Mood Disorders Overview: Depression and Mania R Salomon

[NOTE: Outline structure presented here is prompted by table and adapted from Alloy, Riskind & Manos, "Abnormal Psychology", 9e, Mood Disorders Chapter Outline, http://highered.mcgraw-hill.com/sites/007242298x/student_view0/chapter10/chapter_outline.html]

ild, temporary changes in mood are normal. Differentiation of depression from prolonged grief can be challenging. Disruptions of mood in which mood swings are so prolonged and extreme that life activities are is seriously affected become pathological. Sadness, happiness are normal emotions; overly constricted affective expression may be equally troublesome.

I. **Depression and Mania:** Discrete episodes, especially early in the course of illness, can be differentiated from chronic, insidious or more progressive forms of the illnesses, and also from fixed characterologic traits. Temporal course, severity and duration contribute to diagnosis and often also to treatment recommendations

A. **Major Depressive Episode**

1. **Major depressive episode** develops over weeks or months, diagnostic severity must lasts at least 2 weeks, may last several months, and ends gradually, often in roller-coaster fashion. Untreated course average 6 months.
2. Both mind and body are affected by depression
   a. Somatic: activities under hypothalamic control
   b. Mental: predominantly alterations in frontal lobe function, usually related to increased anterior cingulate activity
3. Altered mental processing of emotions and somatic : distinct findings that are characteristic of
   a. Melancholic patients, especially, see no way that their situations can be helped, called **helplessness-hopelessness syndrome**
   b. A loss of pleasure or interest in usual activities; known as **anhedonia** is far-reaching and becomes pervasive
   c. Disturbance of appetite, either way, preferences for sweets, chocolate
   d. Sleep disturbance, classically (not always) advanced REM, disrupted mid- and late-nocturnal sleep quality, and early morning awakenings. Many SSRI's cause increased dream vividness and intensity
   e. Psychomotor retardation or agitation; in **retarded depression,** person seems overcome by fatigue; **agitated depression** involves incessant activity and restlessness, clothes picking behaviors
   f. Loss of energy, both as diminished mental volition and somatic sensation of fatigue
   g. Feelings of worthlessness and guilt, often associated with (a) above.
   h. Difficulties in concentration, attention, interests in normal activities. May be hyperfocused on maladaptive thoughts, unable to read newspaper or follow TV sit-com
   i. Recurrent thoughts of death or suicide, important to diagnosis even if low risk due to religious convictions, insight

B. **Manic Episode**

1. Disturbances of sleep often precede abrupt episode onset over about 2 days to 2 weeks. Must last 1 wk (or any duration if hosp. necessary) for DSM-IV dx.
2. Manic episode may last days to several months and then ends abruptly, classically followed by severe depression (manic-depression) although only a minority show this pattern. Patterns predict success in treatment.
3. Manic episode has several diagnostic characteristics:
   a. Elevated, expansive or irritable mood. Note that irritability may also present in depression, where irritability may be misinterpreted as a depressive symptom, and result in missed diagnosis of Mixed State.
   b. Inflated self-esteem or grandiosity
   c. Sleeplessness (needs none, or feels well-rested after only 2-3 hrs)
   d. Talkativeness or pressure to keep talking
   e. Flight of ideas or subjective experience that thoughts are racing
   f. Distractibility (drawn to unimportant, irrelevant stimuli)
   g. Increased goal-directed activity (social, work, school, sex) or agitation
   h. Excessive pursuit of pleasure at peril for subsequent pain, e.g. reckless buying, sex, business transactions
4. For diagnosis, episode must last at least 1 week and seriously interfer with person's functioning, without meeting criteria for MIXED episode
5. Not due to substances, medications, GMC, ECT, antidepressants...
6. A briefer, less severe manic condition is called a *hypomanic episode*

7. Impairment must be marked: social activity, relationships, safety requirement for hospitalization, or psychosis.
8. First clear manic episodes often comes years, up to decades, after onset of depressive episodes; commonly Bipolar diagnoses are missed early in illness

II. **Mood Disorders are defined by types of Episodes present currently or historically**

A. **Major Depressive Disorder**

1. People who experience one or more major depressive episodes with no mania are diagnosed with **major depressive disorder**
2. One of the greatest mental health problems in United States
   a. Prevalence is 4% of men and 6% of women; Lifetime risk is 17%
   b. Second only to schizophrenia for admissions to mental hospitals
   c. Often more debilitating than many other chronic medical conditions
   d. Major depression is a leading cause of disability and premature death worldwide
3. Course
   a. In 80% of cases, first episode is not the last
   b. Median lifetime # of episodes is 4, with median duration of 4.5 months
   c. Course varies considerably; sometimes episodes come in clusters
   d. Early presentations before or at puberty are associated with familial forms, and increased likelihood of subsequent mania later in life
   e. Most, especially early in illness, return to their premorbid adjustment
   f. Depressive episodes may be triggered by stress, but generate additional stress events that maintain depression. Later episodes may not be associated with clear stress triggers.
4. Groups at Risk for Depression
   a. Race and marital status are risk factors
   b. Risk for women is one to three times higher than for men
      i. Men and women respond to depressed moods differently
      ii. Women wonder why depression is occurring; men distract themselves
   c. Bimodal: The young are risk, as are the old for depression
   d. Symptoms differ depending on gender and age group

