

Review on Mood Disorder

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Abstract

Mood disorders, which include major depressive disorder, bipolar disorder, and persistent depressive disorder, represent a significant global health problem, affecting millions of people and resulting in significant disability and reduced quality of life. These disorders are characterized by persistent mood changes, including depressive episodes, manic or hypomanic states, and emotional instability. Mood disorders are multifaceted, including genetic, neurological, environmental, and psychological factors. The recent results in the field of neural images and molecular biology have strengthened the understanding of the main mechanisms and reveals changes in neurotransmitters and brain co-rencence systems. Effective treatment strategies include pharmacological therapy, psychotherapy, and lifestyle modifications. However, issues such as treatment resistance and comorbidities remain common. Current research aims to refine diagnostic criteria and improve treatment outcomes, highlighting the importance of personalized medicine in addressing the various symptoms of mood disorders. To determine the etiology of mood disorders. Review the appropriate evaluation of mood disorders. Outline the management options available for mood disorders. Describe interprofessional team strategies to improve care coordination and communication to improve care and outcomes for patients with mood disorders.

Keywords: Mood Disorder, Depression, Hypomania, Mania, Depressive Disorder

Continuing Education Activity

Mood is defined as a pervasive and enduring state of mind that is endured internally and impacts nearly every aspect of a person's behavior in the external world. Mood disorders are described by the marked disturbances in the emotion (severe lows called depressions or peaks called hypomania or mania). These includes the bipolar disorder, cyclothymia, hypomania, major depressive disorder, disruptive mood dysregulation disorder, persistent depressive disorder, and premenstrual dysphoric disorder. These are common psychiatric disorders leading to increased morbidity and mortality. This exercise examines the role of the interprofessional team in the diagnosis and treatment of this disorder.

Introduction

Mood is defined as a pervasive and sustained feeling tone that is endured internally, and that impacts nearly all aspects of a person's behaviour in the external world. Mood disorders or affective disorders are described by the marked disruptions in emotions (severe lows called depression or highs called hypomania or mania). These are the common mental disorders and increase the affection rate & mortality rate.

According to the 5th edition (DSM-5), the diagnosis and statistical manual (DSM-5) is mainly classified as bipolar disorders and depression disorders. [1] Bipolar disorder is another medical condition induced by bipolar, bipolar II, bandy disorder, bipolar disorder, substance /drugs, relevant non -recognition disorders, and bipolar and associated Unspecified. It is also classified as bipolar and related disability. Hindrance.

Bipolar I disorder is defined as a syndrome in which a full range of manic episodes (elevated mood accompanied by three or more of the following symptoms: increased goal-directed activity, grandiosity, decreased need for sleep, inattention, rapid thinking, increased agitation/oppressive comments and reckless behaviour) last for at least one week or require hospitalization. If the mood is irritable rather than elevated, four or more of the above symptoms must be present to meet the criteria for a manic episode. Bipolar II

disorder is a condition in which current or past severe depressive episodes alternate with current or past hypomanic periods of at least 4 days duration.

Cyclothymic disorder is defined as a subthreshold bipolar trait or temperament with subthreshold severe depression and milder affective signs of mild hypomania. The diagnosis is made in adults who do not meet the criteria for mania, hypomania, or major depression and who have experienced periods of hypomania and depression for at least two years. For a child or adolescent to be diagnosed with cyclothymic disorder, symptoms must have persisted for at least one year.

Hypomania is defined as a nonpsychotic, milder or subthreshold manic state of short duration, lasting at least four consecutive days and without marked social and occupational impairment. It requires elevated mood with (three or more symptoms) or irritable mood (with four or more of the following symptoms): increased goal-directed activity, grandiosity, decreased need for sleep, distractibility, racing thoughts, increased/rushed speech, and reckless behavior. According to the International Classification of Diseases, 11th edition (ICD-11), cyclothymic disorder and hypomania are considered^{ed} prodromal symptoms of bipolar disorder, and according to the DSM-5, hypomania is a component of bipolar II disorder [2].

Major depressive disorder is diagnosed when five of the nine symptoms are present: sad mood, insomnia, feelings of guilt, decreased energy levels, poor concentration, decreased appetite, decreased pleasurable activities (anhedonia).

