Mood Disorders

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

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

Depressive Disorders

Description of the Disorder

- Among the most common disorders in youth and adults
- Characterized by sadness, lack of interest in usual hobbies, sleep and appetite disturbances, feelings of worthlessness, and thoughts of death and dying
  - Somatic complaints are also common.
- Associated with increased suicide risk

Diagnosis

- Common among all depressive disorders
  - Mood symptoms (e.g., feeling sad, empty, worries, or irritable)
  - Vegetative symptoms (e.g., fatigue, social withdrawal, and agitation)
  - Sleep and appetite disturbance
  - Cognitive symptoms (e.g., low self-esteem, guilt, or suicidal ideation)

Diagnosis

- Major Depressive Disorder
  - At least one depressive episode (depressed mood or anhedonia with at least five other symptoms) present for at least 2 weeks, all day, nearly every day
- Dysthymic Disorder
  - Chronic depression (less severe than MDD) lasting at least 2 years, all day, on more days than not
  - No major depressive episodes during a 2-year period
- Depressive Disorder NOS
  - Includes premenstrual dysphoric disorder, minor depressive episodes, and others

Diagnosis

- Depression that may not be a depressive disorder
  - Depression following a significant life stressor (adjustment disorder)
  - Depression following a manic episode (bipolar disorder)
  - Medical conditions (hyperthyroidism)
  - "Normal" sadness

Clinical Picture

- Each depressive disorder varies from the others, but they do share commonalities:
  - Negativistic thinking (i.e., pessimistic and critical)
  - Somatic symptoms
  - Difficulty engaging in and enjoying formerly pleasurable activities
  - Passive coping skills
  - Loss of productivity at work and/or school

Diagnostic Considerations

- Medical/psychological illness
  - Depression is often comorbid with other mental disorders (e.g., anxiety disorders).
  - Endocrinological disorders (hypo- and hyperthyroidism) can produce symptoms of depression.
  - Acute medical illnesses

Diagnostic Considerations

- Drug and alcohol abuse
  - Strongly associated with depressive symptoms
- Grief and bereavement
  - Some disagreement in field with respect to whether bereavement is a form of clinical depression
- Depression due to other psychiatric disorders
  - Individuals with Axis II disorders, particularly those with borderline, avoidant, or obsessive-compulsive personality disorders

Diagnostic Considerations

- Late-life depression
  - NOT a natural consequence of aging, although it is common among older adults
    - Commonly report memory problems and somatic complaints
    - Associated with increased mortality and health service usage

Epidemiology

- Community samples
  - Prevalence of MDD ranges from 5.8% to 12%, and dysthymia ranges from 2.5% to 6%.
- Sex
  - Some evidence suggests that depression is more prevalent among women.
- Ethnic minority samples
  - Rates among African Americans are similar to Caucasians, whereas Asian Americans have the lowest rates.
  - Among Hispanics, rate depends on immigration status.

Etiological Considerations

- Most research has focused on MDD
- Familial and genetic factors
  - Evidence from twin and family studies indicates that genetic factors contribute to development of depression.
  - Some twin and familial rates are not compelling.
  - Overall rate of heritability ranges from 31% to 42%.
  - Recurrent, early-onset MDD seems most heritable.
  - Genetic factors increase the propensity to develop the disorder, but no strong connections have been identified yet.

Etiological Considerations

- Neuroanatomy and neuro-circuitry
  - Brain areas associated with depression:
    - Amygdala
    - Orbitofrontal cortex
    - Dorsolateral prefrontal cortex
    - Anterior cingulate cortex
    - Together, these areas assess threat, modulate emotions, perform decision-making, and initiate coping behaviors

Etiological Considerations

- Neurochemistry
  - Dysregulation of norepinephrine and serotonin
    - Antidepressants increase availability of receptor sites for these neurotransmitters.
- Neuroendocrinology
  - Overabundance of cortisol
  - Thyroid dysregulation

Etiological Considerations

- Learning and modeling
  - Cognitive appraisal of self and others
  - Problem-solving strategies
  - Coping strategies
    - Learned helplessness
  - Low levels of reinforcement
- Life events
  - Particularly prolonged exposure to stressful life events

Etiological Considerations

- Racial-ethnic
  - Unclear why rates differ across ethnic groups
    - Low SES and exposure to violence in minority groups
- Sex
  - More commonly reported by women
    - Men are reluctant to express depressed feelings.
    - Women are more willing to seek treatment.

Course

- Early onset (before 20 years old) of MDD has a more severe course than late onset (during 30s).
- Average depressive episode lasts 6 months, though episodes are recurrent.
  - Patients who have one episode have a 36.7% chance of having another.
  - Each additional episode increases the chances of another by about 15%.
- Mean length of dysthymia is 30 years.
  - Half develop MDD as well.

Prognosis

- Early diagnosis and treatment aids outcome.
- Few stressful life events and social support indicate a good prognosis.
- Those with dysthymia have the worst prognosis.
  - Few long-lasting options for treatment
  - Current medications effective in the short-term
- Self-esteem also predicts prognosis.
  - Higher self-esteem associated with positive prognosis.

