Mood Disorders

1. Major Depressive Disorders
2. Dysthymic Disorder
3. Bipolar Disorder
   Bipolar I disorder
   Bipolar II disorder
4. Cyclothymic Disorder

1. Major Depressive Disorders

Introduction

Major depressive disorder is a chronic condition that waxes and wanes over time, but seldom fully remits. The first depressive episode usually lasts about 9 months, and subsequent episodes tend to be shorter, lasting around 5 months. The average number of episodes in a patient's lifetime is 4. However, these episodes may not entirely remit, leaving a few residual symptoms in the period between episodes. The age of onset occurs between 25 and 29, though there is a global trend of onset becoming earlier and earlier with each passing decade. An early onset (before the age of 21) predicts a poor prognosis and greater chronicity of the disorder. In addition, women are more likely to be diagnosed with MDD than men.

A prominent issue in depression is the very real risk of suicide. Research suggests that 15% of people with depression commit suicide and that as many as 60% of all suicides are related to depression. Although women are more likely to attempt suicide than men, men complete suicide 3 to 4 times more than women. This could be because men generally choose more lethal methods to commit suicide.

Symptoms

Major depressive episode

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure
    - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others

(e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
    - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
    - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
    - Insomnia or hypersomnia nearly every day
    - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
    - Fatigue or loss of energy nearly every day
    - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
    - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
    - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Single episode
    - Presence of a single major depressive episode
- Recurrent
    - Presence of two or more major depressive episodes (Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a major depressive episode)

2. Dysthymic Disorder

Introduction

Dysthymic disorder or dysthymia is a type of depressive disorder that involves chronically depressed mood that occurs for most of the day for more days than not for at least 2 years without any significant interruption. The symptoms observed in dysthymic disorder are not as severe as those seen in MDD and are fewer in number. However, they have greater chronicity. This condition lacks the episodic quality of the other mood disorders; instead, the person's mood is stable and constant. The median duration of a dysthymic episode is approximately 5 years in adults and 4 years in children. Dysthymic disorder and MDD are not exclusive as dysthymic disorder can eventually lead to MDD. This occurs when one or more major depressive episodes are experienced after dysthymic disorder develops. Thus, even when the person is no longer in a depressive episode, his or her mood never rises above a dysthymic level, a condition known as double depression.

Symptoms

- Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.
- Presence, while depressed, of two (or more) of the following:
    - Poor appetite or overeating
    - Insomnia or hypersomnia
    - Low energy or fatigue
    - Low self-esteem
    - Poor concentration or difficulty making decisions
    - Feelings of hopelessness
- During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in the aforementioned points for more than 2 months at a time
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Causes and risk factors

A genetic vulnerability appears to be implicated in the development of depression, and what is inherited could be the tendency to have an overactive neurobiological response to stressful life events. Depression could also be related to a functional deficit in the amount of dopamine, norepinephrine, or serotonin in the brain system, which keeps the person from functioning normally. For example, when serotonin levels are atypically low,

the amount of other neurotransmitters normally regulated by serotonin tends to fluctuate more widely and becomes dysregulated, contributing to mood irregularities, such as depression.

The predominant theory explaining the etiology of depression is Aaron Beck's cognitive theory of depression. Beck proposes that the psychological factors involved in depression include the cognitive triad (of thinking errors), negative schemas, and faulty information processing, all of which are interconnected. The cognitive triad reflects discrete manifestations of deep-rooted negative schemas that develop early on after the experience of a series of negative events. It is a general tendency to interpret everyday events in a negative way, which includes a negative view of the self, the immediate world, and the future. Some faulty information processing strategies include contingent self-worth (making self-worth dependent on performance or ability), dichotomous thinking (all-or-nothing thinking), and selective abstraction (only focusing on the negative).

Stressful life events also play a significant role in the development of depression. They work as a vulnerability factor, increasing the likelihood of developing depression later in life, as well as a precipitating factor, triggering a depressive episode. The presence of stressful life events can also complicate the disorder as they predict poorer response to treatment and a greater likelihood of recurrence. However, it should be noted that stressors alone do not cause depression if other etiological factors are not also in place to contribute to the development of depression.

