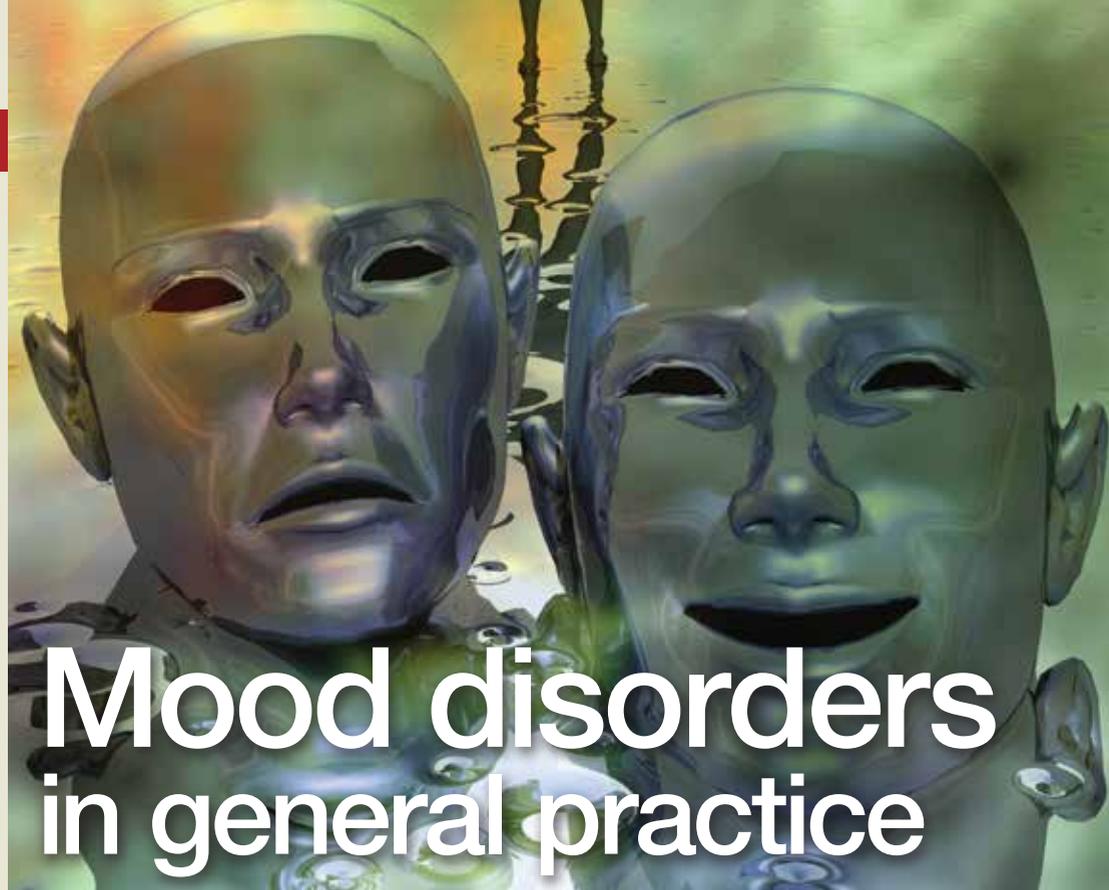


Key points

- Mood disorders are commonly encountered in general practice and include the depressive disorders, bipolar disorders and cyclothymia.
- Patients may present with psychological symptoms, somatic symptoms or affective cues, or may attend about another problem not directly associated with their mood disorder.
- Sensitive and empathic exploration of the symptoms and problems offered by the patient is the essential first step; subsequent assessment should include biological, psychological and contextual issues, including comorbidities and vascular risk factors.
- Management is multimodal, including psychoeducation, lifestyle advice, talking and behavioural therapies, medication and appropriate referral.
- Structured problem solving can be a useful strategy for helping the patient address psychosocial stressors.
- The doctor's therapeutic alliance with the patient is an essential aspect of management.



Mood disorders in general practice

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Mood disorders are commonly encountered in general practice. Some patients with mood disorder require referral but all will benefit from careful assessment and specific interventions in general practice.