The mood disorders In the DSM-5 include three new depressive disorders:

Disruptive mood dysregulation disorder (MDD) is seen in children and adolescents with frequent angry outbursts and hypersensitivity disproportionate to the situation.

Persistent depressive disorder (PDD) or dysthymia. It refers to a depressed mood that is not severe enough to meet the criteria for major depression. PMDD is defined as a depressed mood that lasts for at least 2 years in adults and 1 year in children and adolescents.

Premenstrual dysphoric disorder (PMDD) is characterized by irritability, anxiety, depression, and mood lability that occur 1 week before the start of menstruation, followed by the disappearance of symptoms after the onset.

Major depressive episodes may precede or occur simultaneously with persistent depressive disorder, which is called dual depression. Other depressive disorders include the depressive disorder due to another medical condition, depressive disorder due to substance use, other specified depressive disorder, and unspecified depressive disorder.

Etiology

The brain areas responsible for controlling our feelings and emotions are the amygdala and the orbitofrontal cortex. Patients with mood disorders have an enlarged amygdala on brain imaging, which supports the belief that abnormalities in these areas lead to mood disorders. Ventricular dilation is the result of repeated mood disorders. [4]

Biological factors

Neurotransmitters that play an important role in mood disorders are serotonin and norepinephrine, whose levels decrease during depressive episodes. Serotonin is the neurotransmitter most commonly associated with depression. Dopamine is also involved in mood disorders, and research suggests that dopamine levels may decrease in depression and increase in mania.

Medical conditions that can cause mood disorders include:

Brain tumors

Syphilis central nervous system

Delirium

Encephalitis

Influenza

Metabolic changes associated with haemodialysis

Multiple sclerosis

Q fever

Cancer

AIDS

Hypothyroidism

There are certain drugs and medications that can cause symptoms similar to mood disorders. These are amphetamines, cocaine, procarbazine, and steroids.[5]

Genetic factors

According to studies based on the search for twins, some genes cause a mood disorder. [6] Family studies and adoption have also indicated the heritage of mood disorders. People who have the strong positive family history of mood disorders are more likely to develop the mood disorders themselves. Parental mood disorders are a significant and consistent risk factor for the development of mood disorders in their children.[7]

Hormonal factors

Increased HPA activity is associated with the stress and depression. Elevated TSH has been shown to be associated with depression. Psychological & social factors

Changes in stressful lives (other important people, parents, siblings, sisters, etc.) Trauma events and infant abuse are the major danger factors of the mood disorders in the year, especially the depressed disorders. It has been proven. [8] Specific personality disorders such as personality characteristics or limits and obsessive-compulsive disorders (OCD) are more frequently related to depression. The problem of attachment and adversity in childhood were related to depression.

Neuroimmunological factors

Research shows that mood disorders result in altered release of neuroactive cytokines such as IL-1beta, IL-6, and TNF-alpha.[9]

Recent studies have identified a critical role for nitric oxide (NO), which is involved in the inflammatory process that leads to the signs and symptoms of mood disorders. Altered NO levels have also been found in patients suffering from mood disorders.[10]

An increased frequency of abnormal hyperintensities is observed in subcortical areas in depressive disorders and bipolar disorder.

Epidemiology

The lifetime prevalence of major depression ranges from 5 to 17%. In men, the rate is approximately twice as high as in women. Men.[11] The annual prevalence of depression among U.S. adults is 7.1%, while the annual prevalence of bipolar disorder is 2.8%. The median age of the onset major depressive disorder is 32 years.[12]

Mood disorders are common among children and adolescents, with an estimated 15% suffering from any mood disorder and 12% suffering from a severe mood disorder.[13] Depression is prominent among children and adolescents, reaching 18% to 22% of girls and 7% to 10% of boys by age 17. Studies have

shown that the prevalence of disruptive mood dysregulation disorder in children ranges from 0.8% to 4.3%. [14] The lifetime prevalence of bipolar disorder subtypes is 0.6% for bipolar I disorder, 0.4% for bipolar II disorder, and 2.4% for bipolar spectrum disorder (BPD). [15]