Treatment

The goal of treatment is typically to delay the next depressive episode or to prevent it entirely, depending on the severity of the patient's symptoms. The two forms of psychological treatment that have received the most empirical support are cognitive therapy for depression and interpersonal therapy. Cognitive therapy involves assisting patients in identifying their negative cognitions and evaluating the validity of those thoughts, with the aim of modifying maladaptive ones. Patients learn to replace these thoughts and underlying assumptions with more accurate and logical interpretations. They are also taught ways to better cope with stressors. Sometimes, therapy may also involve encouraging patients to comply with their medication regimen. Interpersonal psychotherapy (IPT) focuses on how interpersonal relationships might work to maintain patients' depression. The main objective of IPT is to address any problems in current relationships and to teach patients how to form healthy new relationships. IPT is based on the belief that regardless of the factors that have caused the depression, it exists in an interpersonal context that exerts considerable influence over its course and presentation.

Pharmacological treatment commonly involves tricyclic antidepressants, MAOIs, SSRIs, and in more severe cases that require an immediate improvement of symptoms, ECT (electroconvulsive therapy). However, in most cases, simply taking medication alone will not be very helpful in alleviating the symptoms of depression. Combined treatment appears to be the most effective way to treat depression.

3. Bipolar Disorder

Introduction

Unlike the depressive disorders (i.e., MDD and dysthymic disorder), bipolar disorder involves shifts from one mood extreme to the other. Thus, although people with bipolar disorder experience depressive episodes like those with MDD, they also experience manic or hypomanic episodes. In bipolar I disorder, the person has both depressive and manic episodes, while in bipolar II disorder, the person has depressive and hypomanic episodes. There are a few differences between the bipolar disorders, even though they are classified similarly. For example, bipolar I disorder has an earlier average age of onset (between 15 and 18) than bipolar II disorder (between 19 and 22), and while bipolar I appears to be equally common in men and women, bipolar II seems to be more common in women. In addition, bipolar II is easier to treat and its patients' lives are not as seriously affected by their symptoms as those with bipolar I.

Bipolar disorder is a chronic disorder, and so does not spontaneously remit. The person usually experiences several episodes of depression before a manic or hypomanic episode occurs. Comorbidity with the substance use and anxiety disorders is not uncommon. Suicide that occurs in people with bipolar disorder typically occurs during a depressive episode. Usually, it is difficult to get patients to take their medication regularly as it weakens the high they experience during a manic episode, which is quite enjoyable to them. A manic episode can last for up to 5 months, though a manic episode that gets out of control can swiftly lead to hospitalisation. During a manic episode, people may make impulsive decisions like quitting their job and spending large sums of money they cannot afford, often creating a dangerous and difficult situation for themselves. Another issue is that patients may get so caught up in their enthusiasm and expansiveness that they fail to see the consequences of their behaviour and often deny that they have a problem.

Symptoms

Manic episode

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalisation is necessary)
- During the period of mood disturbance, three (or more) of the following symptoms have been present to a significant degree:
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    - More talkative than usual or pressure to keep talking
    - Flight of ideas or subjective experience that thoughts are racing

    - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
    - Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
    - Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features

Hypomanic episode

- A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood
- During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
    - More talkative than usual or pressure to keep talking
    - Flight of ideas or subjective experience that thoughts are racing
    - Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
    - Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
    - Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engaged in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic
- The disturbance in mood and the change in functioning are observable by others
- The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalisation, and there are no psychotic features

Mixed episode

- The criteria are met both for a manic episode and for a major depressive episode (except for duration) nearly every day during at least a 1-week period
- The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features

