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MOOD DISORDERS

Mood disorders are **p**sychological disorders characterized by prolonged and marked disturbances in mood that affect how people feel, what they believe and expect, how they think and talk, and how they interact with others. DSMIV-TR distinguishes between two categories of mood disorders: depressive disorders and bipolar disorders. Depressive disorders are mood disorders in which someone's mood is consistently low; in contrast, bipolar disorders are mood disorders in which a person's mood is sometimes decidedly upbeat, perhaps to the point of being manic, and sometimes may be low.

DSM-IV-TR defines four types of episode of a mood disorder: major depressive episode, manic episode, hypomanic episode, and mixed episode.

These are the four building blocks for diagnosing bipolar disorders.

1. A major depressive episode involves symptoms of severe depression that lasts for at least 2 weeks.

2. A manic episode involves elated, irritable, or euphoric mood (mood that is extremely positive and may not necessarily be appropriate to the situation).

3. A hypomanic episode involves elated, irritable, or euphoric mood that is less distressing or severe than mania and is different than the individual's non depressed state. That is, how a person behaves during a hypomanic episode is different from his or her usual state. Two key features distinguish manic and hypomanic episodes: (1) Hypomania does not impair functioning; mania does. (2) Symptoms of a hypomanic episode must last for a minimum of 4 days, compared to 1 week for a manic episode.

4. A mixed episode involves symptoms of both a major depressive episode and a manic episode. Prominent symptoms usually include agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. 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 (1) depressed mood or (2) loss of interest or pleasure

(1) 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).

(2) 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)

(3) 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.

(4) Insomnia or Hypersomnia nearly every day.

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) 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

B. The symptoms do not meet criteria for a mixed episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one. The symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

According to DSM-IV-TR, once someone's symptoms meet the criteria for a major depressive episode, he or she is diagnosed as having **major depressive disorder (MDD) or unipolar depression**—five or more symptoms of an MDE lasting more than 2 weeks. But, more than half of those who have had a single depressive episode go on to have at least one additional episode, noted in DSM-IV-TR as MDD, recurrent depression. Some people have increasingly frequent episodes over time, others have clusters of episodes, and still others have isolated depressive episodes followed by several years without symptoms.

The DSM-IV-TR criteria list includes specifiers—specific sets of symptoms that occur together or in particular patterns. Specifiers help clinicians and researchers identify variants of a disorder, which is important because each variant may respond best to a particular treatment or have a particular prognosis.

- Depression with melancholic features includes complete anhedonia—the patient doesn't feel any better after positive events. When a patient experiences depression with melancholic features, the symptoms usually fluctuate during the day—he or she typically wakes early in the morning, feels worse in the morning, and loses his or her appetite.

- In contrast, atypical depression is characterized by depressed mood that brightens when good things happen, along with at least two of the following: hypersomnia, increased weight gain, heavy feelings in arms or legs, and persistent sensitivity to perceived rejection by others. Atypical depression is likely to respond to different medications than is depression with melancholic features.

➢ Symptoms of depression may also include catatonic features, which are specific motor symptoms—rigid muscles that hold odd postures for long periods of time, or a physical restlessness.

➢ Although not common, depression can occur with psychotic features—hallucinations (e.g., in which a patient can feel that his or her body is decaying) or delusions (e.g., in which the patient believes that he or she is evil and living in hell).

➢ Sometimes recurrent depression follows a seasonal pattern, occurring at a particular time of year. Referred to as **seasonal affective disorder (SAD)**, this disorder manifests itself in two patterns:

• Winter depression is characterized by recurrent depressive episodes, hypersomnia, increased appetite (particularly for carbohydrates), weight gain, and irritability. These symptoms begin in autumn and continue through the winter months. The symptoms either disappear or are much less severe in the summer. Winter depression often can be treatedeffectively with **phototherapy** (also called light-box therapy), in which full-spectrum lights are used as a treatment.

• Summer depression, which is less common, tends to appear in late spring. Symptoms often include poor appetite and weight loss, less sleep, and psychomotor changes. Treatment for summer depression usually includes antidepressant medication.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. 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.

B. Presence, while depressed, of two (or more) of the following:
(1) poor appetite or overeating
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No major depressive episode has been present during the first 2 years of the disturbance
(1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic major depressive disorder, or major depressive disorder, in partial remission.

E. There has never been a manic episode, a mixed episode, or a hypomanic episode, and criteria have never been met for cyclothymic disorder

F. The disturbance does not occur exclusively during the course of a chronic psychotic disorder, such as schizophrenia or delusional disorder

G. The symptoms are not due to the direct physiological effects of a substance or a general medical condition

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

CAUSAL FACTORS OF DEPRESSION

- Neurological factors related to depression include low activity in the frontal lobes, and implicate abnormal functioning of various neurotransmitters (dopamine, serotonin, and norepinephrine). The stress–diathesis model of depression highlights the role of increased activity of the Hypothalamic- Pituitary –Adrenal (HPA) axis and of excess cortisol in the blood; an overreactive HPA axis is thought to affect serotonin activity and impair the functioning of the hippocampus. People with atypical depression have the opposite pattern—decreased activity of the HPA axis. Genes can play a role in depression, perhaps by causing a person to have disrupted sleep patterns or by influencing how an individual responds to stressful events, which in turn affects activity of the HPA axis.

