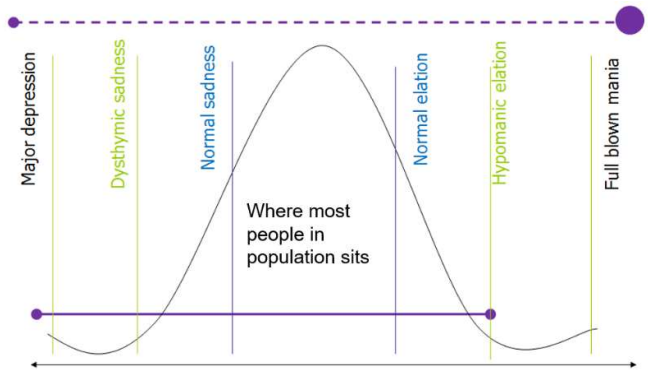
7. Mood Disorders (18 Apr, LP)

Types of Mood Disorders

- Mood disorder is an affective disorder when a group of individuals experience unusual deviations in their mood that can be unusually low (depression), high (mania) or fluctuating between the two (bipolar).
- Unipolar: one polar mood i.e. depression
    - Further divided into Major Depressive Disorder or Dysthymia
- Bipolar: two polar moods fluctuating between periods of depression and mania
    - Further divided into Bipolar I, Bipolar II or Cyclothymia
- Mood lies on a continuum and even in non-clinical population, we fluctuate between feeling down to feeling happy to 50-50 depending on the situation.
    - Mood mostly lies between range of normal sadness/elation and only small proportion moves towards the extremes
    - It's not unusual for mood to fluctuate and for us to experience periods of when we are concerned about our mood.



Depression

- First recognised by Egyptians
- Hippocrates: people thought that mental disorders were due to overabundance of bodily fluids
    - Depression treatment was to refrain from doing anything excessively lest the body becomes overactive and produces more toxic black bile
- Depression is a normal human emotion characterised by feelings of sadness, despair or unhappiness.
    - Grief is an appropriate affective sadness in response to recognised external loss. It's not necessarily a concern when realistic, appropriate to what has been lost and self-limiting.
    - Grief becomes a concern if prolonged, out of proportion and increased intensity of sadness.
- Clinical vs 'normal' depression
    - Intensity: mood change pervades all aspects of the person and impairs socio-occupational function
        - People with depression think that their depression is always with them all the time
        - Depression makes it difficult to do daily activities e.g. get out of house, leave bed, etc.
    - Absence of precipitants: mood may develop in the absence of any discernible precipitants or be grossly out of proportion to precipitants
        - Some people can tell what their depression is triggered by e.g. life events, but sometimes it comes out of nowhere e.g. 'Life is great, but I just feel unhappy'
        - Precipitants can help normalise the experience or put strategies in place to mitigate the experience, so it's absence makes it harder to work on.
    - Quality: mood change is different from that experienced in normal sadness
        - Third parties can feel the sadness and lack of energy feeling from them
        - E.g. heavy feeling after talking to affected individual
    - Associated features: accompanying signs and symptoms including somatic and cognitive features
        - Hypersomnia: feeling more fatigued so they need more sleep
        - Insomnia: rumination occupies the mind
        - Appetite changes: overeating or not eat
        - Unable to make decisions
        - Slower thinking and frequent drifting in thoughts
        - Low self-esteem and sense of self-worth
        - Psychomotor changes requiring more physical effort to do normal things
        - Higher level of agitation
        - Suicidality
- DSM divides depressive disorders into several subtypes.

Disruptive Mood Dysregulation Disorder (DMDD)

- Severe recurrent temper outbursts manifested verbally (e.g. verbal rages) and/or behaviourally (e.g. physical aggression) that are grossly out of proportion in intensity or duration to the situation to provocation
- Temper outbursts inconsistent with developmental level
- Mood between temper outbursts persistently irritable or angry most of the day, nearly every day, and is observable by others e.g. parents, teachers, peers.
    - While children's moods fluctuate greater than adults, kids with DMDD are mostly irritable all the time.
- There were increases in diagnosis of bipolar disorder in children (<18) but no criteria for bipolar diagnosis has been established, so they replaced DMDD criteria with irritability and anger for children.
    - Pathologizes normal children behaviour and the diagnosis for aggression and temper problems could restrict the clinician's thinking and neglect environment as a factor for child's behaviour

