International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
www.homoeopathicjournal.com
IJHS 2024; 8(3): 375-379
Received: 08-08-2024
Accepted: 10-09-2024

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Understanding the double-edged sword genetics & stress of mood disorder & managing it with a soothing nudge of homoeopathy

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DOI: https://doi.org/10.33545/26164485.2024.v8.i3f.1241

Abstract
Mood refers to the pervasive feeling experienced internally that influences an individual's way of behaving and perceiving of the world. It can be neutral, euphoric or full of despair, with a wide range of expressions. In healthy individuals, there is control over mood and emotions. However, in a mood disorder, there is a lack of control and excessive stress. The impact of stress on the quality of life is significant, affecting interpersonal relationships at home, in the workplace, and at school or college. A child faces a 10-25% risk of developing the same disorder if one of the parents are suffering from mood disorder and the threat heightens when both parents are already suffering from these disorders. Mental disorders carry a significant burden due to a lack of awareness about it as well as a shortage of mental health professionals worldwide.

Keywords: Mood disorder, homoeopathy, the double-edged sword of stress & genetics

Introduction
"Mental health problems don't define who you are, they are something you experience, you walk in the rain and you feel the rain, but you are not the rain."

- Matt Haig

As per the World Health Organization, Mental health is the ability to remain healthy on all planes including the physical, mental, emotional & social planes. It is about balancing and coping with the stresses of life in a healthy way. It is much more than just being devoid of any sickness. The mental pain is less dramatic than the physical pain but it is also more common & harder to deal with. Stress & family history tends to remain two of the most crucial factors governing the mood disorders. Crude mental illness can consequently lead to compromised health and performance professionally, adding to increased risk of suicide along with less chances of employment.

Defining mood disorders
These are medical condition recognized by lack of emotional control along with high stress. They experience a great level of enthusiasm, a wide range of propositions and affectation.

Prevalence of mood disorders
Mood disorders have a widespread presence, a great indisposition & a high death rate. They are often unrecognized due to apparently under-rated symptoms like lack of sleep, exhaustion & pain with no organic pathology. The bipolar disorder tends to secure 6th position in the in the world's most disturbing illness, just like depression. According to WHO-globally, 3.8% of population experience mood disorders. (Approx. 280 million people in world), in India, according to national institute of health, it ranges from 0.5-78 per 1000 population. According to the latest surveys, major depression has greatest extensiveness (17%). The yearly occurrence of major depressive disorder is 2% and that of bipolar is less than 1% but it is difficult to estimate as milder forms of bipolar are primarily unrecognised. Annual presence of bipolar disorder I across more than 10 countries ranged from 0% to 0.6%.12 Annual prevalence of bipolar disorder 2 II is 0.3%. The lifetime widespread occurrence of cyclothymic disorder is approximately 0.4-0.1%.

Yearly occurrence of premenstrual dysphoric disorder is approximately in the range of 1.8% & 5.8% of menstruating women. In 2019, around 1 in every 10 people around the world were surviving with a mental disease.

Types of mood disorder

1. Hypomania
2. Manic episode
3. Major depressive episode
4. Minor depressive episode
5. Recurrent brief depressive disorder
6. Premenstrual dysphoric disorder
7. Cyclothymia
8. Dysthymia
9. Bipolar disorder I
10. Bipolar disorder II
11. Substance induced mood disorder
12. Depressive disorder secondary to chronic illness

Etiology of mood disorder

- **Genetic factors:** The central aspect of genetic studies has been recognizing particular susceptibility genes using molecular genetic methods. Family studies point out that the risk doubles for a child to suffer from a mood disorder when one of the parents is known to suffer from the same.
- **Psychological factors:** Life events & environmental stress with personality factors are a major cause for mood disorder. The stress produces permanent transition in the brain which changes the functional physiology of neurotransmitters, leading to occurrence of a mood disorder. Researchers have identified that triggers that the patient goes through, that negatively impact his or her self-worth have greater tendency to produce depression.
- **Biological factors:** The mono amine theory is now seen as broader, neuromodulator physiology, & changes are as likely to be sub- ordinate effects as they are directly or indirectly related to the causative modality.
- **Biogenic amines:** Norepinephrine & Serotonin are the most vital neurotransmitters involved in pathophysiology of mood disorders.
- **Neurotransmitter disturbances:** Like acetylcholine & dopamine are also known to cause mood disorder.
- **Alterations of hormonal regulation:** Leading to changes in neuroendocrine responses can cause early stress. Any disturbance in regulation of TSH, prolactin & growth hormone can also cause mood disorders.
- **Alteration of sleep neurophysiology:** The dysregulation with melatonin production due to prolonged screen time changes the normal circardian patterns, leading to either excess or lack of sleep.
- **Immunological disturbances**: Depression is directly propotional to immunological pathologies including decreased WBC'S maturation, growth and production in response to other forms of cellular or humoral immunity. (Autoimmune diseases like rheumatoid arthritis).