B. **Bipolar Disorder**

1. **Bipolar disorder** patients display both manic and depressive phases
2. Common pattern is for diagnosis made after an initial manic episode followed by normal phase, then a depressed episode, then normal period. Additional inquiry often reveals prior bouts of depression.
3. In rapid-cycling type, there are swings between depressive and manic or mixed episodes over long period with little or no normal functioning between
4. Other differences exist between bipolar and major depression
   a. Bipolar disorder much less common
   b. Different demographic profiles, course, prognosis
   c. Married or those in intimate relationships less likely to develop major depression; does not matter in bipolar disorder
   d. People with major depression tend to have histories of low self-esteem, dependency, and obsessional thinking; those with bipolar tend to have history of hyperactivity, moodiness, being "life of the party"
   e. Bipolar depressives more likely to show pervasive slowing down
   f. Bipolar disorder more likely to run in families
5. *DSM-IV-TR* divides bipolar disorder into two groups, likely continues in DSM-V
   a. Bipolar I disorder--person has had at least one manic or mixed episode and usually, not necessarily, at least one major depressive episode
   b. Bipolar II disorder--person has had at least one major depressive episode and at least one hypomanic episode but does not meet criteria of manic or mixed episode
6. Dysthymic Disorder and Cyclothymic Disorder – *formes frustes*
   a. **Dysthymic disorder** involves a mild but noticeably persistent depressive symptoms, at least 2 years (1 year if <18 y old)
   b. **Cyclothymic disorder** chronic oscillation of hypomanic and sub-threshold depressive symptoms, no manic or major depressive episode
   c. Both disorders have slow gradual onset often in adolescence
   d. Often familial
   e. Prevalence, gender demographics mirror full-syndrome counterparts

7. Dimensions of Mood Disorder
    a. Psychotic Versus Neurotic
        i. Depressive and manic episodes can have psychotic features where the individual loses touch with reality
        ii. Many cases remain at the neurotic level
        iii. Some argue that neurotic and psychotic level mood disorders are different entities altogether
        iv. The **continuity hypothesis** says that distinctions are more quantitative than qualitative – they cover a spectrum
    b. Endogenous versus Reactive Disorder
        i. Some regarded neurotic forms of mood disorders as psychogenic and psychotic forms as biogenic
        ii. Depression linked to external event was called **reactive**
        iii. Depression not linked to external event was called **endogenous**
        iv. Currently a stress-triggered biological predisposition is theorized.
    c. Early versus Late Onset
        i. Earlier onsets have familial hx of same or other mood disorder
        ii. Early onset cases have higher "genetic loading" for mood disorders
        iii. Still leaves environmental factors influencing onset, severity
    d. Comorbidity: Mixed Anxiety-Depression
        i. Symptoms of anxiety and depression overlap
        ii. Findings raise questions about disorders being two distinct entities or different manifestations of same underlying disorder

III. Suicide

A. A common reason for suicide

1. Depression accounts for about half. Adjustment disorder, psychoses also contribute. Bipolar disorders disproportionately represented.

B. Lifetime risk of suicide

1. People with mood disorders = 19%; 55% were depressed before fatal attempt

C. The Prevalence of Suicide

1. Many people who commit suicide make their deaths look accidental
2. Eight people attempt suicide for every completed suicide
3. Suicide is 8th most common cause of death in United States

D. Groups at Risk for Suicide

1. Certain demographic variables are strongly correlated with suicide
2. The modal suicide *attempter* is native-born Caucasian woman, a homemaker in her 20s or 30s who attempts suicide by overdose and gives the reason as marital difficulties or depression
3. The modal suicide *completer* is native-born Caucasian man in his 40s or older, isolated, in ill health, depressed, and/or with marital difficulties; by shooting, hanging or carbon monoxide poisoning
4. Recent shifts have been observed in suicide-related variables, particularly with age and race
5. Teenage Suicide
    a. Suicide rate has risen 200% since 1960
    b. Teenagers exposed to situations as stressful as those facing adults, but lack resources such as emotional self-control
    c. Trouble within family another major risk factor
    d. Problems of suicidal teenagers rooted in families' problems; they feel there is no solution to their problems
    e. Black box warning for SSRIs; risk/benefit in adolescents/young adults, need for warning
6. Myths About Suicide
    a. "If they threaten, they won't do it": More than half clearly communicated their suicidal intent within 3 months of fatal act
    b. "From nowhere": About 40% made previous attempts or threats
    c. "No contact with healthcare": Majority saw primary caregivers within prior month for somatic or other vague complaint
    d. "Can't stop 'em": Most clinicians agree that encouraging patients to talk about suicidal wishes helps them overcome their wishes
7. Suicide Prediction
    a. Suicide is often directly related to stress; preceded by "exit" events