Mood disorders are a group of mental health problems characterised by an abnormal alteration of mood – depressed or elevated – which goes beyond the normal degree of unhappiness, sadness or joy that accompanies life. The group includes major depressive disorder, the bipolar disorders, cyclothymia and persistent depressive disorder. The last is a new category in the *Diagnostic Statistical Manual Fifth Edition* (DSM-5) that includes both dysthymia and persistent major depression.¹

In any 12-month period, approximately 7% of women and 5% of men experience a mood disorder, and 45% of these will seek professional help, usually from a GP. Patients with a mood disorder may present with psychological symptoms, somatic symptoms or affective cues of various kinds (see below), or may attend about another problem not directly associated with their mood disorder (Box 1). Major depression

and other mood disorders are more prevalent among people with chronic physical illness, especially if it is painful or disabling. Conversely, depression is a risk factor for other diseases, especially of the cardiovascular system.²

This article describes a safe and comprehensive approach to the assessment, diagnosis and management of patients with a mood disorder in general practice.

ASSESSING THE PATIENT

Responding to affective cues

Affective cues are signs or symptoms that suggest the possibility of an underlying mood disorder and are displayed by the patient or observed by the doctor within the doctor–patient interaction. It is important for the doctor to respond to affective cues; a lack of response is likely to inhibit the display of further cues by the patient, whereas an appropriate response will elicit further information about the patient's mood state.³

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1. PRESENTATIONS OF MOOD DISORDER

Symptoms

- Psychological symptoms: depressed mood, lack of motivation, anhedonia (reduced or lost ability to experience pleasure), pessimism or hopelessness
- Cognitive symptoms: difficulty concentrating, slowed thoughts, 'pseudodementia'
- Somatic symptoms: persisting fatigue, low back pain or chronic headache

Affective cues

- Verbal cues such as 'I just feel so out of sorts'
- Prosodic cues (the rhythm, stress and intonation of speech)
- Nonverbal cues such as posture, facial expression, tears or lack of self-care

Appropriate responses to verbal cues can include:

- a repeat of the patient's own words, such as 'Not well since your mother died'
- a summary, such as 'You say that recently you've been feeling fed up and irritable'
- a request for further clarification, such as 'Can you describe to me further what you mean when you say you feel tired all the time?'

Useful ways of responding to prosodic and nonverbal cues include:

- a question, such as 'I wonder if that upset you more than you'd like to admit'
- a statement of your observation, such as 'I can hear tears in your voice'.

Sensitive and empathic exploration of the symptoms and problems offered by the patient is the essential first step in assessing a patient with possible mood disorder (Box 2). By eliciting this material and placing it in the context of a psychological disorder you are laying the basis of a joint understanding of the problem, which is essential for an informed collaborative approach to

2. ASSESSING THE PATIENT

- Explore the presenting issues
- Enquire about diagnostic features for specific disorders
- Identify comorbidities and measure severity
- Consider the whole person
- Assess risk of harm
- Formulate your assessment

management. This exploration includes asking the patient to give a detailed description of their illness, including duration and pattern of reported symptoms.

Identifying major depression and bipolar disorder

It is important to enquire systematically about the diagnostic features of major depression (Box 3). In a patient who appears to have major depression, consider the possibility of bipolar disorder by enquiring after a family history of this disorder and a personal history of mania or hypomania (Box 4). Useful screening questions include:

- 'Have you ever had times when you were neither depressed nor feeling normal, but felt more energised and wired?'⁴
- 'What is the stupidest or silliest thing you have ever done? Tell me about that time.'

The possibility of other disorders, particularly post-traumatic stress disorder (PTSD), personality disorder, psychosis or substance abuse should be considered, as should any relevant differential diagnoses for somatic symptoms such as headache, back pain or fatigue.

Broadening the enquiry

Substance use

Mental illnesses including mood disorders are frequently accompanied by substance abuse or dependence, often as a precipitating or perpetuating factor. Ask about the use of alcohol and prescribed and

3. FEATURES OF MAJOR DEPRESSION

- Depressed mood and/or loss of interest or pleasure (at least one of these features, present most or every day, for at least two weeks)
- Change in weight or appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death

recreational drugs. The use of substances may be rationalised by patients with depression or another mood disorder as self-medication, and decreasing or stopping substance abuse may be undermined by fears of how they will cope without this substance.

Comorbidities

Mood disorders may also coexist with other chronic illness, especially if painful or disabling. Optimal treatment of comorbidities is essential. Depressive disorders are a risk factor for cardiovascular disease, and cardiovascular disease is a risk factor for depression. All patients' vascular risk should be assessed and managed appropriately. This includes advice and assistance for smokers to quit.⁵

Self-harm

Risk of self-harm should be assessed in all patients living with depression. Risk factors for suicide include:

- previous self-harm
- recent losses
- painful or disabling physical illness
- easy access to lethal means
- lack of social support
- alcohol or substance misuse.