- Psychological factors that are associated with depression include a bias toward paying attention to negative stimuli, dysfunctional thoughts (including cognitive distortions related to the negative triad of depression- hopelessness, helplessness, worthlessness), rumination, a negative attributional style (particularly attributing negative events to internal, global, and stable factors), and learned helplessness.

- Social factors that are associated with depression include stressful life events, social exclusion, and problems with social interactions or relationships (particularly for people who have an insecure attachment). Culture and gender can influence the specific ways that symptoms of

depression are expressed.

• Neurological, psychological, and social factors can affect each other through feedback loops. According to the stress–diathesis model, abuse or neglect during childhood (a stressor) and increased activity in the HPA axis can lead to overreactive cortisol-releasing cells (a diathesis), which respond strongly to even mild stressors. Psychological factors can create a cognitive vulnerability to depression, which in turn can amplify the negative effects of a stressor and change social interactions.

TREATMENT FOR DEPRESSION

• Biomedical treatments that target neurological factors for depressive disorders are medications (SSRIs, SNRIs, etc) and brain stimulation like Electro convulsive therapy.

• Treatments for depression that target psychological factors include CBT (particularly with behavioural activation).

• Treatments that target social factors include Interpersonal therapy and family systems therapy.

MANIC EPISODE

The hallmark of a **manic episode**, is a discrete period of at least 1 week of abnormally euphoric feelings, intense irritability, or an expansive mood.

During an **expansive mood**, the person exhibits unceasing, indiscriminate enthusiasm for interpersonal or sexual interactions or for projects. Typically, a manic episode begins suddenly, with symptoms escalating rapidly over a few days; symptoms can last from a few weeks to several months. Compared to major depressive episode, a manic episode is briefer and ends more abruptly.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. 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:

(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor
agitation
(7) 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)

C. The symptoms do not meet criteria for a mixed episode.

D. 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 hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

The presence of different types of mood episodes—different building blocks—leads to different diagnoses. According to DSM-IV-TR, there are two types of bipolar disorder: bipolar I disorder and bipolar II disorder. The presence of manic symptoms—but not a manic episode—is the common element of the two types of bipolar disorder. The types differ in the severity of the manic symptoms. To receive the diagnosis of the more severe bipolar I disorder, a person must have a manic or mixed episode; a major depressive episode may also occur with bipolar I. Thus, just as major depressive episode automatically leads to a diagnosis of MDD, having a mixed or manic episode automatically leads to a diagnosis of bipolar I.

In contrast, to be diagnosed with bipolar II disorder, a person must alternate between hypomanic episodes and major depressive episodes; bipolar II can be thought of as less severe because of the absence of manic episodes.

DSM-IV-TR DIAGNOSTIC CRITERIA

A. Presence (or history) of one or more major depressive episodes.

B. Presence (or history) of at least one hypomanic episode.

C. There has never been a manic episode or a mixed episode.

D. The mood symptoms in Criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

CAUSAL FACTORS OF BIPOLAR DISORDERS.

• Neurological factors that are associated with bipolar disorders include an enlarged and more active amygdala. Norepinephrine, serotonin, and glutamate are also involved. Bipolar disorders are influenced by genetic factors, which may influence mood disorders in general.

• Psychological factors include the cognitive distortions and negative thinking associated with depression. Moreover, some people with bipolar I disorder may have residual cognitive deficits after a manic episode is over.

• Social factors that are associated with bipolar disorders include disruptive life changes and social and environmental stressors.

• The different factors create feedback loops that can lead to a bipolar disorder or make the patient more likely to relapse.

TREATMENT FOR BIPOLAR DISORDERS

• Treatments that target neurological factors include lithium and anticonvulsants, which act as mood stabilizers. When manic, patients may receive an antipsychotic medication or a benzodiazepine. Patients with a bipolar disorder who have major depressive episodes may receive an antidepressant along with a mood stabilizer.

• Treatment that targets psychological factors—particularly CBT—helps patients recognize warning signs of mood episodes, develop better sleeping strategies, and, when appropriate, stay on medication.

• Treatments that target social factors include interpersonal and social

rhythm therapy (IPSRT), which can increase the regularity of daily events and decrease social stressors; family therapy, which is designed to educate family members about bipolar disorder, improve positive communication, and decrease criticism by family members; and group therapy or a self-help group, which is intended to decrease shame and isolation.