


PSYCH 335
Psychological Disorders

Chapter 11
Mood/Bipolar and Related
disorders & Suicide


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Agenda/Overview

- Mood disorders
 - Major depression
 - Persistent Depressive Disorder (Dysthymia)
 - Bipolar disorder
 - Cyclothymia
- Causes/treatments
- Suicide

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Mood Disorders

- fundamental distinction: unipolar (depression only) or bipolar (depression and mania)
- most prevalent class of disorders after the anxiety disorders.
- Five broad kinds of symptoms
 - emotional
 - motivational
 - behavioral
 - cognitive
 - somatic

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Major Depressive Episode

- A. 5 or more symptoms x two weeks
- Must have either
 - 1. depressed mood, most of the day, nearly every day or
 - 2. markedly diminished interest or pleasure
- and
 - 3. weight gain or loss without dieting
 - 4. sleep disturbance
 - 5. psychomotor agitation or retardation
 - 6. lack of energy, fatigue
 - 7. feeling worthless or inappropriate guilt
 - 8. problems thinking or concentrating
 - 9. recurrent thoughts of death, suicidal ideation

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MDE/MDD

- Exclusions
 - do not meet mixed episode criteria
 - not due to organic cause and not better accounted for by normal bereavement
- Major Depressive Disorder Single Episode or Recurrent
 - One or more episodes
 - No evidence of manic/mixed or hypomanic episode
- Patterns of MDD
 - Females 2x as likely to be sufferers.
- Epidemiology
 - lifetime-12 month: males 12.7%-7.7%, females 21.3%-12.9%, overall 17.1%-10.3%
 - Genetic component, MZ-54% DZ-19% from a Danish twin study.

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Persistent Depressive Disorder (formerly – Dysthymia)

- less severe than major depression
- always chronic
- depressed mood most of day, majority of days for 2 years
- must have 2 or more of: a. poor appetite/overeating, b. sleep disturbance, c. low energy level, d. poor self-esteem, e. concentration/decision making problems, f. hopelessness
- symptoms never absent for over 2 months
- criteria for MDD may be continuously present for the full two years
- exclusions
 - (formerly - no major depressive episode the first two years)
 - no manic, mixed, or hypomanic episode
- Prevalence: lifetime-12 month: males 4.8%-2.1%, females 8%-3%, overall 6.4%-2.5%
- "Double depression"

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Case video

- o Barbara – Major Depressive Disorder

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Bipolar Disorder

- o In DSM 5, Bipolar I / II distinction
- o Bipolar I - manic or mixed episodes
- o manic episode - abnormally and persistently elevated, expansive, or irritable mood lasting at least a week
- o Bipolar II - no full-blown manic episode, has been hypomanic with a MDE
- o Same 5 general symptoms: emotional; motivational; behavioral; cognitive; & physical – in opposite direction

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Manic Episode Criteria

- o 3 or more of (4 if mood only irritable)
 - grandiosity
 - decreased need for sleep
 - more talkative than usual
 - flight of ideas/racing thoughts
 - distractibility
 - increase in activity or agitation
 - excessive pleasurable activities

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Bipolar Disorder

- Epidemiology
 - About equally prevalent across genders.
 - Prevalence (NCS): lifetime-12 month: 1.6%-1.3% (Text says 1.6% for BP I & 1% for BP II)
 - Genetic component: MZ concordance-79%, DZ-24%
- Differential diagnosis
 - Bipolar I differentiated from psychotic disorders by
 - rapid onset of symptoms
 - absence of prodromal signs of schizophrenia
 - quick return to previous level of functioning

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Treatment

- Psychotherapy alone useless
- Medications effective in about 80%
- Lithium primarily – also anticonvulsants (valproic acid/ carbamazepine)
- Historical figures with Bipolar disorder

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Cyclothymia

- periods of hypomanic and depressive symptoms
- not either a manic or major depressive episode
- symptoms last at least 2 years
- no symptom free interval > two months.
- borderline personality disorder associated with shifts in mood that may suggest cyclothymia
- if criteria met for both, both diagnoses are given
- Cyclothymic Disorder on Axis I and BPD on axis II
- One year prevalence about 0.4%, no gender difference

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Mood disorders

- Causes
 - Neurotransmitters – 5-HT & NE
 - Ions – Na & K
 - Brain structure – basal ganglia & cerebellum
 - Hormonal dysregulation – HPA axis, stress
 - Genetic – polygenetic
- Psychological Perspectives/Treatments:
Cognitive, Learned Helplessness Paradigm,
Psychodynamic

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Cognitive behavioral therapy

- pessimistic and pervasively negative cognitions
- addresses the cognitive triad
 - depression-negativity about the self, the world, and the future
- automatic thoughts
 - confronted
 - modified
- distortions addressed and depressive schemata exposed and modified
- Beck's four phases

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Learned Helplessness/ Psychodynamic

- Learned Helplessness
 - increase perceptions of efficacy
 - increasing perceptions over control of outcomes
- Psychodynamic treatment
 - aims at achieving insight
 - anger not being appropriately expressed
 - finding ways to do so

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Biological treatments

- Norepinepherine and serotonin
- Tricyclics block reuptake of norepinepherine
- MAO inhibitors prevent breakdown of NE
- SSRI's prevent reuptake of serotonin
Issue re: text table of antidepressants
- Polypharmacy – fairly common now
- ECT-works very quickly

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Case video

- Mary – Bipolar I Disorder

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Suicide

- very poor at predicting who will kill themselves
- best predictor: previous suicide attempt
- alcohol & drug use often associated. why?
- Shneidman: "psychache"
- depressed at greatest risk – risk can increase as symptoms improve
- should the state interfere with a decision to end one's own life?
- 37K suicides vs. 17K homicides in US
- suicide prevention

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