Module 4: Mood Disorders

Module 4 Outline

4.1. Clinical Presentation – Depressive Disorders
4.2. Clinical Presentation – Bipolar Disorders
4.3. Epidemiology
4.4. Comorbidity
4.5. Etiology
4.6. Treatment

Module 4 Learning Objectives

- Describe how depressive disorders present.
- Describe how bipolar disorders present.
- Describe the epidemiology of mood disorders.
- Describe comorbidity in relation to mood disorders. Describe the etiology of mood disorders.
- Describe treatment options for mood disorders.

4.1 Clinical Presentation – Depressive Disorders

Section 4.1 Learning Objectives

- Identify and describe the two types of depressive disorders.
- Classify symptoms of depression.

Section 4.1 Key Terms

Anhedonia: The loss of interest in previously interesting activities.

Major depressive disorder: Characterized by pervasive sadness and loss of interest in activities of daily life; sleep and appetitie are commonly affected. The symptoms must persist for at least two weeks and cause marked distress or significantly impaired functioning.

Persistent depressive disorder: Previously known as dysthymia, is a continuous and chronic form of depression; symptoms must persist for at least two years.

Section 4.1 Key Takeaways

- Mood disorders fall into one of two groups – depressive or bipolar disorders – with the key distinction between the two being episodes of mania/hypomania.
- Persistent Depressive Disorder shares symptoms with Major Depressive Disorder though they are usually not as severe and ebb and flow over a period of at least two years.
- Symptoms of depression fall into one of four categories – mood, behavioral, cognitive, and physical.

Section 4.1 Review Questions

1. What are the different categories of mood disorder symptoms? Identify the symptoms within each category.

2. What are the key differences in a major depression and a persistent depressive disorder diagnosis?

4.2 Clinical Presentation – Bipolar Disorders

Section 4.2 Learning Objectives

- Distinguish the forms bipolar disorder takes.
- Describe a manic episode.
- Define cyclothymic disorder.

Section 4.2 Key Terms

Cyclothymic disorder: Someone with this disorder experiences periods of hypomanic symptoms and *mild* depressive symptoms.

Hypomanic episode: Similar to a manic episode in that the individual will experience abnormally and persistently elevated, expansive, or irritable mood and energy levels; however, the behaviors are not as extreme as in mania, and no psychotic symptoms are present.

Manic episode: The key feature of a manic episode is a specific period of time in which an individual reports abnormal, persistent, or expansive irritable mood for nearly all day, every day, for at least one week. Additionally, the individual will display increased activity or energy during this same time. With regards to mood, an individual in a manic episode will appear excessively happy, often engaging haphazardly in sexual or personal interactions. Psychotic symptoms may also be present during the manic episode.

Mood lability: Rapid shifts in mood, ranging from happy, neutral, to irritable.

Section 4.2 Key Takeaways

- An individual is diagnosed with Bipolar I disorder if they have ever experienced a manic episode and are diagnosed with Bipolar II disorder if the criteria has only been met for a hypomanic episode.
- A manic episode is characterized by a specific period of time in which an individual reports abnormal, persistent, or expansive irritable mood for nearly all day, every day, for at least one week.
- A hypomanic episode is characterized by abnormally and persistently elevated, expansive, or irritable mood and energy levels, though not as extreme as in mania, and must be present for at least four days.
- Cyclothymic disorder experience periods of hypomanic and mild depressive symptoms without meeting the criteria for a depressive episode which lasts two or more years and is interrupted by periods of normal moods.

Section 4.2 Review Questions

1. What is the difference between Bipolar I and II disorder?
2. What are the key diagnostic differences between a hypomanic and manic episode?
3. What is cyclothymic disorder?

4.3 Epidemiology

Section 4.3 Learning Objectives

- Describe the epidemiology of depressive disorders.
- Describe the epidemiology of bipolar disorders.
- Describe the epidemiology of suicidality.

Section 4.3 Key Terms

Prevalence: The percentage of the population that has a particular disorder.

Section 4.3 Key Takeaways

- Depressive disorders are experienced by about 7% of the population in the United States, afflicting young adults and women the most.
- Bipolar disorder afflicts less than 1% of the US population and Bipolar II is more common in women.
- Rates of suicide are greater in individuals with depressive disorders, particularly bipolar disorder.

Section 4.3 Review Questions

1. What are the prevalence rates of the mood disorders?
2. What gender differences exist in the rate of occurrence of mood disorders?
3. How do depressive disorders affect rates of suicide?

4.4 Comorbidity

Section 4.4 Learning Objectives

- Describe the comorbidity of depressive disorders.
- Describe the comorbidity of bipolar disorders.

Section 4.4 Key Terms

Comorbidity: When an individual has two or more diagnosed disorders.

Section 4.4 Key Takeaways

- Depressive disorders have a high comorbidity with substance use disorders, anxiety disorders, ADHD, and substance abuse with these other disorders often causing the depression.
- Bipolar disorder has a high comorbidity with anxiety disorders, disruptive/impulse-control disorders, and substance abuse disorders.

Section 4.4 Review Questions

1. Identify common comorbidities for major depression.
2. Identify common comorbidities for bipolar disorders.

4.5 Etiology

Section 4.5 Learning Objectives

- Describe the biological causes of mood disorders.
- Describe the cognitive causes of mood disorders.
- Describe the behavioral causes of mood disorders.
- Describe the sociocultural causes of mood disorders.

Section 4.5 Key Terms

Artifact theory: Suggests that the difference between genders is due to clinician or diagnostic systems being more sensitive to diagnosing women with depression than men.