Bipolar I disorder

- Single manic episode
    - Presence of only one manic episode and no past major depressive episodes. Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms
- Most recent episode hypomanic
    - Currently (or most recently) in a hypomanic episode
    - There has previously been at least one manic episode or mixed episode
    - The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Most recent episode manic
    - Current (or most recently) in a manic episode
    - There has previously been at least one major depressive episode, manic episode, or mixed episode
- Most recent episode mixed
    - Currently (or most recently) in a mixed episode
    - There has previously been at least one major depressive episode, manic episode, or mixed episode
- Most recent episode depressed
    - Currently (or most recently) in a major depressive episode
    - There has previously been at least one manic episode or mixed episode
- Most recent episode unspecified
    - Criteria, except for duration, are currently (or most recently) met for a manic, a hypomanic, a mixed, or a major depressive episode
    - There has previously been at least one manic episode or mixed episode
    - The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Bipolar II Disorder

- Presence (or history) of one or more major depressive episodes
- Presence (or history) of at least one hypomanic episode
- There has never been a manic episode or a mixed episode
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

4. Cyclothymic Disorder

Introduction

Cyclothymic disorder is a lifelong disorder that can be described as a less severe form of bipolar disorder. Like bipolar disorder, it involves a swinging from a depressed state to a manic state, but its troughs are not as deep and its peaks are not as high. People with cyclothymia tend to be in one mood state or the other for many years with relatively few periods of neutral mood in between these states. Unfortunately, having this disorder increases the risk of developing the more severe bipolar disorder later on.

Symptoms

- For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode. Note: In children and adolescents, the duration must be at least 1 year.
- During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in the abovementioned criterion for more than 2 months at a time
- No major depressive episode, manic episode, or mixed episode has been present during the first 2 years of the disturbance. Note: After the initial 2 years (1 year in children and adolescents) of cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar II disorder and cyclothymic disorder may be diagnosed)
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Causes and risk factors

Some people may be genetically predisposed to bipolar disorder, though not everyone with this vulnerability will develop the disorder. Other factors also play a part in determining whether or not psychopathology will develop. Neurobiological abnormalities such as neurochemical imbalances, thyroid dysfunction, circadian rhythm disruptions, and abnormally high levels of the stress hormone cortisol, have been linked to bipolar disorder as well.

Environmental factors can either trigger a manic or depressive episode or exacerbate current symptoms. Stressful life events that involve significant changes, such as the death of a loved one or getting a big promotion, can precipitate a depressive or manic episode in those who are biologically predisposed to bipolar disorder. The abuse of

substances that induce feelings of depression or mania (e.g., alcohol and ecstasy) can also trigger episodes and worsen the person's condition.

Treatment

A drug that has often been used in the treatment of bipolar disorder is lithium. Although it has been found to be effective in treating manic episodes, preventing suicide, and even preventing relapse, because patients usually enjoy the high feeling that manic produces and wish to maintain or re-experience a manic state, compliance rates are low for such drugs. Anticonvulsants also have a mood-stabilising effect and may help to improve symptoms, while antipsychotics are sometimes prescribed to those who do not respond to anticonvulsants. Sometimes, antidepressants can be given to patients, depending on their presentation. However, because antidepressants may trigger manic episodes, they are usually taken with a mood stabiliser.

Although medication can help to stabilise mood, psychotherapy should be administered at the same time to help patients deal with their disorder more effectively. During cognitive behavioural therapy, patients may discuss their thoughts, feelings, and behaviours with their clinician, who can then help to identify those that might be contributing to their problems. Working on changing such maladaptive cognitions and behaviours may be useful in alleviating distressing symptoms. In therapy, patients also learn to identify triggers of their episodes, and how to response to them more effectively. In addition, patients are taught stress management strategies so that they will be better equipped with to deal with difficult situations. The psychological therapies used to treat bipolar disorder can be similar to those used in the treatment of depression, since people with bipolar disorder also experience major depressive episodes. For example, interpersonal therapy, which focuses on improving patients' relationships with others, is also employed in the treatment of bipolar disorder. There are some therapies more specific to manic episodes, such as social rhythm therapy, which involves establishing regular daily schedules to prevent the occurrence of manic episodes.