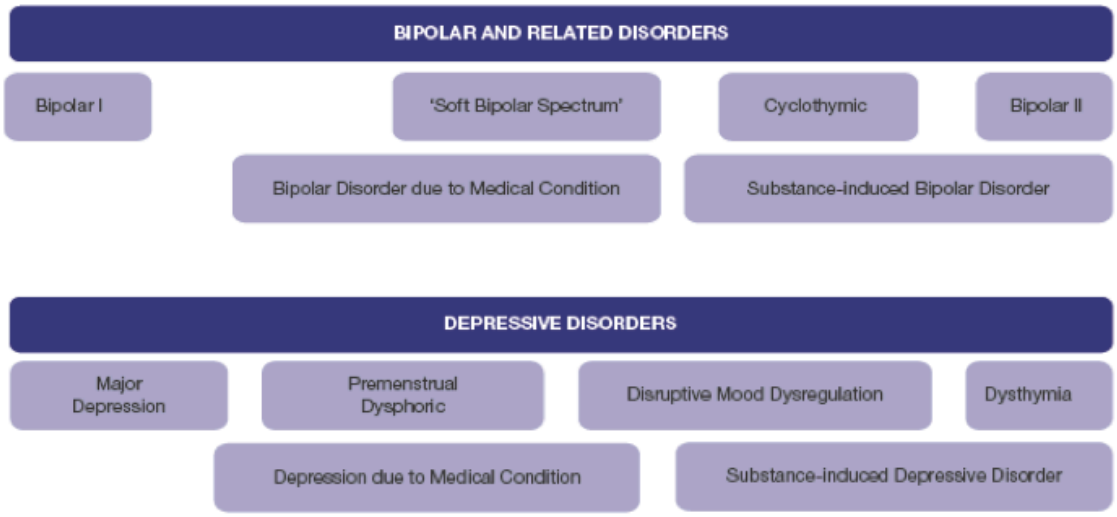
SLK 310 – ADULT PSYCHOPATHOLOGY

CHAPTER 7

MOOD DISORDERS AND SUICIDE



[1]**Mood disorders** (UMBRELLA TERM):

- *Group of disorders involving severe and enduring disturbances in emotionality ranging from elation to severe depression.* Composed of different types of mood 'episodes':
  - ***Major depressive episodes***
  - ***Manic episodes***
  - ***Hypomanic episodes***

^^ Periods of depressed or elevated mood lasting days or weeks.

[1] **Mood:** *enduring pain or emotionality.*

MAJOR DEPRESSIVE EPISODE:

Morbid or pathological expression of depression including:

- **Anhedonia** (inability to experience pleasure)
- Feelings of guilt and worthlessness
- Sleep and Appetite disturbances
- Poor concentration or indecisions
- Suicidal thoughts and thoughts around death

Most days of the week for at least **TWO weeks.**

The most central indicators of a full major depressive episode are the:

2. Neurovegetative symptoms along with behavioural and emotional 'shutdown' (as reflected by low scores on behavioural activation scales)
3. Anhedonia (low positive affect, not just high negative affect) is more characteristic of severe episodes of depression rather than reports of sadness or distress (for example)
    - Weepiness (which occurs equally I depressed and non-depressed individuals) also does NOT reflect severity or the presence of a depressive episode.

Major Depressive Episode

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.
Note: Do not include symptoms that are clearly attributable to another medical condition.
    1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
    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).
    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. (**Note:** In children, consider failure to make expected weight gain.)
    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 cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.[1]

The duration of a major depressive episode (if untreated) is approx. 4-9 months.

- The occurrence of one major depressive episode (conforming to the above diagnostic criteria), defines the existence of MAJOR DEPRESSIVE DISORDER.

MANIC[2] EPISODE

Period of abnormally elevated or irritable mood that may include inflates self-esteem, decreased need for sleep, pressure speech/talk, flight of ideas, agitation or self-destructive behaviour and may be accompanied by psychotic symptoms

Note: DSM-5 criteria for a manic episode require a duration of only **ONE WEEK** (less if the episode is severe enough to require hospitalisation: e.g. self-destructive spending spree)

- The duration of a manic episodes (untreated) is usually 3-4 months.

