3rd and 4th lectures – 09/03/16

- Mood disorders are a group of disorders in which an individual feels a deviation in their mood and emotional experience of the world. We are thinking about high and low moods. Mood is a related concept to emotion.
- **Unipolar**- one polar mood, which is 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, II, or cyclothymia. This depends on the intensity of the mood change and how rapid the moods change.
- **Mood disorders** may be thought of as on a continuum. The continuum goes from major depression, dysthymic sadness, normal sadness, normal elation, hypomanic elation, and full-blown mania.
- **Depression** was first recognised by the Egyptians. Hippocrates thought of depression as a toxic overabundance of black bile, and that treatment was for abstinence from all excesses.
- 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 should be realistic, appropriate to what has been lost, and self-limiting (also known as uncomplicated bereavement).
- Some people may have grief responses that are debilitating, but this is relatively rare. More complicated bereavement is judged on intensity and how much functionality is diminished.
- Clinical vs. normal depression- **Intensity**- the mood change pervades all aspects of the person and impairs social and occupational function.
- **Absence of precipitants-** mood may develop in the absence of any discernible precipitants or be grossly out of proportion to precipitants.
- **Quality-** the mood change is different from that experienced in normal sadness.
- **Associated features-** the mood change might be accompanied by a cluster of signs and symptoms including somatic and cognitive features.
- **Disruptive mood dysregulation disorder-** recurrent temper outbursts grossly out of proportion in intensity and duration to the situation or provocation. Temper outbursts are inconsistent with developmental level. They occur average three times a week. Meet is persistently irritable or angry most of the day, nearly every day, and is observable by others.
- **Background of disruptive mood dysregulation disorder**- there was an increase in diagnosis of bipolar disorder in children noticed in late 90s and 2000s. There were no criteria for diagnosis in children established. Researchers made up criteria- replacing manic or hypomanic episode (adult) with irritability and anger. At the same time- new antipsychotics released- thought to be beneficial for bipolar- so clinicians started prescribing.
- This disorder was added to the DSM-V for the first time with the focus on more discussion about this matter. There is controversy about this disorder, is it might be pathologising normal development, might increase medication use when little trial has happened, and might ignore root causes of the patient's malady.

- **Major depressive disorder-** depressed mood for most of the day, nearly every day; decreased pleasure and interest in activities; significant weight loss or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive/inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; recurrent thoughts of death/suicide. It is an episodic disorder
- **Persistent depressive disorder/dysthymic disorder-** 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 two years. Presence, while depressed, of tow or more of the following: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness.
- **Epidemiology-** national survey of mental health and wellbeing (2000)- 12-month prevalence of depressive disorders: 5.8% of adult population (7.4% women, 4.2% men). Major depression is the leading cause of disability worldwide, and was the fourth contributing disease to burden to society.
- **Protective factors-** exercise, normal body weight, car ownership, being physically attractive or tall, genetic factors, old age, positive social support.
- **Brodaty (2001)-** 25 year follow-up of individuals with MDD- average of 3 depressive episodes over 25 years; 12% recovered and remained continuously well; 84% experienced recurrence of illness; 2% experienced unremitting course; 2% suicided. Degree of recovery depends on age of onset, responses to treatment, how quickly people get treatment etc.
- **Musliner (2016)-** Danish people that were diagnosed between 1995 and 2002. Participants followed for 10 years from date of initial MDD diagnosis. There are four trajectories of MDD.
- MDD may precede persistent depressive disorder. MD episodes may occur during persistent depressive disorder. PDD often precedes MDD and may be a risk factor for MDD. There are effects on social and occupational functioning as great if not greater than MDD.
- 60% of people with depression seek treatment in Australia.
- **Overlap with anxiety disorders-** people that experience depressive disorders are likely to experience other disorders, including anxiety disorders. There may be underlying factors as to why comorbidity occurs.
- At least half of people with MDD in primary care have another major medical disorder. Depression can be precipitated by medical conditions and medical treatment. Up to 60% of suicides are associated with a mood disorder (75% of adolescent suicide). Caused in large part by feelings of hopelessness.
- **Causes of depression- genetics-** risk of depression in first-degree relatives of patients with unipolar major depression of 5-25%. Heritability of MDD is 40-70% (Lesch, 2004).
- **Neurobiology-** serotonin, dopamine, noradrenaline, stress hormones (cortisol, acetylcholine).
- **Stressful events-** stressors 2.5 times more likely in depressed patients than controls. In community samples, 80% of depressed cases were preceded by major life event. 'Loss' experiences appear particularly important. Stress generation- role of the individual in contributing towards stress occurrence.