Looking Ahead: *DSM-5*

- No substantial changes for the depressive disorders
- Addition of a dimensional assessment for co-occurring disorders
- Removal of grief exclusion for depression

Bipolar Disorder

Manic Episode

- Elated, expansive, or irritable mood
- Plus at least three (four if the mood is only irritable) of the following:
  - Decreased need for sleep
  - Racing thoughts or flight of ideas
  - Rapid speech
  - Inflated self-esteem (grandiosity)
  - Impulsive, reckless behavior (spending sprees, hypersexuality)
  - Increased energy and activity
  - Distractibility
- Present for at least 1 week or interrupted by hospitalization or emergency treatment
- Cause severe functional impairment
- Characteristic of Bipolar I disorder

Hypomanic Episode

- Parallel symptoms to manic episode
  - Symptoms only need to last for 4 days
  - Need to show a distinct, observable change in functioning
- Characteristic of Bipolar II disorder

Depressive Episode

- Episodes last for at least 2 weeks
- Characterized by sad mood, loss of interest or pleasure in daily activities
- Plus at least five of the following:
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Increases or decreases in weight or appetite
  - Loss of energy
  - Difficulty concentrating or making decisions
  - Feelings or worthlessness
  - Suicidal ideation or behavior
- Must cause functional impairment

Mixed Episode

- Describes a simultaneous manic and depressive episode.
- Symptoms must last at least 1 week.
- 40% of bipolar patients have at least one mixed episode.

Bipolar I

- Presence of a single manic or mixed episode (not substance-induced).
  - Do not need to have had a major depressive episode!

Bipolar II

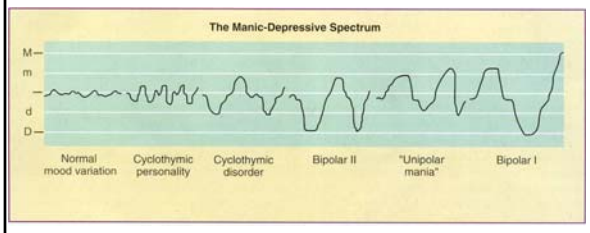
- Major depressive episodes alternating with hypomanic episodes
- One in 10 Bipolar II patients develop a full manic or mixed episode.

Cyclothymia

- Two or more years of alterations between hypomanic and depressive symptoms but not meeting criteria for hypomania or a major depressive episode

Bipolar Disorder NOS

- Disorder meets minimum symptom requirements
- Does not meet duration requirements



Epidemiology

- Lifetime prevalence rates
  - Bipolar I: 1.0%
  - Bipolar II: 1.1%
  - Subthreshold: 2.4%
  - Cyclothymia: 4.2%
- Mean age of onset about 18–20 years of age
  - Getting younger
  - Earlier age of onset associated with rapid cycling and poorer outcomes in adulthood

Epidemiology: Sex and Race

- Sex
  - Both women and men are equally likely to develop Bipolar I.
  - Women report more depressive episodes and are more likely to have Bipolar II.
  - Women are more likely to meet criteria for rapid-cycling bipolar disorder.
- Race
  - African Americans
    - More likely than Caucasians to have attempted suicide and to have been hospitalized.
    - Less likely than Caucasians to be prescribed mood stabilizers or benzodiazepines and more likely to be prescribed antipsychotics.

Suicide Risk

- Rates of suicide completion are **15 times** higher than in the general population and **4 times** higher than those with recurrent major depression.
- 50% attempt suicide during their lifetime
  - 15% to 20% are suicide completers
- Factors that increase the risk of suicide:
  - Being a young male with recent onset
  - Having comorbid alcohol or substance abuse, social isolation, depression, significant anxiety, aggression, or impulsiveness
  - Having a family history of suicide

Functional Impairment

- Within the first year after hospitalization, only half the patients who recover from a manic or mixed episode demonstrate full recovery.
- Diminished work, social, and family functioning persists for up to 5 years after a manic episode.
- Many famous artists, musicians, writers, and politicians have had or likely have bipolar disorder.

Course and Prognosis

- Biological and genetic models are not very explanatory about the course of bipolar disorder.
- Psychosocial predictors are more useful.
  - Bipolar patients with high life-events-stress scores were 4.5 times more likely to relapse than were patients with medium or low life-events-stress scores.
  - Patients returning to negative or hostile home environments are at high risk for relapse.

Treatment

- Ideally, should consist of a combination of pharmacological treatment and psychosocial intervention.
  - Most only receive the pharmacological piece.

Pharmacological Treatment

- Stabilization and maintenance
- Commonly combine:
  - **Mood stabilizers** (lithium carbonate, divalproex sodium, carbamazeprine)
  - **Atypical antipsychotics** (olanzapine, quetiapine, risperidone, aripiprazole, ziprasidone, clozapine)
- **Antidepressants** should be used with caution.
- Can also use the **anticonvulsant** lamotrigine
- Medication compliance issues

Psychotherapy

- Psychoeducation
- Medication adherence
- Avoidance of alcohol and recreational drugs
- Stress management
- Strategies
  - Family-focused therapy
  - Interpersonal and social rhythm therapy
  - Cognitive-behavioral therapy

Etiology

- Heritability
  - Estimates of heritability range from 59% to 87%
  - Bipolar parents are four times more likely to have a bipolar child than are healthy parents.
    - Children of bipolar parents have a threefold risk of developing nonaffective disorders.
- Several genomic regions have been found, but findings are inconsistent.

Etiology

- Neurotransmitters
  - Hypersensitivity of dopamine
  - Decreased sensitivity of serotonin receptors
  - Current research suggests dysregulation of dopamine and serotonin systems interacts with deficits in GABA and substance P.
- Brain regions involved
  - Amygdala hyperactivity
  - Diminished activity of the hippocampus and prefrontal cortex