Major Depressive Disorder (MDD)

- Episodic disorder; short-term but intense
- ≥5 of the following symptoms over a 2-week period representing a change from previous functioning:
    1. Depressed mood most of the day, nearly every day;
    2. Markedly diminished interest or pleasure in activities;
    3. Significant weight loss when not dieting or weight gain;
    4. Insomnia or hypersomnia nearly every day;
    5. Psychomotor agitation or retardation;
    6. Fatigue or loss of energy;
    7. Feelings of worthlessness or excessive/inappropriate guilt;
    8. Diminished ability to think or concentrate, or indecisiveness;
    9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation, or a suicide attempt or a specific plan for committing suicide.
- 1 and 2 has to be present.
- Brodaty et al. (2001): 25-year follow-up of individuals with MDD
    - Average of 3 depressive episodes over 25 years
    - Some recovered and remained continuously well
    - Vast majority experienced recurrences of illness (more than one episode of depression)
    - Small minority experienced unremitting course (experienced depression over 25 year period) or committed suicide
- Musliner et al. (2016):
    - Participants born in Denmark 1955 or later, with first recorded MDD diagnosis >40 yo and followed for 10 years from date of initial MDD diagnosis
    - Very similar results to Brodaty's findings; 4 longitudinal courses of MDD
    - Some people may have one episode of major depression but never again, possibly due to effective professional help and experience is one-off

Persistent Depressive Disorder (PDD)

- Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others for at least 2 years
- Presence of ≥2 of the following:
    - Poor appetite or overeating.
    - Insomnia or hypersomnia.
    - Low energy or fatigue.
    - Low self-esteem.
    - Poor concentration or difficulty making decisions.
    - Feelings of hopelessness
- PDD can be lower in intensity than MDD but feeling is more persistent
    - PDD can be associated with higher levels of dysfunction and disability than episodic experiences

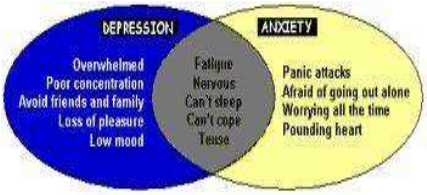
- Course:
    - MDD may precede or occur during PDD
    - PDD often precedes and may be a risk factor for MDD
    - Effects on socio-occupational functioning is as great, if not greater than MDD.

Protective factors (Kaelber et al., 1995)

- If you are of good physical health, you are likely to have better mental health.
- Physical appearances: exercise, normal body weight, being physically attractive
- Car ownership i.e. having financial resources and capacity to surround themselves in things that are not just the basic things they need to have
- Genetics: can be compensated by other physical things
- Old age: unlikely to start getting depressive episodes later in life when completely healthy
- Positive social support: welcoming and supportive emotional sharing with community

General Comorbidities

- People who are depressed are likely to experience another mental illness



- Overlap between depression and anxiety is the greatest and can be on the symptomology level, but may also reflect in terms of life course of individual
    - Transdiagnostic models thinks that we should look at the common underlying features and address them to address comorbidity between disorders
- High comorbidity between physical and mental health problems
    - At least half of depressive disorders seen in primary care occur in patients with other major medical disorders
    - Depression can be precipitated by medical conditions and medical treatment
- Feelings of hopelessness and low self-worth stemming from depression can interact with suicidality
    - Up to 60% of suicides are associated with a mood disorder

Causes

- Genetics:
    - Risk of depression in first-degree relatives of patients with unipolar major depression 5-25%
    - Heritability of unipolar depression 40-70%
- Neurobiology
    - NT implicated in development and maintenance of depression, but not sure exactly how
    - NT possibly interact with one another and increasing emphasis is put on stress hormones and the role of these neurochemicals and hormones in precipitating and maintaining depression
- Stressful events:
    - Most people do not become depressed if they experience a stressful event, so individual differences e.g. resilience can affect our stress responses
    - Stress generation: exposure to increased levels of stressors predicts recurrence of depression in self-perpetuating cycle of stress and depression.
        - Factors contributing include effects of depression itself and potential for conflict and loss
    - Depressed individuals 'select themselves' into stressful environments e.g. domestic violence victims leaving the abusive relationship may face financial stress and other difficulties so they choose to stay in the environment.
        - Not blaming, but proposes that situation may contribute to the stress as well
- Personality factors: not fully causative

Cognitive model of depression (Beck, 1976)

- Many people with depression didn't respond well to psychoanalytic therapies, so Beck thought that maybe the treatment needs to consider existing beliefs and thoughts.