Box 5 provides a graded series of questions for assessing risk of self-harm,

including enquiry about protective factors. Not all these questions need to be asked at every consultation, but it is important to ask about safety and how the patient's level of suicidality has altered since the previous assessment. Importantly, there is no evidence that asking questions such as these increases the risk of suicide, and many patients express relief at being able to talk about distressing feelings and thoughts.⁶ It should be noted, however, that self-harming behaviour is impossible to predict with accuracy in individual patients.

The whole person

Consideration of the whole person should extend beyond the biological and personal to their physical and social environment, cultural context, home and family life, and work and leisure (see the Figure).⁷ It is helpful to enquire about economic, social and other stressors, loss experiences, social supports and the impact of the patient's illness on their daily functioning. It is also useful to quantify the severity of the patient's mood disorder using an instrument such as the Kessler Psychological Distress Scale (K10) or the Depression, Anxiety and Stress Scale (DASS21).^{8,9}

SUMMARISING AND DISCUSSING MANAGEMENT OPTIONS

Following a thorough assessment, it is important to summarise your observations back to the patient before offering your diagnosis. This demonstrates your attention to their story, and provides a firm basis for negotiating a management plan. A decrease in the bond between you and the patient at this stage, which may be reflected by a change in eye contact, change in topic or avoidance of the discussion, suggests a failure in the empathic relationship between you and the patient or inconsistencies in your understandings of the illness. Tracking back and exploring where you lost that understanding is important, both for the ongoing relationship and for patient concordance with the management plan.

4. DSM-5 CLASSIFICATION OF BIPOLAR DISORDERS¹

Bipolar I disorder: one or more episodes of mania with or without major depressive episodes

Bipolar II disorder: one or more episodes of hypomania with at least one major depressive episode with no psychotic features

Cyclothymic disorder: low grade cycling of mood with both hypomanic episodes and periods of depression that do not meet criteria for major depressive episodes

Other bipolar and related disorders

As you develop a management plan, it is helpful to demonstrate flexibility and to take an evidence-based but empirical approach. No specific treatment suits everyone, and despite recent advances in brain science, it remains impossible to predict with confidence who will respond to any particular management option. The management options for patients with mood disorders are summarised in Box 6.

Psychoeducation and lifestyle strategies

Psychoeducation about their illness, and advice about self-management strategies, including the value of regular sleep,

5. ASSESSING RISK OF HARM – GRADED SEQUENCE OF QUESTIONS

- Do you ever feel like giving up?
- Are there times when you wish you were not alive?
- Do you sometimes wish you'd die?
- Have you ever considered ending your life?
- Have you made plans?
- How close have you come to doing something?
- What has stopped you? (Protective factors)
- How safe do you feel?
- Has this changed?

exercise and a healthy diet, should be offered to all. Recent evidence suggests that not only is moderate- to high-intensity exercise a treatment in its own right for depression but that smoking and diet are also important. Quitting smoking is likely to be associated with significant improvements in mental health.¹⁰ A diet of processed or fried foods, refined grains and sugary products is a risk factor for depression when compared to one characterised by vegetables, fruit, fish and whole grains.¹¹

Patients consuming risky amounts of alcohol or using recreational drugs should

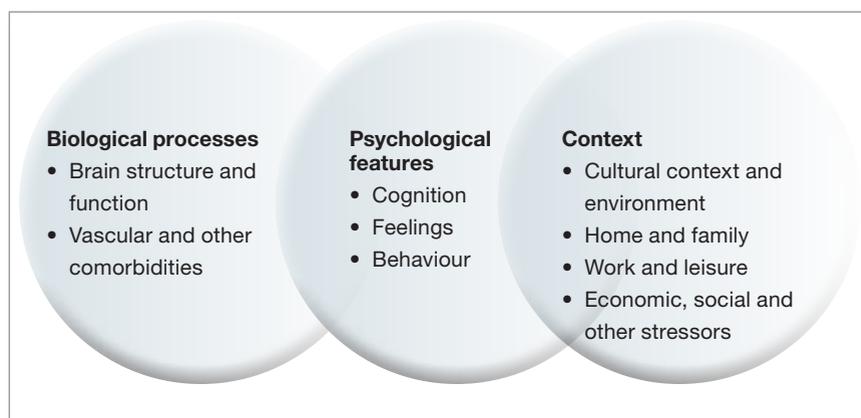


Figure. Consider the whole person.