The occurrence of a single manic episode (conforming to the diagnostic criteria) defines the presence of:

- BIPOLAR I DISORDER (irrespective of earlier major depressive or hypomanic episodes)

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

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), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

[2] **Mania:** *Period of abnormally excessive elation, euphoria or irritability associated with increased goal-directed activity, inflated self-esteem, decreased need for seep and rapid thinking and communication, often accompanied by psychotic features lasting at least one week, unless successfully treated.*

HYPOMANIC EPISODE

Attenuated form of mania, with similar but less severe symptoms and less disruption occurring at least 4 days without the occurrence of psychotic symptoms or the need for hospitalisation. Hypomanic episodes define Bipolar II and Cyclothymic disordered, but may also occur during the course of Bipolar I disorder.

Hypo: means below (thus, episode is below the level of a manic episode)

- A hypomanic episode itself isn't necessarily problematic, but its presence does contribute to the definition of several mood disorders such as:
  - Bipolar II
  - Cyclothymic disorder

Note: Difference between the time frame of Manic and Hypomanic episode:

- Hypomanic episode (less severe) last **FOUR DAYS** rather than **ONE WEEK** (Manic episode – more severe).

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, 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), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Bipolar I Disorder:

- *Occurrence of one manic or mixed manic episodes, often recurrent or alternating with major depressive episodes.*

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A–D under "Manic Episode" above).

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Bipolar II Disorder:

- *Occurrence of Hypomanic episodes, frequently alternating with major depressive episodes. Bipolar II disorder has a greater tendency of recurrent cycles of mood disturbance.*

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A–F under "Hypomanic Episode" above) and at least one major depressive episode (Criteria A–C under "Major Depressive Episode" above).

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Cyclothymic disorder:

- *Chronic (at least 2 years) mood disorder characterized by alternating mood elevation and depression levels that are not as severe as manic or major depressive episodes.*

Cyclothymic Disorder

Diagnostic Criteria **301.13 (F34.0)**

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

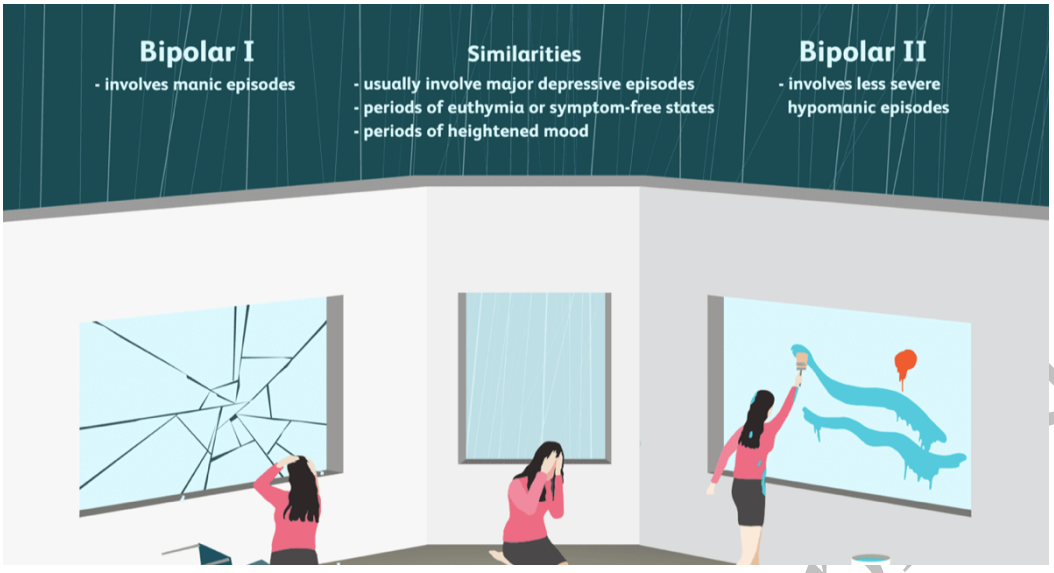
D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