Pathophysiology in mood disorders

The monoamine deficinecy theory	Impact of stress
It describes that the etiological pathophysiology of depression is a decreased level of neurotransmitters like serotonin, nor-epinephrine & dopamine in the CNS. Serotonin is the most widely studied & explained neurotransmitter for the same. Nor-epinephrine – the association between reduced activity of the beta adrenergic receptors & practical antidepressants responses is a vital piece of proof indicating a direct role for the noradrenergic system in disorders like depression. Serotonin is most widespreadly related with depression. Reduced serotonin triggers depression, patients with great suicidal impulses are known to have low concentration of serotonin metabolites. Dopamine- it is marked that dopamine surge is reduced in depression & the same i.e. elevated in mania.	The psyconeuroendocrine axis combines of systems of human body including psychiatry, endocrinology, and neurology. This axis relates that the mind & body are correlated. Any deviation in function of this axis leads to either physical or mental illness. The HPA & its regulatory mechanism is managed by cortisol, activating the sympathetic nervous system leading to responses like Fight, Flight, Freeze, and Fauna. Fight or Flight respnses are majorly associated with a hyperstimulated sympatho- adrenergic system, leading to activation of brain-stem nucleus along with the vagal nerve & the medulla (inner part) of supra renal gland. This leads to the release of nor- adrenaline & adrenaline into the circulatory system. Chronic stress frequently leads to hyper- secretion of adrenal hormones (glucocorticoids), resisting a normal feedback mechanisms, bringing the negative effects of excessive cortisol leading to vulnerable changes in the brain regions like hippocampus that maintain emotional regulation & cognition.

Briefing the mood disorders

Mania

Definition it is defined as a period of abnormal and continuous uplifted mood, extensive & snappy tempered lasting at least a week or less.

Kraepelin divided it in 4 stages: hypomania, acute mania, delusional mania, delirious mania respectively.

Diagnostic & Clinical features

- Definite period of continually elevated, irritable lasting at least 1 week or more which is very different from the usual mood.
- Here, 3 or more than 3 symptoms like, haughtiness with decreased need of sleep, more lascivious, wide range of ideas, lack of concentration, psychomotor agitation, excessive activities that involve risking life.
- Symptoms that cannot be categorised for mixed episode.
- Social & Professional life is hindered.
- Symptoms that occur due to the effect of a substance or general medical condition are not considered.

Risk factors

- First degree relative like a parent or sibling with bipolar disorder.
- Traumatic events like death of a loved one that has prolonged period of stress.
- Drug or alcohol abuse.

Hypomania

Definition - an episode of mania that does not coincide for a maniacal episode. It lasts minimum for 4 days and is similar to maniacal episode, it is not severe enough to cause disturbances in social/occupational function and no psychotic features are present.

Diagnostic & Clinical features: Definite time of continually raised, grumpy, snappy mood lasting 4 days, different from the usual mood.

- During interval of this time, 3 or more than 3 symptoms like, haughtiness with decreased need of sleep, more lascivious, wide range of ideas, lack of concentration, psychomotor agitation, excessive activities that involve risking life.
- Indisputable change in performing.
- Dysregulation in mood is noticed by others.
- No impairment in social life & occupational work.

Risk factors

- High level of stress.
- Changes in sleep pattern.
- Seasonal changes in some cases or use of alcohol/other recreational drugs.

Major depressive episode

Definition- a constant feeling of sadness with loss of interest in all activities. It affects emotions, cognition and behaviour consequently leading to emotional & physical disturbances.

Diagnostic & Clinical features

- 5 or more than 5 of the below mentioned symptoms during same 14 days interval & presents change from former functioning with at least 1 of them seen as – depressed mood or loss of interest.
- Sadness most of the day which can be perceived by others.
- Decreased interest in all activities.
- Profound loss of weight when not following a strict diet or any change in usual appetite every single day.
- Psychomotor hyperactivity or lack of nearly every day.
- Exhaustion.
- Wound of worthlessness is precipitated.
- Lack of concentration.
- Increased thought of death.
- Symptoms are not considered for mixed episode
- Episode is profound enough to cause marked disturbance in social or occupational function.
- Symptoms are not because of direct effect of a substance or general medical condition. Symptoms aren't better regarded as grief or sorrow**.**

Risk factors

- Volatile factor-negative conception is a vital factor for major depressive disorder.
- Environmental-childhood trauma, stressful life events.
- Genetic & physiological-family members with major depressive disorder possess approximately four times higher risk than others.
- All major non-mood disorders increase the risk like chronic diseases & substance induced symptoms along with anxiety & borderline personality disorders.

