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Mood Disorders

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What Are Mood Disorders?

In mood disorders, disturbances of mood are intense and persistent enough to be clearly maladaptive

Key moods involved are mania and depression

Encompasses both unipolar and bipolar

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Unipolar vs. Bipolar

In unipolar disorders the person experiences only severe depression

- MDD, Dysthymia

In bipolar disorders the person experiences both manic and depressive episodes

- Bipolar, cyclothymic

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Prevalence of Mood Disorders

The lifetime prevalence of unipolar disorder is
- 13% for males
- 21% for females

The lifetime prevalence for bipolar disorder ranges from 0.4–1.6%

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Unipolar Depression

Two fairly common causes of depression that are generally not considered mood disorders are
- Loss and the grieving process
- Postpartum blues

Two main categories of mild to moderate depressive disorders are
- Adjustment disorder with depressed mood
- Dysthymia

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Depressive Symptoms

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment

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Dysthymia

Long term problem with moderate symptoms

Depressed mood most of time for two years

Plus two other symptoms of depression

Increased risk for major depression

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DSM-IV Dysthymia Criteria

A. A person has depressed mood for most the time almost every day for at least two years. Children and adolescents may have irritable mood, and the time frame is at least one year.

B. While depressed, a person experiences at least two of the following symptoms:
   A. Either overeating or lack of appetite.
   B. Sleeping to much or having difficulty sleeping.
   C. Fatigue, lack of energy.
   D. Poor self-esteem.
   E. Difficulty with concentration or decision making.
   F. Feeling hopeless.

C. A person has not been free of the symptoms during the two-year time period (one-year for children and adolescents).

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DSM-IV Dysthymia Criteria

D. During the two-year time period (one-year for children and adolescents) there has not been a major depressive episode.

E. A person has not had a manic, mixed, or hypomanic episode.

F. The symptoms are not present only during the presence of another chronic disorder.

G. A medical condition or the use of substances (i.e., alcohol, drugs, medication, toxins) do not cause the symptoms.

H. The person's symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

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Seasonal Affective Disorder

Cyclic severe depression and elevated mood

Seasonal regularity

Unique cluster of symptoms

- Intense hunger
- Gain weight in winter
- Sleep more than usual
- Depressed more in evening than morning

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DSM-IV Criteria For Major Depression

Four hallmarks, nine symptoms:

- depressed mood
- anhedonia (loss of interest/pleasure)
- four physical symptoms
- three psychological symptoms

For diagnosis - depressed mood or anhedonia *and* at least 5 of the 9 symptoms

Symptoms most of time for two weeks

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Major Depression - Course

Average age of onset 27 years, with spontaneous remission in 9-12 months for 90%

Most straightforward is major depressive episode, single episode

Episodic in nature, only 5-15% experience one episode, instead the average is 5-6 episodes over a lifetime

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Major Depression - Course

Recurrence is common

- 50% recur within two years following first episode, 80% chance of third episode if two previous depressions

Suicide is also common - around 15% of people with MDD suceed

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Situational Bases for Depression

Positive correlation between stressful life events and onset of depression

- Is life stress causal of depression?

Most depressogenic life events are losses

- Spouse or companion
- Long-term job
- Health
- Income

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Evidence of Brain Abnormalities

Research suggests abnormalities in the prefrontal cortex, basal ganglia, hippocampus, thalamus, cerebellum, and temporal lobes.

Some evidence suggests increased size of the cerebral ventricles may suggest the loss of neural tissue.

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Biological Bases for Depression

Neurotransmitter theories
- dopamine
- norepinephrine
- serotonin

Genetic component
- more closely related people show similar histories of depression

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Gene-Environment Interaction

A gene that might be implicated in MDD is the serotonin-transporter gene

Occurs in one of three combinations:
- Two short alleles (ss)
- Two long alleles (ll)
- One of each (sl)

Caspi and colleagues published a study in which they tested for a gene-environment interaction involving this gene

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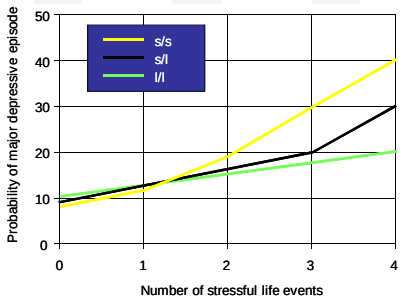
Gene-Environment Interaction



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Psychosocial Causal Factors

Stressful life events are linked to depression

- Independent vs. dependent
- 20-50% of people's depressions are initiated by a severely stressful event

Diathesis-stress models propose that some people have vulnerability factors that may increase the risk for depression

- Personality, early adversity/parental loss

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Cognitive Bases for Depression

A.T. Beck: depressed people hold pessimistic views of themselves, the world, and the future

Depressed people distort their experiences in negative ways

- Exaggerate bad experiences
- Minimize good experiences

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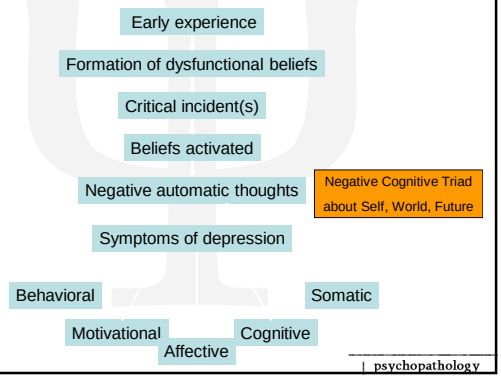
Beck's Cognitive Model



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Depression Treatment

Psychotherapy
- Alone or as adjunctive therapy
- Should be first treatment of choice for mild to moderate depression