- Depression results from the tendency to interpret everyday events as negative.
- Three main cognitive components to the maintenance and aetiology of depression:
  - Negative automatic thoughts (NATs)
  - Systematic logical errors
  - Depressogenic schemas

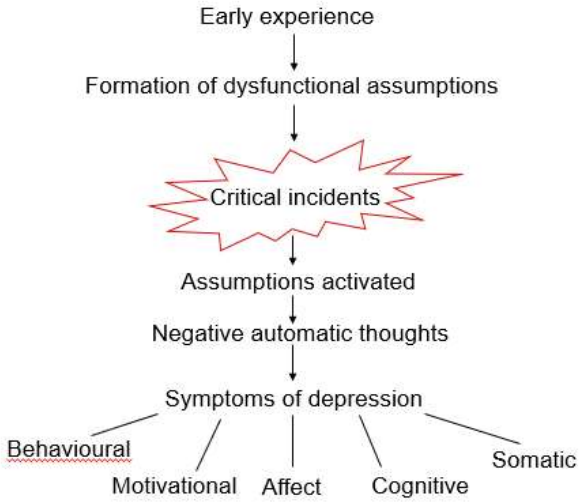
- NATs: automatic, unprompted, immediate, unchallenged
  - Negative thoughts about self (I am a failure)
  - Negative thoughts about the world (this neighbourhood is a dump)
  - Negative thoughts about the future (Everything will be bad forever)

- Depressogenic schemas/core beliefs
  - Enduring assumptions that represent the way an individual organises their past and current experiences
  - Develop over many years and may not be evident to the individual
    - Can be influenced by childhood experiences, or observation of other people's experiences
  - Activated by stressful circumstances (stress-diathesis model)
  - Examples:
    - Fear of losing control
    - Fear of abandonment; "I must do well at everything I do, or I will be rejected"
    - Social undesirability; "if someone thinks badly of me I cannot be happy"
    - Incompetence
    - Deserve to be punished

- Systematic logical errors
  - Black and white thinking with no grey area.
  - Conclusions about the self, world, and the future reached by flawed logical structuring of ideas
    - All-or-nothing thinking
    - Mental filtering
    - Should statements
    - Personalisation
    - Mental filtering

- Cognitive Behavioural Therapy (CBT)
  - Targets NATs and underlying assumptions
  - Unpacks NATs and look at evidence against them to reshape the thoughts people have against themselves

- Cognitive model doesn't acknowledge genetics, culture and social contexts and is strictly cognitive, so there is no indication of how they respond to treatment.



Premenstrual Dysphoric Disorder

- In majority of menstrual cycles, presents at least 5 symptoms in final week before onset of menses and start to improve within a few days of onset and become minimal or absent in the week post.
    - Marked affective lability e.g. mood swings
    - Marked irritability or anger or increased interpersonal conflicts
    - Marked depressed mood, feelings of hopelessness or self-deprecating thoughts
    - Marked anxiety, tension, and/or feelings of being keyed up or on edge
- One (or more) symptoms of depression must also be present
- Standard for diagnosis PMDD is observation duration over 3 months as one bad month isn't indicative of a real problem so there needs to be effort on both clinician and patient's sides.
- Differentiates between gender in a very clear way.
- History of interpersonal trauma may increase risk of PDD.

Post-natal Depression

- MDD coinciding with post-natal period; not a standalone diagnosis in DSM.
- Risk factors associated with pregnancy:
    - Stressful pregnancy: increased anxiety related with mood impacts
    - Depression during current pregnancy
    - Prolonged labour and/or delivery complications
    - Problems with baby's health
    - Difficulty breastfeeding
    - Having an unsettled baby i.e. difficulties with feeding and sleeping
    - Having unrealistic expectations about motherhood
- Other risk factors:
    - Past history of depression and/or anxiety
    - Family history of mental disorders
    - Lack of practical, financial, and/or emotional support
    - Past history of abuse
    - Difficulties in close relationships
    - Being a single parent
- Post-natal depression can affect mother's relationship with their child, especially if prolonged into early childhood, and may turn into complications for the child's mental health due to a rough early childhood experience.