Minor depressive disorder: Definition- it means to witness 2-4 depressive symptoms, with either depressed mood or loss of interest in a 14 days interval.

Diagnostic & Clinical features

At least two & below five of the mentioned points are noted

- Depressed mood everyday
- Lack of interest in most of the activities
- Significant weight loss without dieting or weight gain.
- Insomnia or hypersomnia every day.
- Fatigue
- Feeling of worthlessness or inappropriate guilt with indecisiveness.
- Frequent thoughts of suicide attempt & death.
- Episode has compelling severity to disrupt social or occupational functioning.
- Symptoms are not caused as a result of direct effect of a substance or general medical condition.
- Symptoms aren't better regarded as grief or sorrow**.**
- No manic, major depressive, mixed, dysthymic, mixed or cyclothymic episode is observed.

Risk factors

- Traumatic or stressful event.
- Genetic load from parent generation.

Recurrent brief depressive disorder

Definition-constituted by numerous, relatively quick episodes (less than 14 days) of depressive manifestation that, except for their short duration, meet the diagnostic criteria for the major depressive disorder.

Diagnostic & Clinical features

- Majority of the criteria are seen to coincide with the major depressive disorder.
- Depressive periods that lasts for 2 days but less than 14 days.
- Depressive episode that aren't associated with menstrual cycle but occurrence is observed minimum once a month for 12 consecutive months.
- Episode is serious enough to disturb harmony in social or occupational function.
- Symptoms are not pertaining to any effect of a substance or general medical condition.
- No occurrence of a manic episode, a mixed episode, a hypomanic episode and cyclothymic disorder is observed.

Risk factors

- Genetic susceptibility from parent generation suffering from mood disorder.
- Environmental & social stressors.
- Substance abuse like drugs or alcohol.

Premenstrual dysphoric disorder

Definition- it is also known as the delayed luteal phase dysphoric disorder. The syndrome constitutes mood, behaviour, physical symptoms. Cascade of manifestation occurs at particular time of menstrual cycle, resolving for a brief time between menstrual cycle.

Diagnostic & Clinical features

- Lability
- Changes in eating pattern
- Breast tenderness, oedema & headaches.
- Symptoms occur specifically during menstrual cycle & they are resolved after menstrual cycle.

Risk factors

- Environmental- stress, past occurrence of inter-personal trauma, seasonal changes & female sexual behavior governed with the socio-cultural aspect.
- Heriditary & physiological- ranging between 30%-80% genetically.
- Women using oral contraceptives pills tend to have fewer symptoms compared to others.

Cyclothymia

Definition- characterized by symptoms less severe than bipolar disorder.

Diagnostic & Clinical features

- For at least 24 months, there have been multiple episodes with hypomanic manifestation not matching criteria for hypomanic episode & multiple episodes with depressive symptoms that not matches with the criteria for major depressive episode.
- The above mentioned manifestation are observed half the time & individual is never devoid of the symptoms for more than 8 weeks at the same time.
- It does not meet with the criteria of major depressive, manic, hypomanic episode.
- Episode is strong enough to disrupt peace in social life or occupational work.
- The direct effect of a substance or general medical condition are not considered.

Risk factors

Genetic & biological- first degree relative of individuals with major depressive disorder, bipolar I, bipolar II tend to have two to four times higher risk than others.

Dysthymia (Persistant depressive disorder)

Definition- characterized by symptoms less severe than major depressive disorder.

Diagnostic & Clinical features

- Sad mood whole day as perceived by others.
- Presence of below symptoms, while depressed:
- Low appetite or eating more
- Lack of sleep or hypersomnia
- Exhaustion
- Low self-worth
- Poor focus or indecisive
- Feeling hopeless
- The above mentioned manifestations have been observed half the time & individual has not been devoid of the symptoms for more than 8 weeks at the same time.
- Standard for major depressive episodes may be persistatly present for 24 months.
- Standard for cyclothmia, manic, hypomanic events haven't coincided.
- Episode is strong & compelling to cause marked impairment in social or occupational functioning.
- Symptoms are not because of consumption of a substance or general medical condition.