b. Cognitive variables, such as hopelessness, may be useful predictors
c. A suicidal scenario is made up of several elements
    i. Pain, related to thwarted psychological needs
    ii. Self-denigration
    iii. Constriction of thought processes
    iv. Sense of isolation
    v. Hopelessness
    vi. Decision that egression is only solution to problem
    vii. Access to means
d. Suicide notes express suffering and neutral statements
e. Most suicide attempters do not really wish to die but are communicating intensity of their feelings

8. Suicide Prevention
    a. Telephone hot lines established in later 1950s
    b. School-based workshops that cover warning signs
    c. Efforts have not been very successful, with only slight drops or not reaching those at risk for suicide

IV. **Theory of Etiology and Guidance for Therapy**

A. **The Psychodynamic Perspective**

1. Reactive Loss
    a. Depression was due to massive defense mounted by the ego against intrapsychic conflict (suicide, the extreme, as anger turned inward)
    b. Abraham suggests that depression arises when one loses a love object toward whom one had ambivalent feelings
        i. The positive feelings give rise to guilt
        ii. The negative feelings give rise to intense anger
        iii. Anger is turned inward, producing self-hatred and despair
    c. Modern theorists have revised theory
        i. Depression is rooted in a very early defects views of good and bad, self and other
        ii. The primal wound is reactivated by recent setback or blow and person re-experiences the infantile trauma
        iii. Regression leads to hopelessness and helplessness
        iv. Ambivalence towards self and others is a fundamental emotion
        v. Loss of self-esteem is primary feature of depression
        vi. Depression has debatable functional role – "withdrawal from situation for healing or solution-finding"
    d. Some research support for dependency on others and role of parental loss and poor parenting
2. Repairing the Loss
    a. Therapist helps patient uncover childhood roots of depression and to explore ambivalent feelings about lost object
    b. Interpersonal psychotherapy has been used and consists of identifying core problem and discussion of solutions through understanding relationship in the patient-therapist dyad

B. **The Behavioral and Interpersonal Perspective**

1. Extinction
    a. Many behaviorists regard depression as result of extinction of positive self-constructs
    b. Amount of positive reinforcement person receives is dependent on several factors
        i. Number and range of stimuli that are reinforcing to person
        ii. Availability of such reinforcers in the environment
        iii. Person's skill in obtaining reinforcement
    c. Some studies have produced supporting results
2. Aversive Social Behavior
    a. Depressives are more likely to elicit negative reactions from others
    b. This has formed basis for interpersonal theories of depression
        i. Depressives try to force caring behavior from others
        ii. Reactions tend to be ineffective, which aggravates their depression
        iii. Some studies have found that rejecting responses do maintain or exacerbate depression

iv. Poor social skills help to maintain depression

3. Increasing Reinforcement and Social Skills
    a. Treatments involve at increasing patient's rate of reinforcement
    b. Another approach is social-skills training
    c. Most behavioral treatments are multifaceted that include monitoring self-statements and training in variety of areas
    d. None of behavioral therapies is more effective than drugs
    e. With rise of cognitive therapy, behavioral therapies without cognitive components were abandoned

C. **The Cognitive Perspective**

1. The way the person thinks about himself/herself, the world, and the future gives rise to other factors in depression
2. Helplessness and Hopelessness
    a. Depression may be link to **learned helplessness,** where the critical factor is the expectation of lack of control over reinforcement
    b. Hopelessness theory says that depression depends on a helplessness expectancy and a negative outcome expectancy
    c. Source of expectations of helplessness and negative outcomes are the attributions and inferences people make about stressful life events
        i. Causes are permanent rather than temporary
        ii. Generalized rather than specific to one area of their functioning
        iii. Internal rather than external
3. Negative Self-Schema
    a. Negative bias--seeing oneself as a "loser" is fundamental cause of depression
    b. Stress can activate the negative schema
    c. Research finds that depressives have very negative self-schemas
    d. Studies indicate that depressives selectively attend to and remember more negative than positive information about themselves
4. Cognitive Retraining
    a. Multifaceted therapy developed to modify dysfunctional thinking and to change schemas
    b. In Beck's therapy, alteration of the schema inoculates the person against future depression
    c. Another treatment, reattribution training, is attempt to correct negative attributions
    d. Cognitive therapies have been found to be at least as effective as drug therapy and perhaps superior at 1-year follow-up
        i. Combining cognitive therapy and drug therapy may be superior
        ii. Cognitive therapy has relapse-prevention effect, unlike drug therapy