Mania

- Mania is abnormally and persistently elevated, expansive, or irritable mood.
    - Irritability is particularly evident when things don't go as they planned
    - Expansive quality of mood characterised by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions
    - Mood is almost infectious and being around someone who is manic can be wearing and tiring due to constant alertness for irrational behaviour.
- Other features:
    - Inflated self-esteem: range from uncritical self-confidence to delusional-intensity grandiosity
    - Decreased need for sleep
    - Pressured speech
    - Racing thoughts
    - Distractibility; cannot follow flow of things
    - Increase in goal-directed activities
    - Psychomotor agitation e.g. fidgeting, not being able to sit still, shaking

Manic episode

- Distinct period of mania lasting at least 1 week (or any duration if hospitalisation is necessary)
- During period of abnormality, presence of following symptoms to a significant degree
    - Agitated, excessively goal directed
    - Flight of ideas: cannot focus on one idea
    - Distractibility
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep
    - Excessive involvement in activities with high potential for painful consequences
- Mania can be a side effect of some drugs (e.g. cocaine, stimulants, antidepressant drugs), medical conditions (e.g. tumours, metabolic disturbance), and medication (e.g. L-dopa).
    - Makes it difficult to prescribe medication because you're unsure of how patient would respond to the drug

Hypomanic episode

- Distinct period of mania lasting at least 4 consecutive days and present most of the day, nearly every day
- A manic episode with lower intensity but more prolonged per episode
    - Episode is associated with a change in functioning that is uncharacteristic of individual
    - Disturbance in mood and change in functioning are observable by others
    - Episode not severe enough to cause marked impairment in socio-occupational functioning or to necessitate hospitalisation

Bipolar disorders

- Bipolar 1 Disorder (BP1): one or more manic episodes usually (but not always) accompanied by major depressive episodes
    - Most frequent symptoms during depressive episodes: dysphoria with anhedonia, suicidial ideation, loss of energy.
- Bipolar 2 Disorder (BP2): one or more depressive episodes accompanied by at least one hypomanic episode
- Cyclothymic disorder: at least 2 years of numerous periods of hypomanic and depressive symptoms that do not meet threshold for manic or depressive episodes
- Epidemiology:
    - Very few report of a one-off episode or chronic, deteriorating illness
    - Majority described multiple episodes with good or partial inter-episode recovery

Bipolar I disorder

- Course of illness:
    - Can have distinct manic and depressive phases or mixed presentations i.e. some manic and depressive symptoms together
    - Can have clear-cut restoration of functioning in between episodes, but also rapid cyclers.
        - Rapid cyclers can rapidly change presentation between manic and depressive presentations with almost no time in between.
    - If not treated, 4 very consistent trajectories:
        - Length of normal periods between episodes decreases
        - Length of each episode increases
        - Depressed phases become more likely
        - Suicidality is a major risk factor in depressed phase but also a problem in manic
- Comorbidity: highly comorbid with anxiety disorders, behaviour disorders, and substance use disorders
- Bipolar disorder is the 6th leading cause of disability worldwide and utilises a lot of healthcare services, usually resulting from behaviour caused by mania phase e.g. reckless behaviour

Aetiology

- Genetic studies:
  - Concordance rates for MZ twins 57%, DZ twins 14%
  - 4x greater risk of children developing bipolar if parents are bipolar
- Neurotransmitter dysregulation:
  - Dysregulation in dopamine and serotonin systems interact with deficits in other NT systems e.g. GABA and substance P to produce symptoms of mood disorders
- Psychological models:
  - Manic-defence model:
    - Psychodynamic model; mania is a defence against loss and painful negative things about self
    - Limited support: negative life events and negative cognitive style do not predict mania
  - Goal dysregulation:
    - Mania may result from excessive goal engagement or reward sensitivity and increased sensitivity of dopaminergic reward pathways
  - Schedule disruption:
    - Social-rhythm disturbance may contribute to triggering manic episode
    - Possibly involvement of dopamine

Suicide prevention

- Bipolar disorder is associated with higher rates of suicide than any other psychiatric disorder
  - Younger age, comorbid personality disorder, and previous suicide attempts are predictors.
- Risk factors and protective factors can be considered on:
  - Individual or personal level
  - Social level
  - Contextual level
  - Modifiable and non-modifiable
  - Distal and proximal