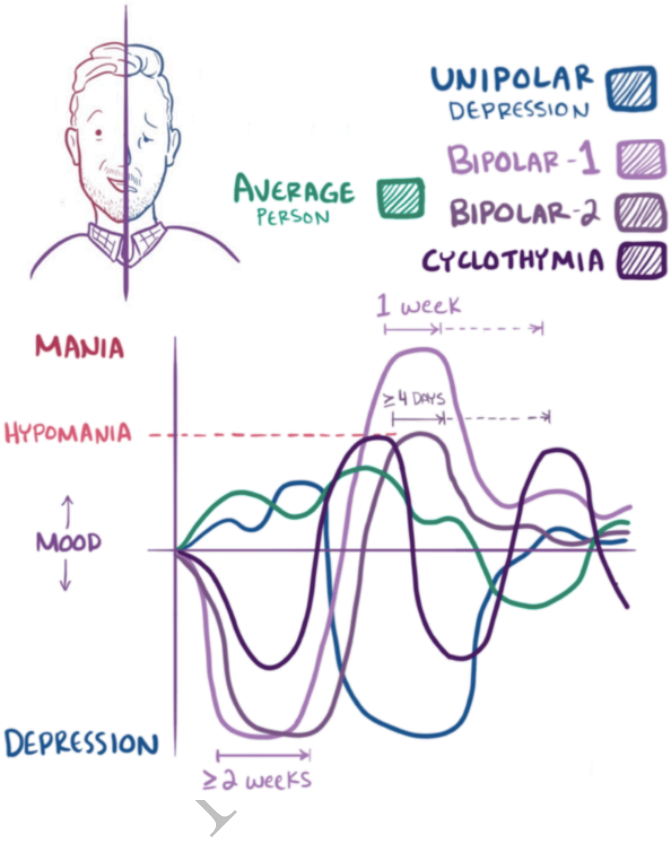
E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

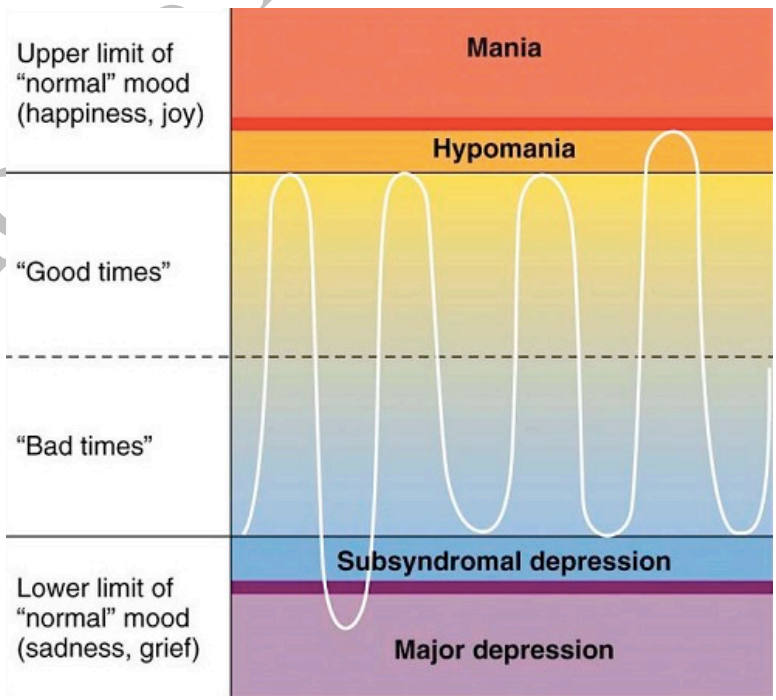
F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With anxious distress (see p. 149)


Bipolar I
- involves manic episodes
Similarities
- usually involve major depressive episodes
- periods of euthymia or symptom-free states
- periods of heightened mood
Bipolar II
- involves less severe hypomanic episodes