Pharmacotherapy
- Effective for major depression and dysthymia
- Questionable effectiveness in minor depression

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CBT for Depression

Patients are taught to understand the relationship between events, emotions, and cognitions

Instructed on identifying, evaluating, and modifying automatic negative thought patterns

Stress management training, social skills training, and activities training

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Antidepressants

Tricyclics

MAO Inhibitors - rarely used by primary care physicians

SSRIs: citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft)

Other new agents (multiple actions)
- bupropion (Wellbutrin)
- mirtazapine (Remeron)
- venlafaxine (Effexor)

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Possible Increased Risk of Suicide

FDA Public Health Advisory March, 2004: risk of suicidality in patients taking antidepressants

Done in reaction to reports of suicidal ideation and attempts in treatment of major depression in pediatric patients.

Black box warning for children / adolescents September, 2004

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Physiological Treatments

Electroconvulsive therapy (ECT)

A brief electrical shock that induces a seizure; used therapeutically to alleviate severe depression when medication is not effective.

Transcranial Magnetic Stimulation (TMS)

Magnetic field causes a weak electrical field and electrical current within the brain. Has been useful in some cases of depression.

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Bipolar Disorders

Distinguished from unipolar disorders by the presence of **manic** or **hypomanic** symptoms

Some people are subject to cyclical mood swings less severe than those of bipolar disorder, or cyclothymia

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Manic Symptoms

Abnormal or excessive elation
Unusual irritability
Decreased need for sleep
Grandiose notions
Increased talking
Racing thoughts
Increased sexual desire
Markedly increased energy
Poor judgment
Inappropriate social behavior

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Bipolar Disorders

Bipolar I
Manic / mixed
AND
Depressive

Bipolar II
Hypomanic
AND
Depressive
WITHOUT
Manic episdoes

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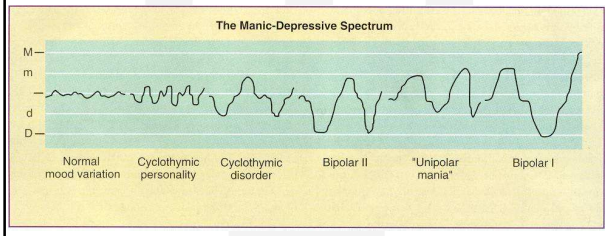
Bipolar Disorders



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Bipolar Disorders - Prevalence

1% of general population, equal for males and females, but women report experiencing Depression first and men Mania

50% of patients with BPD have a parent with BPD. 25-30% of offspring have BPD.

Of 253 patients, only 33% worked full-time, 57% reported being unable.

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Bipolar Disorders - Course

Average onset 18 and 22 years (Bipolar I & II, respectively), rarely after 40

In BPD I, 93-100% have more than one episode

- 19-85% have 3+ episodes
- 15-53% chronically ill.

Duration typically 4 months, depressed phase longer than mania

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Bipolar Disorders - Course

Median number of episodes is 8

Suicide common, 19% (range 9-60%)

Rapid Cycling (4+ episodes in a year)

- 20% experience, first onset is usually depression.
- 90% of rapid cyclers are female

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Bipolar Causal Factors

Large genetic contribution
- More so than unipolar depression

Norepinephrine, serotonin, and dopamine all appear to be involved in regulating our mood states

Number of stressful life events and Personality variables
- Neuroticism and high levels of achievement striving)

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Sociocultural Factors

Prevalence of mood disorders varies considerably among different societies
- Psychological sx's of depression are low in China and Japan
- Among several groups of Australian aborigines there appear to be no suicides

In U.S., unipolar depression rates are inversely related to SES, but not race

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Misdiagnosis of Bipolar Patients

Potential risks from antidepressants
- May induce mania or hypomania
- Can cause rapid cycling

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Bipolar Treatment

Medication, such as Lithium, is typically prescribed for this disorder.

Therapy helps the client understand the illness and it's consequences and be better able to know when a manic or depressive episode is imminent and to prepare for this.

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Physiological Treatments

Lithium

A chemical element; lithium carbonate is used to treat bipolar disorder

Carbamazepine

An anticonvulsive drug (trade name: Tegretol) that is used to treat seizures originating from a focus, also used to treat mania in bipolar disorder

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Suicide

The risk of suicide is a significant factor in all types of depression

Suicide ranks among the top ten leading causes of death in most Western countries

Attempts are most common between 25-44, completed suicides for 65+

Women are more likely to attempt suicide, but men are more likely to complete suicide

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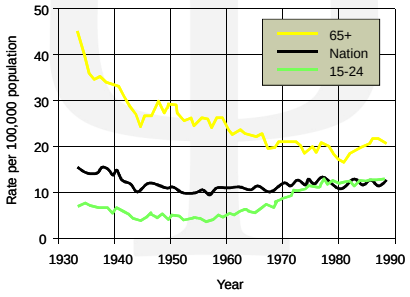
Suicide Rates



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Who?

Conduct disorder and substance abuse are relatively more common among the *completers* of suicide

Mood disorders are more common among *nonfatal* attempters

Whites have much higher rates of suicide than African-Americans

Rates of suicide vary across cultures and religions

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Suicidal Ambivalence

Some people do not really wish to die but instead want to communicate a dramatic message concerning their distress

Research has disproved the belief that those who threaten to take their lives seldom do so

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Prevention & Intervention

Two main thrusts to preventive efforts:

- Treatment of the person's current mental disorder(s)
- Crisis intervention

Emphasis on the need for broad-based preventive programs aimed at high-risk groups

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