Pathophysiology

Depression is a complex neuropsychiatric disorder characterized by severe anhedonia (a marked inability to enjoy pleasurable activities), sad mood, feelings of guilt, suicidal tendencies, and cognitive impairment. One of the main risk factors for the development of a depressive disorder is chronic stress. The pathophysiology of chronic stress results from overactivation of the hypothalamic-pituitary-adrenal (HPA) axis, which results in elevated levels of the glucocorticoid cortisol. [16] Neural plasticity also plays an important role in the pathophysiology of mood disorders. Patients with poor social support show signs of impaired neuronal plasticity, which predisposes them to mood disorders. Deterioration of plasticity of neurons from light to medium may cause depression, but serious troubles lead to enthusiasts. [17]

Other symptoms of mood disorders are sleep and decrease in appetite. There may be an increase (excitation) or decrease in mental motor activity. Increased agitation can be life-threatening as it can lead to muscle breakdown and even kidney failure (due to increased creatinine), and in severe cases, psychiatric symptoms such as delusions and hallucinations can appear. In the case of mood disorders, attention and concentration, recent remote memory, and changes in neurons recognition detected, and execution functions have been detected. These signs and the symptoms are due to the interaction of the factors such as genetic vulnerabilities, positive family history, and social support systems. [18]

History and physical

History and Physical Condition Assessment of mood disorders requires a complete and detailed medical history. Bipolar disorder is easily diagnosed when a patient experiences a manic episode characterized by inflated self-esteem, grandiosity, impulsivity, irritability, increased psychomotor activity, and delusions or hallucinations. Patients distinguish duplicate depression if they have depression, such as sad mood, decrease in concentration, decrease in wine, decrease in interest in comfortable behaviour, think of self -bubble and suicide. It is very important, from bipolar depression. The clinical characteristics of bipolar depression are the beginning of the childhood, acute, episodes of depression (more than five episodes), positive family history, hypotherletic, and psychiatric symptoms of bipolar disorder. Positive history of the depression is postpartum depression, depression, mixed depression in the order to increase up to the 25 years. [19] In history, patients often ignore the episodes of past light MANY or MAN disease, so clinicians are deregulating the need for sleep and the deregulation of the mood related to the increase in past energy. You need to study the period. A careful assessment of suicide and homicide risk is important.

Once the patient's condition has stabilized, a formal mental status examination is required. Depressed patients have limited or poor eye contact during the interview, flat or dulled affect, impaired speech skills, and slowed reaction times. They appear dishevelled, have unkempt hair, and poor hygiene. Psychomotor activity is significantly decreased. In contrast, manic patients have increased psychomotor activity, agitation, irritability, talkativeness, pressured speech, stuttering speech, slowed reaction times, and difficulty stopping to converse. Patients in a manic state may experience hallucinations, delusions, and paranoia. Major depression may have psychotic features.

Evaluation

Following the history of a longitudinal and deep family, a detailed test of the mental state is important, and it is very important for early diagnosis of mood disorders. Secondary mood disorders associated with the abuse of mental active substances require a test of urine drugs. You can also use a specific evaluation to evaluate mood disorders. The evaluation scale of Hamilton, a depression scale of depression (HAM-D) and Montgomery Asberg, is designed for depression, and the evaluation scale of Young Mania (YMR) is designed for enthusiasts. [20]

HAM-D is an evaluation scale of the 17 elements of depression introduced by a doctor. It rates depressed mood, sleep difficulties, the ability to concentrate, guilt, suicidality, anxiety symptoms, & somatic symptoms on a 3 or 5 point scale. A score of 0 to 7 is considered normal, a score of more than 20 needs intervention. The MADRS is a questionnaire used by doctors to diagnose depression. It rates sadness, inner tension, appetite, sleep, and thoughts of self-harm or suicide on a scale of 0 to 60. A score of 0-6 is considered normal, 7-19 is considered mild depression, 20-34 is considered moderate depression, and a score above 34 is considered severe depression.