UNIPOLAR DEPRESSION
AVERAGE PERSON
BIPOLAR-1
BIPOLAR-2
CYCLOTHYMIA
1 WEEK
MANIA
≥4 DAYS
HYPOMANIA
MOOD
DEPRESSION
≥2 WEEKS


Upper limit of "normal" mood (happiness, joy)
Mania
Hypomania
"Good times"
"Bad times"
Subsyndromal depression
Lower limit of "normal" mood (sadness, grief)
Major depression

Depressive disorders:

The DSM-5 lists several types of depressive disorders, differing in the frequency and severity with which depressive symptoms occur, the course of the symptoms and the likelihood that they will become established as chronic (or enduring). The 2 factors that describe mood disorders are:

1. *Severity*
2. *Frequency*

Two factors that strongly describe mood disorders are **severity** and **chronicity**.

DSM-5 (Unipolar) Depressive Disorders:

- Major depressive disorder
- Persistent depressive disorder

New to DSM-5:

- Premenstrual dysphoric disorder
- Disruptive mood dysregulation disorder

MAJOR DEPREESSIVE DISORDER

Major depressive disorder (single or current episode): *Mood dirosder involving 1 (single episode) or more (seprated by at least two months without depression recurrent) major depressive episodes.*

- *It is defined by absence of mania or hypomania during the course of the condition.*

Recurrence; important in predicting the future course of the disorder and choosing appropriate treatment.

- Unipolar depression is often a chronic condition that waxes and waned over tie, but seldom disappears.
- The median lifetime of major depressive disorder is 4 – 7, and the duration is of recurrent major depressive episodes is 4 – 5 months

Major Depressive Disorder

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.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
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).

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. (**Note:** In children, consider failure to make expected weight gain.)
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 cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.[1]

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

PERSISTET DEPRESSIVE DISORDER (DYSTHIMA)

Persisent deressive disorder (Dysthmia): *Mood disorder involving persistently depressed mood, with low self-esteem, withdrawal, pessimism or despair, present for at least 2 years, with no absence of symptoms for more than 2 months.*

- Shares many symptoms of major depressive disorder but differs in course and chronicity
    - There may be fewer symptoms but depression remains relatively unchanged over long periods, sometimes 20 or 30 years or more.
    - It is considered more severe √≠ since patients with persistent depression present with higher rates of comorbidity with other mental disorders
    - Are less responsive to treatment
    - Show a slower rate of improvement over time
    - Symptoms can persist unchanged over long periods (> 20 years)

Dysthymia: is a state of mild low mood. 'Dysthymic disorder' is an outdated term for PDD with no major depressive episodes (now called PDD with pure dysthymic syndrome).

- Klein and colleagues suggest that chronicity is the most important distinction in diagnosing depression independent of whether the symptom presentation meets criteria for a major depressive disorder because these two groups (chronic and non-chronic) seem different, not only in course over time but also in family history and cognitive style.
- 22% of people suffering from persistent depression with fewer symptoms (dysthymia) eventually experienced a major depressive episode.

These individuals who suffer from both major depressive episodes and persistent depression with fewer symptoms are said to have **double depression.**

- **Double depression:** *severe mood disorder typified by major depressive episodes superimposed over a background of persistent depressive disorder or dysthymia. Also called persistent disorder with intermittent major depressive disorders.*
    - A few depressive symptoms develop first, perhaps at an early age, and then one or more major depressive episodes occur later only to revert to the underlying pattern of depression once the major depressive episode has run its course.
    - Identifying this particular pattern is important because it is associated with even more severe psychopathology and a problematic future course.
    - Research has shown that patients suffering from double depression had not recovered from the underlying pattern of depressive symptoms two years after the follow up and that patients who had recovered from the superimposed major depressive episode experienced high rates of relapse and reoccurrence.

Persistent depressive disorder is further specified depending on whether or not a major depressive episode is part of the picture:

- One might meet the criteria for the disorder 'with pure dysthymic syndrome'
    - meaning the patient has not met criteria for a major depressive episode in at least the preceding two years, 'with persistent major depressive episode' indicating the presence of a

major depressive episode over at least two-year period or 'with intermittent major depressive episode.