- Hammen (2001)- women with depression are much more likely to experience high levels of episodic-like events to which they had contributed than women with bipolar, medical illness or no health problems. Finding repeated in studies with other depressed groups.
- **Personality factors-** neuroticism, introversion, negative self-esteem/self-schema, interpersonal sensitivity.
- **Vulnerability to depression** is influenced by genetic vulnerability and early loss vulnerability, recent stress, depressed physical state, depressed relationships, depressed action, depressed thinking (maintaining factors). Cognitive model of depression- Beck's ABC model.
- **Beck's cognitive model-** three main cognitive components to the maintenance and aetiology of depression. These include negative automatic thought (NATs), systematic logical errors, and depressogenic schemas (core beliefs)
- **Negative automatic thoughts-** automatic, unprompted, immediate, unchallenged. Negative triad: 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-** enduring assumptions that represent the way an individual organises their past and current experience. They develop over many years and may not be evident to the individual. They are activated by stressful circumstances (diathesis-stress model).
- **Examples of depressogenic schemas-** fear of losing control, fear of abandonment, social undesirability, incompetence, deserve to be punished, 'I must do well in everything I do or I will be rejected', 'if someone thinks badly of me I cannot be happy'.
- **Systematic logical errors-** conclusions about the self, the world and the future are reached by 'all-or-nothing' thinking, mental filtering, should statements, personalization, mental filtering etc.
- **Beck's cognitive model of depression-** early experience, formation of dysfunctional assumptions, critical incidents, assumptions activated, negative automatic thoughts, symptoms of depression (behavioural, motivational, affect, cognitive, somatic).
- **CBT for depression-** targets negative automatic thoughts and underlying assumptions. It also incorporates basic problem solving, assertiveness training, and activity scheduling.
- **Premenstrual Dysphoric Disorder-**
- A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
- B. Also, one or more of the following: marked affective lability (mood swings, feeling suddenly sad or tearful, increased sensitivity to rejection), 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.
- C. One or more must be additionally present to reach a total of five symptoms when combined with B: decreased interest in usual activities, subjective difficulty in concentration, lethargy, easy fatigability, marked lack of energy, marked change in appetite; overeating, or specific food cravings, hypersomnia/insomnia, a sense of

being overwhelmed or out of control, physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of 'bloating', or weight gain.