The YMRS is a doctor-administered measure. Early diagnosis and treatment of mood disorders can reduce associated morbidity and mortality. The first step in selecting the most appropriate treatment is a thorough assessment of the patient's safety and level of functioning. The characteristic goal of psychiatric treatment is to strengthen and maintain the treatment alliance, teach patients about the signs and symptoms of mood disorders, enhance the compliance of drugs, the importance of normal sleep and appetite, stress viewing, and recurrence. There are recognition, social and functional reductions. Hindrance.

Drug therapy for bipolar disorder of mania. It is an 11 item scale with the 4 items (irritability, speech, thought content, and disruptive behaviour) graded on a 0 to 8 scale & the remaining items (elevated mood, increase in the motor activity, libido, sleep, appearance, & insight) are graded on a 0 to 4 scale. Scores less than 12 indicate remission, 13 to 25 as moderate, & 38 to 60 as severe Mania

Treatment /Management

Early diagnosis and treatment of mood disorders can reduce associated morbidity and mortality. The first step in selecting the most appropriate treatment is a thorough assessment of the patient's safety and level of functioning. The characteristic goal of psychiatric treatment is to strengthen and maintain the treatment alliance, teach patients about the signs and symptoms of mood disorders, enhance the compliance of drugs, the importance of normal sleep and appetite, stress viewing, and recurrence. There are recognition, social and functional reductions.

Drug therapy for bipolar disorder

If the episode is an episode, it is a MAN disease episode with severe symptoms or a mixed episode. Start with a stabilizer (lithium or sphere) and an on -the -specific antipsychotics (risperidon, orangzapine, quetian pins, gyprasidon, alipyprazole).

If the patient is an episode that is not so serious: lithium single drug therapy, anti -clench or non -defined antipsychotics. The alternative to lithium or barprono acid is carbamazepine or oxalubazepine.

If the episode presentation is a depressed episode: prescribe a combination of Kethetian, Radon or Ramotrigine, or a full Okicetine.

Lithium is a major mood stabilizer. Its mechanism of action is to inhibit the hydrolysis of inositol-1-phosphate by inositol monophosphates. As a result, it reduces the supply of free inositol for the regeneration of membrane phosphatidylinositol, a source of inositol triphosphate and diacylglycerol, and it also inhibits the enzyme glycogen synthase kinase, impairing the supply of inositol from extracellular sources, preferentially affecting overactive neurons involved in manic states. Recommended Dosage – For adults, the starting dose is 300 milligrams of regular release formulation two to three times daily. For older adults with renal failure, the starting dose is 300 milligrams once or twice daily. Doses of 900 to 1,200 milligrams produce the plasma concentrations of drug 0.6 to 1.0 Millie equivalents per liter, making them effective in the treating bipolar disorder. Doses of 1,200 to 1,800 milligrams produce plasma concentrations of 0.8 to 1.2 Millie equivalents per litre.

Side effects include gastrointestinal upset, tremors, polyuria and polydipsia (poor urine concentration), leading to increased risk of nephrogenic diabetes insipidus, hypothyroidism, hyperthyroidism, hyperparathyroidism and cognitive impairment. Check sodium, calcium, phosphorus, ECG, creatinine, urinalysis, complete blood count, thyroid function tests, renal function tests and pregnancy test. Lithium has a narrow therapeutic index, so its blood levels must be monitored.

Sodium valproate—Blocks voltage-gated sodium channels and enhances inhibitory gamma-aminobutyric acid (GABA) transmission. Suggested dose: For patients with acute mania, the oral dose is 20 to 30 milligrams/kg/day. Therapeutic plasma concentrations are achieved with doses of 1200 to 1500 milligrams/day given in divided doses. BarpemoDususSnatrium can also be prescribed in intravenous injection (IV) to stabilize the patient quickly with excitement.

Adverse effects: weight gain, gastric irritation, hair loss, thrombocytopenia, leukopenia, red blood cell hypoplasia, tremor, menstrual irregularities, polycystic ovaries, hyperandrogenism, hirsutism, obesity, insulin resistance, fatal hepatotoxicity, pancreatitis, hyperammonaemia-induced encephalopathy.

Carbamazepine, oxcarbazepine: These are anticonvulsant drugs. They work by blocking sodium channels.