It is important to note if the patient is currently in a major depressive episode or not.

Types of PDD:

1. Mild depressive symptoms without any major depressive episodes (with pure dysthymic syndrome).
2. Mild depressive symptoms with additional major depressive episodes occurring intermittently (double depression).
3. Major depressive episode lasting two or more years (with persistent major depressive episode).

Persistent Depressive Disorder (Dysthymia)

Diagnostic Criteria **300.4 (F34.1)**

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. 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.

   Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

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 individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

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

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).

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

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited

number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

With anxious distress (p. 184)
With mixed features (pp. 184–185)
With melancholic features (p. 185)
With atypical features (pp. 185–186)
With mood-congruent psychotic features (p. 186)
With mood-incongruent psychotic features (p. 186)
With peripartum onset (pp. 186–187)

Specify if:

In partial remission (p. 188)
In full remission (p. 188)

Specify if:

Early onset: If onset is before age 21 years.
Late onset: If onset is at age 21 years or older.

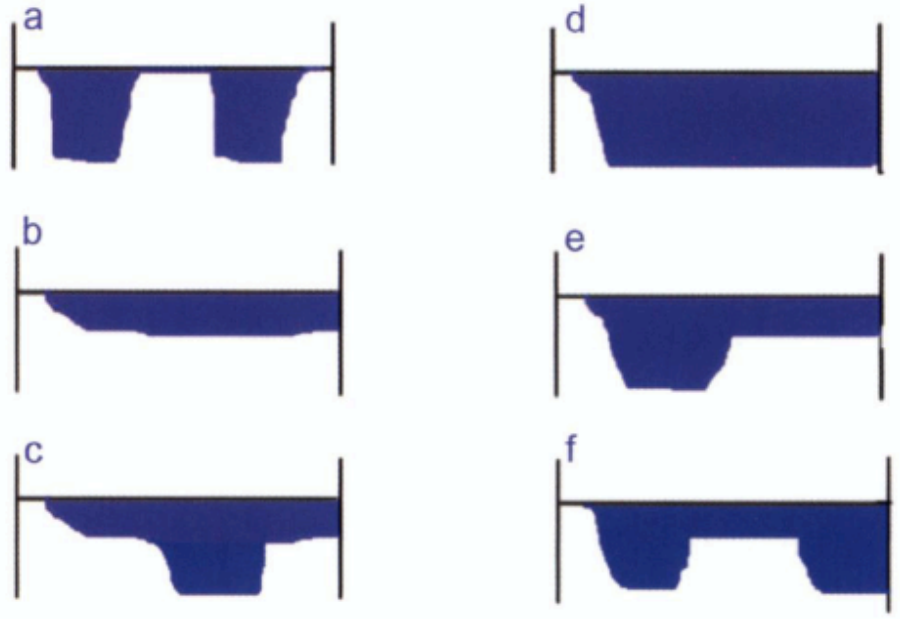
Specify if (for most recent 2 years of persistent depressive disorder):

With pure dysthymic syndrome: Full criteria for a major depressive episode have not been met in at least the preceding 2 years.
With persistent major depressive episode: Full criteria for a major depressive episode have been met throughout the preceding 2-year period.
With intermittent major depressive episodes, with current episode: Full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.
With intermittent major depressive episodes, without current episode: Full criteria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

Specify current severity:

Mild (p. 188)
Moderate (p. 188)
Severe (p. 188)

***NB:**



Possible Course of Depressive Disorders:

^^ The above figure is a graphic representation of various course configurations of non-bipolar depression.

- The horizontal axis represents **time** and the vertical axis represents **mood**, with the horizontal black line representing euthymic, or normal, mood and the magnitude of downward deflection (the blue area) reflecting severity of depressive symptoms.

➔ Panel (a) is non-chronic major depressive disorder (in this case, recurrent, as two depressive episodes are depicted).

➔ Panel (b) is persistent depressive disorder with pure dysthymic syndrome.

