- They are 2-10 more likely to have major depression.
- Concordance rate for monozygotic twins is approximately 60 %, it is 15 % in dizygotic twins.
- **Stressor (Negative Life Events)**
- **Substance Abuse:** Adolescents who use cannabinoids are at risk at developing bipolar disorder.

Course and Prognosis of BAD

- less favorable than that of major depression.

* 10 % of all patients have a single manic episode.

* 45 % have recurrent multiple episodes.

* Recurrence occurs within 2 years of the previous episode in 50 % of cases.

* 45 % have a chronic disorder with partial improvement on medication.

Management of BAD

*** Hospitalization**

- **Pharmacological treatment**
- **ECT**
- **Prevention of relapses**

Pharmacological treatment

- 1. Control of agitation by low-potency antipsychotics, e.g., chlorpromazine.
- 2. High-potency antipsychotics are needed to control psychotic features.
- 3. Mood stabilizers, e.g., lithium and antiepileptics.
- 4. Antidepressants are better avoided to prevent shifting the patient into Rapid Cycling Bipolar Disorder.

Prevention of relapses:

- 1. Prophylaxis by the use of mood stabilizers (lithium or anticonvulsants) for many years after the active episode has ended.
- 2. Therapeutic alliance with the patient and his family to monitor early signs of relapse in order to start treatment early in subsequent episodes.
- 3. Family education to inform the family about the nature of the illness and its management.

Thank you