Recommended dose: The target dose for antimanic activity is 1,200 mg per day. The harmful effects include dizziness, twin tube, drowsiness, athletic imbalance, nausea and headache, drying of mouth, swelling, hypo sodium, and sexual dysfunction. Preliminary work includes CBC, liver function (LFT), electrolyte, and ECG. Lamotrigine— It acts by blockade of voltage-sensitive sodium channels, which in turn modulate the release of glutamate and aspartate and a slight effect on calcium channels.

Dosage recommendation— 50 to 200 milligrams per day is used for bipolar depression. Usually, starting at 25 mg per day, the dosage gradually gives the title upwards to reduce the risk of Stevens-Johnson syndrome.

Side effects -Increasing the risk of eruptions (Stevens -Johnson /toxic epidermal necrosis). This is related to the speed of the dose. The appearance of any type of rash requires abrupt discontinuation of lamotrigine.

Other anticonvulsants that can be used as mood stabilizers include riluzole, topiramate, zonisamide, gabapentin, pregabalin, and levetiracetam. Of these, topiramate is the most commonly used and is associated with kidney stones.

Benzodiazepines, which act as anxiolytics, sedative-hypnotics, and anticonvulsants, are valuable complements to mood stabilizers. As anxiety and panic disorders are important comorbidities in bipolar disorder, they may be useful adjunct treatments. Thyroid Hormones: Triiodothyronine may stabilize mood in some people with bipolar disorder. Because thyroid abnormalities are associated with rapid cycling bipolar disorder, it is important to stabilize hypothyroidism with levothyroxine. Pharmacological treatments for unipolar depression or dysthymia:

Selective serotonin reuptake inhibitors (SSRIs): sertraline, fluvoxamine, fluoxetine, citalopram, escitalopram, and paroxetine.

SSRIs are the first-line treatment option for depression because they are well tolerated and have few side effects. It usually takes 4 to 5 weeks for the full effects to kick in. It is important to monitor for suicidal thoughts while taking SSRIs, especially in young adults. The most commonly observed side effects are nausea, vomiting, diarrhoea, dizziness, loss of appetite, decreased libido, anxiety, and insomnia.

Serotonin-norepinephrine reuptake inhibitors (SNRIs): venlafaxine, desvenlafaxine, duloxetine, milnacipran, and levomilnacipran

These are the next drugs in line for the treatment of depression after the SSRIs. This category of drugs has a dual action and has been found to be useful in cases of concomitant pain. Common side effects include nausea, dry mouth, high blood pressure, fatigue, loss of appetite, insomnia, sweating, and anxiety.

Atypical antidepressants: Bupropion and mirtazapine. Agomelatine is also an atypical antidepressant, but is not available in the United States.

Mirtazapine also works as a second-line treatment for depression. Side effects include drowsiness, increased appetite, and weight gain. Bupropion lowers the seizure threshold and is contraindicated in epilepsy and eating disorders.

Tricyclic antidepressants (TCAs): desipramine, nortriptyline, imipramine, amitriptyline.

Although this category of medications can be effective, they are no longer used as the primary treatment for depression because of a variety of side effects and toxicity from overdose. Common side effects include weight gain, drowsiness, orthostatic hypotension, increased heart rate, constipation, dizziness, and urinary retention.

Serotonin modulators: nefazodone, trazodone, vilazodone, and vortioxetine. Serotonin modulators act as antagonists and agonists at postsynaptic serotonin receptors and inhibit postsynaptic serotonin reuptake. Nefazodone is contraindicated in patients with hepatic disease. Priapism may occur while taking trazodone.

Monoamine oxidase inhibitors (MAOIs):

These include tranylcypromine, phenelzine, and selegiline. These are scarcely used to their particular dietary regulations to avoid the hypertensive crisis and serotonin syndrome. Commonly observed side effects include orthostatic hypotension & decreased sleep.

Phototherapy (bright light therapy) is used to treat seasonal affective disorder (SAD). Newer drugs such as intravenous and intranasal ketamine (esketamine) have shown good results in treating mood disorders. Ketamine has also been shown to help rapidly reduce suicidal thoughts, but its effects require repeated treatments and are not long-lasting. Synepetic treatment, such as stimulating vagus nerve, is used for patients with resistant depression. [11]

Anti-inflammatory disease such as Alipiprazole can be used for additional depression treatment.

