PSYCH 335
Psychological Disorders

Chapter 11
Mood/Bipolar and Related disorders & Suicide

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

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 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

Treatment

- Psychotherapy alone useless
- Medications effective in about 80%
- Lithium primarily – also anticonvulsants (valproic acid/ carbamazapine)
- 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