Risk factors

- Volatile factor-negative conception is a vital factor for major depressive disorder.
- Environmental-adverse childhood experiences, stressful events like death or separation from parents is a high risk factor.
- Genetic & physiological the heritability range is not very clear unlike other disorder. However, brain regions like hippocampus, amygdala have been implicated in dysthymia.

Bipolar disorder-I

Definition- it is a definite duration of abnormal mood lasting 7 days & it involves separate bipolar disorder I diagnosis for a singular manic episode & a recurrent episode based on presentation including the characteristics of manic episode.

Diagnostic & Clinical features

- It can get manifested either with mania, hypomania or depression.
- Previous at least one occurrence of maniacal episode, hypo-maniacal episode or depressive episode or a mixed disorder.
- Mild, moderate or severe psychotic features.
- Covers most symptoms of manic episode.

Risk factors

Environmental- common occurrence in developed countries than in developing countries. Higher rates of bipolar disorder I are more observed in separated, divorced, or widowed individuals than who are married or who have never been married.'

- Hereditary & Biological most potent risk factor. The risk increases by 10 fold if 1st generation suffers from it.
- Suicide risk- individuals suffering with bipolar disorder is estimated to be at least 15 times more succeptible than the rest of the people.

Bipolar disorder-II

Definition- patients that suffer from manic as well as depressive episodes are said to suffer from bipolar disorder.

Diagnostic & Clinical features

- Presence of one or more major depressive or hypomanical episodes.
- Event is severe enough to cause major disruption in social life or occupational functions.
- Symptoms travel from 1 pole to other either with depression or highly elevated mood which can be euphoria or mania.
- Cover the major pointers for the episode of hypomania & major depressive episode with other symptoms.

Risk factors

- Heriditary & Biological- bipolar disorder tends to be occurring in highest possibility among relatives of people with bipolar II disorder.

Rubrics related to the mood disorder (kent repertory)

- Mind- mood alternating- moonlight in
- Mood alternating- sadness
- Mania- paroxysmal
- Cheerful-Altetrnate with sadness
- Cheerful-Alternate with violence
- Cheerful-Alternate with irritability
- Rage-Alternating
- Rage-Kill people try to
- Rage-Strength increases
- Rage-Alternate violence with
- Suicidal-Thoughts
- Suicuidal-Throw himself from height
- Suicuidal-Hanging by
- Delirium-Maniacal
- Delirium-Loqacious
- Delirium-Laughing
- Hysteria-Fainting
- Hysteria-Lacivious
- Hysteria-Sexual excess after
- Insanity-Suppressed emotion after

Useful homoeopathic medicine in case of mood disorder

Disorder	Frequently used remedy
Bipolar	Alumina, Belladonna, Ignatia, Lycopodium, Natrum Muriaticum, Platina, Nux Moschata, Antimonium crudrum,etc
Depression	Aurum Metallicum, Natrum Muriaticum, Causticum, Arsenic Album, Mercurius, China, Thuja, Antimonium Crud, Kali Bromium, Etc.
Mania	Arsenic Album, Belladonna, Hyocyamus, Lycopodium, Nux Vomica, Stramonium, Veratrum Album, Etc.
Dysthmia	Alumina, Staphysagria, Natrum Carb, Natrum Mur, Acid Phoshoricum, Aurum Metallicum, Causticum, Sepia, Etc
Premenstrual dysmorphic	Sepia, Lachesis, Ignatia, Natrum Mur, Lycopodium, Nux Vomica, Etc

Conclusion

Stress and Genetic influence (family history) are unequivocally the primary causative factors behind the occurrence and development of mood disorders. The approach to the case unequivocally relies on the totality of symptoms at a given time and episode, leading to finding the most similar remedy.

Constitutional prescribing involves selecting a remedy that addresses all mental and physical symptoms that a person is experiencing at a specific time. It takes into account the overall mental and physical state of the patient over an extended period. This approach differs from acute prescribing, which focuses on a few specific symptoms. In some cases, an acute remedy may be used constitutionally for temporary illness, and a polycrest may be prescribed for localized symptoms associated with acute or chronic conditions regardless of the patient's overall state.

Conflict of Interest

Not available.

Financial Support

Not available.

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How to Cite This Article
Tandel N, Naik Y. Understanding the double-edged sword genetics & stress of mood disorder & managing it with a soothing nudge of homoeopathy. International Journal of Homoeopathic Sciences. 2024;8(3):375-379.