Psychotherapy

In addition to medication, patients suffering from depression and other mood disorders benefit from several types of non-pharmacological treatments:

Mindfulness-Based Cognitive Therapy (MBCT) and Acceptance and Commitment Therapy (ACT): These appear to help ease symptoms of mood disorders and curb relapse. Interpersonal psychotherapy: Recognizes interpersonal problems and role transitions.

Cognitive behavioral therapy: Improves dysfunctional cognitions and attitudes that may contribute to depression. Among psychotherapeutic methods, CBT is the most studied treatment for depression.

Dialectical behavior therapy: This is a form of CBT that includes mindfulness, stress tolerance, and emotional regulation. Behavioral activation involves encouraging people with depression to take part in activities that improve their mood, such as exercise, learning a new skill, or doing household chores.

Brain stimulation therapy

Repetitive transcranial magnetic stimulation has shown promising results in treating mood disorders. rTMS is a technique that uses pulsed magnetic fields to promote changes in brain activity. Repeated cortical stimulation can enhance or decrease localized brain activity. The rTMS procedure involves approximately five sessions over a period of four to six weeks. The patient does not need the general anesthetic while undergoing rTMS, and it can be administered in outpatient unit. Dissimilar to ECT, it does not cause cognitive side effects. The main side effects are headache and scalp discomfort at the administration site.[21]

Electroconvulsive therapy is used in treatment-resistant cases, severe depression where the patient refuses to eat or drink, during pregnancy, and in highly suicidal patients. Side effects include headache, cognitive impairment, and memory loss (anterograde and retrograde), which are the main concerns of patients undergoing ECT.

Healthy Living

Diet and Mental Health: Studies have shown that following a “healthy” diet is associated with a reduced risk of mood disorders.

Exercise and Yoga: Regular exercise and yoga protect against the development of mood disorders. Physically inactive people are at higher risk of developing depression, and a possible mechanism for this may be the effect of regular exercise on brain-derived neurotrophic factor (BDNF). **Smoking:** The cessation of smoking is linked to an increased mood and quality of life increased and unless they become anxious and depressed in relation to ordinary smoking.

Omega-3 fatty acids: The antidepressive effects of omega 3 fatty acids are due to the regulation of neurotransmitters (serotonin, dopamine) and its anti-inflammatory and antioxidant effects.

Differential Diagnosis

Differential Diagnosis: According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the following are differential diagnoses for mood disorders.[18]

Generalized anxiety disorder, panic disorder, posttraumatic stress disorder (PTSD), or other anxiety disorders: A thorough history is necessary to distinguish generalized anxiety disorder from a mood disorder, as anxious ruminations may be confused with racing thoughts. Actions to reduce anxiety may be understood as aggressive behaviour seen during a manic episode. Similarly, signs and symptoms of PTSD, including anger and aggression, must be differentiated from those of bipolar disorder.

Substance- or medication-induced mood disorder: Substance use disorders may have symptoms suggestive of mania/depression that must be differentiated. The primary diagnosis of a mood disorder should be based on symptoms that persist after the patient stops using the substance. Certain medications (steroids and alpha interferon) can cause manic or depressive symptoms. To differentiate these symptoms from mood disorders, clinical assessment and a careful history are necessary.

Attention Deficit Hyperactivity Disorder (ADHD): This disorder is common among adolescents and children and can be confused with bipolar disorder. Symptoms such as increased psychomotor activity, difficulty stopping speech, being easily distracted, and a decreased need for sleep are consistent with those of a manic episode. The episodic nature of bipolar disorder may help distinguish manic episodes from ADHD.

Personality disorders: The symptoms of some personality disorders, such as borderline personality disorder, can be strikingly similar to those of bipolar disorder. Rabbi atmosphere, impulsivity, error, and hallucinations are generally observed in two troubles. These symptoms must appear in episodes with a significant increase in increased increase, compared to the initial levels classified as bipolar disorder.