D. **The Sociocultural Perspective**

1. Society and Depression
    a. Durkheim saw suicide as an act that occurs within society and under control of society – "anomie" as one of four causes
    b. Socioeconomic conditions affect suicide rate
    c. Prevalence of depression in United States has increased and age of onset has dropped
        i. Social change may account for the prevalence
        ii. Family structures, moving away, moving down socioeconomic ladder may be related
2. Suicide prevention programs have not been especially effective
3. Perhaps better approach is to attack social problems associated with suicide such as delinquency, teenage pregnancy, and family distress

E. **The Neuroscience Perspective**

1. Genetic Research
    a. Family studies suggest genetic component in mood disorders; first-degree relatives of those with mood disorder are more likely to develop disorders
    b. Concordance rates for bipolar disorder: 72% among MZ twins and 14% for DZ; for unipolar disorder: 40% for MZ twins and 11% for DZ
    c. Genetic factors are more important in bipolar disorder than in depression
    d. Environmental factors such as individual-specific environments are important; less important are shared environmental factors
    e. Adoption studies provide most impressive evidence for the heritability of mood disorders

f. Linkage analysis provides mixed results

2. Neurophysiological Research
   a. Mood disorders may be related to biological rhythms such as sleep disturbances like shortened REM latency
   b. One theory suggests that when important social zeitgeber is removed from person's life, its removal is a loss but also disrupts body's circadian rhythms leading to consequences
   c. **Seasonal Affective Disorder(SAD)** is closely related to biological rhythms
      i. For diagnosis of SAD, person must meet criteria for major depressive episode, remission and onset tied to seasons, pattern must have lasted for at least 2 yrs
      ii. Winter version of SAD tied to shorter photoperiod
      iii. Women are at greater risk with average age at onset of 23
      iv. Theory suggests that lag in circadian rhythms causes SAD
      v. Most SAD patients report improvement with light therapy
3. Neuroimaging Research
   a. CT and MRI studies suggest mood disorders involve abnormalities in brain structure and function (e.g., ventricles, frontal lobe, cerebellum, basal ganglia)
   b. Suggests that these brain areas are involved in mood regulation
4. Biochemical Research
   a. Hormone Imbalance
      i. Depression associated with malfunction in hypothalamus
      ii. Mood related to dyscontrol of hormone production
      iii. Depression treatments enhanced by hormone supplement
      iv. Hormone imbalances are characteristic of endogenous and psychotic depression; steroids commonly alter mood
      v. **Dexamethasone suppression test** used to differentiate between endogenous and reactive cases
      vi. Hormone imbalances occur both in major depression and in depressive episodes of bipolar disorder, but does not seem to be a primary cause
   b. Neurotransmitter Imbalance
      i. Catecholamine hypothesis argues that increased levels of norepinephrine produce mania, whereas decreased levels produce depression
      ii. Tricyclic drugs block reuptake of norepinephrine and serotonin
      iii. Serotonin involved in mood disorders and suicide by indirect evidence
      iv. Another theory suggests that atrophy of certain neurons in the hippocampus triggers depression; antidepressant drugs may influence brain-derived neurotrophic factor
5. Antidepressant Medication
   a. The major classes of antidepressant medication are **Monoamine Oxidizers (MAO) inhibitors, tricyclic antidepressants (TCAs), and selective serotonin reuptake inhibitors (SSRIs)**
   b. Drugs work by increasing levels of neurotransmitters by interfering with an enzyme or by inhibiting transmitter reuptake in synapse
   c. Balancing symptoms' relief with side effect an important consideration
   d. Tricyclics effective 50-70% of patients with depression
   e. Selective serotonin reuptake inhibitors
      i. Probably less effective than TCA's, but less side effects
      ii. Black box warning for suicide, requires informed consent and close monitoring.
      iii. Significant CYP-450 interactions
   f. Main antimanic drug is **lithium (lithium carbonate)**
      i. Effective in ending about 70% of manic episodes
      ii. Lithium's effectiveness is primarily preventive
      iii. Regular blood tests important to monitor level of drug, renal function, TFTs
6. Electroconvulsive Therapy (ECT)
   a. Seizure activity following electric current to frontal regions in **electroconvulsive therapy** can relieve severe depression
   b. Versions have included unilateral and bilateral ECT; both highly effective
   c. Treatment can involve 9 or 10 sessions over period of several weeks to months
   d. Most common side effect is memory dysfunction; probably worse with bilateral
   e. Variations in side effects have been found when using unilateral vs. the bilateral methods

f. Many patients are very frightened of ECT
g. Multiple sessions of ECT usually required, one single session ineffective
h. Monthly maintenance recommended if depression reoccurs