Attributional style: The way you explain a negative event to yourself; it can be *positive* and focused on the external, unstable, and specific influence of the environment or *negative* and focused on the internal, stable, and global influences in our daily lives.

Automatic thoughts: Thoughts that come to mind automatically.

Cognitive distortions: Errors in thinking; among the most common are catastrophizing, jumping to conclusions, and overgeneralization.

Cognitive triad: Negative thoughts about oneself, others, and the world around us.

Cortisol: A hormone released as part of the stress response.

Etiology: The cause of a disorder.

Family-social perspective: This perspective focuses on examining how family members and intimate couples interact on a daily basis and arrive at shared understandings of their situations This perspective suggests that depression is related to the unavailability of social support.

Gender roles theory: Suggests that social and or psychological factors related to traditional gender roles also influence the rate of depression in women.

Hormone theory: Suggests that variations in hormone levels trigger depression in women more often than in men.

Learned helplessness: A condition in which a person suffers from a sense of powerlessness, arising from a traumatic event or persistent failure to succeed; thought to be one of the underlying causes of depression.

Life stress theory: Suggests that women are more likely to experience chronic stressors than men, thus accounting for their higher rate of depression.

Multi-cultural perspective: According to this perspective, one's cultural background may influence which symptoms of depression are experienced.

Rumination theory: Suggests that women are more likely than men to ruminate, or intently focus, on their depressive symptoms, thus making them more vulnerable to developing depression at a clinical level.

Section 4.5 Key Takeaways

- In terms of biological explanations for depressive disorders, there is evidence that rates of depression are higher among identical twins (the same is true for bipolar disorders), that the 5-HTT gene on chromosome 17 may be involved in depressive disorders, that norepinephrine and serotonin affect depressive (both being low) and bipolar disorders (low serotonin and high norepinephrine), the hormones cortisol and melatonin affect depression, and several brain structures are implicated in depression (prefrontal cortex, hippocampus, and amygdala) and bipolar disorder (basal ganglia and cerebellum).
- In terms of cognitive explanations, learned helplessness, attributional style, and maladaptive attitudes to include the cognitive triad, errors in thinking, and automatic thoughts, help to explain depressive disorders.
- Behavioral explanations center on changes in the rewards and punishments received throughout life.
- Sociocultural explanations include the family-social perspective and multi-cultural perspective.
- Women are twice as likely to experience depression and this could be due to women being more likely to be diagnosed than men (called the artifact theory), variations in hormone levels in women (hormone theory), women being more likely to experience chronic stressors (life stress theory), the fostering of an interdependent functioning in women (gender roles theory), and that women are more likely to intently focus on their symptoms (rumination theory).

Section 4.5 Review Questions

1. How do twin studies explain the biological causes of mood disorders?
2. What brain structures are implicated in the development of mood disorders? Discuss their role.
3. What is learned helplessness? How has this concept been used to study the development and maintenance of mood disorders?
4. What is the cognitive triad?
5. What are common cognitive distortions observed in individuals with mood disorders?
6. What are the identified theories that are used to explain the gender differences in mood disorder development?

4.6 Treatment of Mood Disorders

Section 4.6 Learning Objectives

- Describe treatment options for depressive disorders. Describe treatment options for bipolar disorders.
- Determine the efficacy of treatment options for depressive disorders.
- Determine the efficacy of treatment options for bipolar disorders.

Section 4.6 Key Terms

Behavioral activation (BA): Similar to the behavioral component of CBT in that the goal of treatment is to alleviate depression and prevent future relapse by changing an individual's behavior.

Interpersonal therapy (IPT): Focuses on establishing effective strategies to manage interpersonal issues (e.g., complicated bereavement, role disputes, role transitions, and interpersonal deficits), which in turn, will ameliorate depressive symptoms

Monoamine oxidase inhibitors (MAOIs): A type of antidepressant medication first developed in the 1950s; no longer widely used due to their side effect profile.

Multimodal treatment: The use of both psychotropic medications and psychotherapy to treat mental disorders; is typically more effective than either medication or psychotherapy alone.

Psychopharmacology: The use of medications to treat mental disorders.

Selective serotonin reuptake inhibitors (SSRIs): A type of antidepressant medication first developed in the 1980s; their mechanism of action involves slowing the reuptake of serotonin in the brain.

Tricyclic antidepressants: A type of antidepressant medication first developed in the 1950s; their mechanisms of action are similar to that of SSRIs, but they (1) affect serotonin receptors in parts of the body outside the brain (e.g., in the gastrointestinal system) and (2) affect the neurotransmitter norepinephrine.

Section 4.6 Key Takeaways

- Treatment of depressive disorders include psychopharmacological options such as anti-depressant mediations, SSRIs, tricyclic antidepressants, and MAOIs AND/OR psychotherapy options to include CBT, behavioral activation (BA), and interpersonal therapy (IPT). A combination of the two main approaches often works best, especially in relation to maintenance of wellness.
- Treatment of bipolar disorder involves mood stabilizers such as Lithium and psychological interventions with the goal of medication adherence, as well as social skills training and problem- solving skills.
- In regard to depression, psychopharmacological interventions are more effective in rapidly reducing symptoms, while psychotherapy, or even a combined treatment approach, is more effective in establishing long-term relief of symptoms.
- A combination of psychopharmacology and psychotherapy aimed at increasing the rate of adherence to medical treatment may be the most effective treatment option for bipolar I and II disorder.

Section 4.6 Review Questions

1. Discuss the effectiveness of the different pharmacological treatments for mood disorders.
2. What are the four phases of CBT? How do they address symptoms of mood disorder?
3. What is ITP and what are its main treatment strategies?
4. What are the effective treatment options for bipolar disorder?