Rabbi atmosphere, impulsivity, error, and hallucinations are generally observed in two troubles. These symptoms must appear in episodes with a significant increase in increased increase, compared to the initial levels classified as bipolar disorder. **Spectrum of schizophrenia and other related psychotic disorders:** Bipolar disorder and major depression with psychotic symptoms must be distinguished from psychotic disorders. Schizophrenia and other related psychotic disorders are defined by the Interval of psychotic symptoms. The Important criteria to the distinguish these two are delusions, and hallucinations in psychotic disorders are seen in the absence of any mood symptoms. The other valuable considerations constitute the concurrent symptoms, the chronology of symptoms, and the longitudinal course. It is very important to distinguish the symptoms of enthusiasts from delusional overactive symptoms, excitement, acute anxiety, and aggressive /aggressiveness.

Prognosis

In the first year of observation in patients who had a childhood disorder, a delay in the diagnosis and a longer duration of an unprocessed disease, they showed a rather significant severity of the disorder, more episodes, additional days in depression, additional ultrady bicycle and limited days of eutimium. [23] About a third of mood disorders are repeated, one third of the patients develop psychotic disorders, and in the other, there, an alarming disorder develops throughout life. Thoughts about death (80.8%) and thoughts of suicide (69.5%) were continuous, and specific plans for suicidal plans were more frequent in women during observation. [24] There are higher chances of concomitant anxiety throughout life, a violation of

toxicomania, absenteeism from work and family disagreements leading to low quality of life. [25] This is also due to the increase in direct and indirect health care expenses from a greater duration of stay in the hospital.

Comorbidities

Studies suggest that there may be an association between longer duration of illness and worsening mood disorders, especially in terms of self-harm/suicide. [26] Mood disorders, especially bipolar disorder, can go undiagnosed or be misdiagnosed for up to 10 years. Delays in diagnosing bipolar disorder have serious consequences. This leads to some forms of drug addiction. Anxiety disorders are one of the most common comorbidities associated with mood disorders throughout life. Hyperactivity defects, opposition, and behavioural disorders are also observed. For example, mood disorders can cause serious dysfunction, such as work abilities, problems, and problems, in order to maintain emotional relationships with family and friends. [27]

Containment and Patient Education

Mood disorders are common mental disorders with high morbidity and mortality. Educating patients about the symptoms and providing prompt treatment are essential to recover from mood disorders. Psychoeducation is important not only for adherence to medication and psychotherapy, but also for continued participation in treatment and reducing the risk of relapse. At discharge, patients and caregivers should be informed of early signs of relapse of mood disorders. If a patient experiences symptoms such as decreased need for sleep, increased talkativeness, faster thinking, and a more energetic mood, they should be taken to a mental health clinic immediately to optimize treatment. Recovery from mania and depression is essential, and adherence to medication and treatment is important to achieve a full recovery. The importance of regular follow-up examinations and adherence to treatment should be emphasized at every doctor's visit.

Improve the performance of a diverse team

The optimal treatment of patients with mood disorders requires the participation of a variety of health professionals, including family physicians, nurses, psychiatrists, psychologists, and social workers, working closely with family and support groups. This forms an integrated care team. In most cases, the patient's first point of contact is their GP, so that they feel comfortable discussing their personal issues with them if they are in a crisis and are unable to cope with the situation. Therefore, the primary care physician plays an important role in understanding the severity of the symptoms, making a diagnosis, and determining whether a referral to a mental health professional is necessary. Patients with moderate to severe symptoms of a mood disorder, with or without active suicidal ideation, should be referred to a psychiatrist.

A mental health manager (mental health nurse) appointed by the mental health team, often in a community mental health setting, is important to coordinate patient care in cases of severe mood disorders. All health care providers involved in the patient's care should be regularly informed of the current treatment plan while the patient is admitted to the psychiatric crisis unit. Outpatient treatment records should be requested from psychiatrists and outpatient providers, along with completed notes detailing the treatment plan at the time of admission to a mental health facility. Psychiatric medications should be sent to outpatient providers prior to discharge from inpatient units. Psychiatrists play an important role in making decisions and patient treatment plans, but if various experts involved in the work with patients care about group teams, general effective response is observed. Masu. Positive reactions to treatment require regular communication between psychiatrists, family doctors, social workers, nurses, management cases, and pharmacists.

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