6. ELEMENTS OF MANAGEMENT

Psychoeducation

- Information about the illness
- Discussion of self-management strategies
- Advice on a healthy diet and exercise
- Discussion on avoiding substance misuse

Talking and behavioural therapies

- Cognitive behavioural therapy
- Interpersonal therapy
- Activity scheduling
- Structured problem solving
- Drug/smoking/alcohol counselling

Online resources

- Didactic resources
- Interactive resources

Medication

- Antidepressants
- Mood stabilisers
- Antipsychotics

Referral

- Psychiatrist
- Psychologist
- Drug and alcohol services
- Hospital

be counselled to reduce or quit, and advised that treatment of their mood disorder is less likely to be effective if they continue substance misuse. Substance use disorders often require specific interventions such as motivational interviewing, behavioural therapy or referral to specialist drug and alcohol services.¹²

Talking and behavioural therapies

Talking and behavioural therapies such as cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) help many people with mood disorders, and are compatible with other interventions, including medication if indicated. There are a growing number of online resources for people living with mood disorders.¹³

7. STRUCTURED PROBLEM SOLVING

1. Clarify the problem
2. Brainstorm potential solutions
3. Explore pros and cons of each
4. Choose and develop an action plan
5. Consider and mitigate risks
6. Implement the plan
7. Follow up

Medication

The option of antidepressant treatment should be discussed with patients who have depression of at least moderate severity.¹⁴ The presence of a personality disorder in someone with depressive disorder is not a reason for failing to prescribe antidepressant medication. However, there is little evidence of benefit from antidepressants in bipolar disorder, even during a depressive episode, and a significant risk in some patients of precipitating mania. First-line treatments for a depressive episode in bipolar disorder include lithium, lamotrigine, quetiapine or olanzapine. Most patients with bipolar disorder will need long-term treatment with a mood stabiliser such as lithium, sodium valproate, carbamazepine or an antipsychotic.^{15,16}

Referral

Although most patients with mood disorders can be effectively and appropriately managed in primary care, many will be helped by referral to a psychologist for CBT, IPT or other talking and behavioural therapy. Indications for referral to a psychiatrist include severe depression, especially if not responding to antidepressant treatment; evidence of personality disorder, psychosis or other significant mental health problem such as PTSD; or the possibility of bipolar disorder. Patients at significant risk of self-harm may require hospital admission.

ADDRESSING ENVIRONMENTAL STRESSORS

Many patients with mood disorders identify family, work, social or other stressors in their lives as contributing to their distress. There are four options for managing environmental stressors: change the situation in some way; leave it, or plan to do so in future; put up with it; or reframe it.¹⁷ An example of the last might be a decision to accept a stressful workplace as a trade-off for a good and stable income. Reframing, however, can be disempowering and lead to future regrets.

It is often appropriate to refer patients to a psychologist to help them think through their options. However, structured problem solving can be a simple yet surprisingly quick and effective way of helping patients in the consulting room (Box 7).¹⁸ Once the situation has been clarified, the patient should be invited to brainstorm potential solutions – actions that they could take to address the stressors. The doctor writes these down for the patient and then invites them to explore the pros and cons of each. Often the patient comes rapidly to a choice. The patient is asked to specify the exact steps they need to take to put their chosen strategy into effect. The doctor and patient then work together to consider potential risks and adverse outcomes, and to plan for these. Finally, the patient is invited to return to discuss their progress in implementing the plan and the result. Interestingly, many patients report that after going home they decided to do something different, but that the structured problem solving process helped their decision and motivation.

REMEMBER YOU ARE PART OF THE TREATMENT

It is important to remember that you, the doctor, are part of the patient's treatment. Many years ago, psychotherapist Michael Balint noted the importance of the drug 'doctor'. A more recent conceptualisation is that of the therapeutic alliance, based on:

- empathy and compassion
- respect and openness

- collaboration and curiosity
- connection and authenticity.¹⁹

Doctors can demonstrate empathy by paying close attention to the patient's story, by summarising, and by verbalising their awareness of the impact of the illness on the patient. Respect and openness should characterise all patient–doctor interactions. No single treatment plan is effective for everyone, so a willingness to collaborate with the patient, and to seek their feedback, is essential as we accompany them metaphorically on their journey. And all good doctors seek connection and demonstrate honesty and authenticity in their relationships with those who seek their care.

CONCLUSION

Mood disorders are common among patients presenting in primary care. A mood disorder may underlie the patient's presenting symptoms, or may be comorbid with other disorders. Careful assessment is essential for diagnosis, risk assessment and appropriate management. The latter is likely to be multifaceted. Some patients may require referral, but all will benefit from specific interventions in general practice, within the context of a supportive, respectful and collaborative doctor–patient relationship. **MT**

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Professor Usherwood: None.

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