Agenda/Overview

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

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
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

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.

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”
Case video
- Barbara – Major Depressive Disorder

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

Manic Episode Criteria
- 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
Bipolar Disorder

- Epidemiology
  - About equally prevalent across genders.
  - Prevalence (NCS): lifetime-12 month: 1.6%-1.3%
    (Text says 0.6% for BP I & 1.1% 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

Treatment

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

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
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

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

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
### 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

### Case video

- Mary – Bipolar I Disorder

### 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