- Premenstrual psychological and physical distress described since Hippocrates; a form of PDD has been included since DSM-III-R, but in appendix requiring further research. A range of prevalence rates have been reported; DSM-IV work groups recommended prospective daily ratings- gold standard assessment approach.
- Prevalence rates range from 1-8% of women depending on sampling and assessment methods. Heritability of premenstrual symptoms 30-80%, history of interpersonal trauma may increase risk of PDD; prevalence of non-fatal suicidal behaviours increased in a graded fashion according to PMDD status (Pilver, 2013). Treatment includes SSRIs, hormones, CBT etc.
- **Post-natal depression-** 50-80% of women experience baby blues in the first week following birth; one in seven women experience more enduring and bigger impact.
- **Risk factors-** past history of depression and/or anxiety, stressful pregnancy, depression during the current pregnancy, family history of mental disorders, experiencing severe 'baby blues', prolonged labour and/or delivery complications, problems with baby's health, difficulty breastfeeding, lack of practical, financial, and/or emotional support, past history of abuse, difficulties in close relationships, being a single parent, having an unsettled baby, having unrealistic expectations about mother hood including that mothers bond with their babies straight away, mothers know instinctively what to do, and motherhood is a time of joy, moving house, making work adjustments (stopping and re-starting work).
- **Mania-** abnormally and persistently elevated, expansive or irritable mood. Expansive quality of mood characterised by unceasing and indiscriminate enthusiasm for interpersonal, sexual or occupational interactions. Other features include inflated self-esteem (ranging from uncritical self-confidence to delusional intensity grandiosity), decreased need for sleep, pressured speech, racing thoughts, distractibility, increase in goal-directed activities, psychomotor agitation.
- **Manic episode-** distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalisation necessary). Same as above
- **Hypomanic episode-** less intense episodes. For at least 4 days, not requiring hospitalisation does not cause marked impairment in social, occupational activities. May precede or follow MD episode, or may be a precursor or full mania. BP1 is mania, and BP2 is hypomania. Cyclothymic disorder is at least 2 years of numerous periods of hypomanic and depressive symptoms that do not meet threshold for manic or depressive episodes.
- **Epidemiology-** 0.4-1.7%; cyclothymia 5-6%; hypomania- 3-5%. Age of onset is average 18 for 1 and 20 for 2. Period of risk is 15-60 years. Very few report a single episode. 18% described continuous symptoms. Majority described multiple episodes with good or partial recovery. (30%).
- **Most frequent symptoms-** elevated or irritable mood, excessive activity, racing thoughts, reduced need for sleep (manic); depressive- dysphoria and anhedonia, suicidal ideation, loss of energy, poor concentration, initial insomnia, diminished libido.
- Almost 90% of BP1 have psychotic symptoms. 20% had hallucinations and 85.7% had delusions.

- **Mania as secondary phenomenon-** side effect of cocaine, amphetamines, ecstasy, SSRIs, CNS disorder (tumours, metabolic disturbance, cancer), and L-dopa.
- **BP1-** course of illness- can have distinct manic and depressive phases or mixed presentations (some manic and some depressive together). Can have clear cut restoration of functioning between episodes, or some have rapid cycles; they are difficult to treat.
- If not treated, four findings are very consistently reported: length of normal periods between episodes decreases, length of each episode increases, depressed phases become more likely, and suicidality is a major risk factor in depressed phase but also somewhat of a problem in manic phase.
- Comorbidity- 75% also meet criteria of others, up to 3- anxiety, behaviour, substance use. Cost and burden- 6th leading cause of disability worldwide. 75% of sample had used outpatient services, 59% had used inpatient services, and almost half had used emergency services. Associated with higher rates of suicide than any other psychiatric disorder. As high as 15 times more completed suicide compared to general population, and 4 times higher in people with recurrent MDD.
- **Aetiology- genetic studies-** concordance rates for monozygotic twins- 57%, dizygotic twins- 14%. Risk of bipolar disorder among children of bipolar parents are 4 times greater the risk among children of healthy parents. Risk to children of bipolar parents of developing a non-bipolar disorder is 2.7 times greater than the risk to children of healthy parents. One of the most heritable of mental health disorders.
- **Neurotransmitter dysregulation-** dopamine and serotonin interact with deficits in other neurotransmitter systems such as GABA and substance P to produce symptoms.
- **Psychological models-** manic-defence model- psychodynamic model- is a defence against loss and painful negative feelings about the self. There are limited support- negative life events and negative cognitive style does 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 (circadian etc); involvement of dopamine.
- Treatment includes lithium, anti-convulsant, CBT, and circadian rhythm regulation.
- **Bipolar disorder and creativity-** found in disproportionate numbers in people with creative talent such as artists, musicians, authors, poets, and scientists. Some credit the condition for their creativity.
- Australian suicide rate is highest in 13 years- 12 per 100 thousand in 2014.
- **Suicide prevention-** risk factors and protective factors- individual and personal level, social level, contextual level, modifiable and non-modifiable, distal and proximal. Best research suggests that understanding risk factors best used to identify populations or specific socio-economic groups that are at risk- rather than attempting to identify individuals. Suicide prevention initiatives should focus on constellations of risk and protective factors.