➔ Panel (c) is double depression (major depressive episode occurring within the course of dysthymia).

➔ Panel (d) is chronic major depressive episode. Panel (e) is major depressive episode in partial remission.

➔ Panel (f) is recurrent major depression without full inter-episode recovery.

Diagnostic Specifiers for Depressive Disorders:

Specifier: *Additional diagnostic label used by clinicians to convey extra information about symptoms*

- Specifiers are not mandatory; only assigned if appropriate

Additional Defining Criteria for Depressive Disorders:

The diagnostic criteria for a major depressive disorder requires the clinician to specify the features of the last depressive episode. These instructions are there because these specific features or specifiers may or may not accompany a depressive disorder – when they do, they are most often helpful in determining the most effective treatment or likely course.

The clinicians also rate the episode as

- mild,
- moderate or
- severe.

Clinicians also use 8 specifiers to describe depressive disorders:

1. **With psychotic features (mood-congruent or mood-incongruent)**
2. **With anxious distress (mild to severe)**
3. **With mixed features**
4. **With melancholic features**
5. **With atypical features**
6. **With cationic features**
7. **With peri-partum onset**
8. **With seasonal pattern**

Specifier	Description
Psychotic features specifier:	Major depressive episodes which also include some psychotic features. Some patients in the midst of a major depressive (or manic) episode may experience psychotic symptoms: • **Hallucinations** *(perceptions in the absence of sensory stimulation – example: voices and visions)* and **Delusions** *(fixed false beliefs).* Patients may have somatic (physical) delusions *(strongly held inaccurate beliefs - example: believing that their bodies are rotting internally and deteriorating into nothingness.)* **Nihilistic** (nihil means 'nothing' in Latin) delusions are when, for example, a patient believes he is dead, or that an organ is missing or has stopped functioning, commonly an organ such as the heart. Some may hear voices telling them how evil and sinful they are. Such hallucinations and delusions are called mood congruent because they seem directly related to the depression.

	On rare occasions, depressed individuals might have other types of hallucinations or delusions such as: • **delusions of grandeur** (believing they are supernatural or supremely gifted) or • **bizarre delusions** *(outside of human experience) that do not seem consistent with the depressed mood.* When inconsistent, or incongruent with the prevailing feeling state, the psychotic phenomena are referred to as **mood-incongruent** • quite rare, this condition signifies a serious type of depressive episode that may progress to schizophrenia (or may be a symptom of schizophrenia to begin with). Delusions of grandeur accompanying a manic episode are mood **congruent.** • Example: it is quite understandable when the manic car-salesman in his mid-forties proclaims at his dealership that he is Shaka Zulu. Psychotic features in general are associated with a poor response to treatment, greater impairment and fewer weeks with minimal symptoms, compared to non-psychotic depressed patients over a ten-year period.
Anxious distress specifier:	The presence and severity of accompanying anxiety, whether in the form of comorbid anxiety disorders (anxiety symptoms meeting the full criteria for an anxiety disorder) or anxiety symptoms that do not meet all the criteria for disorders define this specifier. • This is perhaps the most important new specifier for mood disorders, added to DSM-5. For all depressive and bipolar disorders, the presence of anxiety indicates a more severe condition, makes suicidal thoughts and suicide more likely, and predicts a poorer outcome from treatment. • The presence of anxiety in a depressive episode also warns of possible bipolar depression □ anxiety points to the likelihood of bipolar disorder when only depression is apparent.
Mixed features specifier:	• Depressive episodes which also include several manic episodes. • Predominantly depressive episodes that have several (at least three) symptoms of mania as described above would meet this specifier, which applies to major depressive episodes within both major depressive disorder and persistent depressive disorder.
Melancholic features specifier:	Major depressive episode accompanied by additional severe symptoms such as early morning awakens, lack of reactivity to positive stimuli. • This specifier applies only if the **full** criteria for a major depressive episode have been met, whether in the context of a persistent depressive disorder or not. Melancholic specifiers include some of the more severe somatic (physical) symptoms (marked diurnal variation in mood, early-morning waking, weight loss, loss of libido (sex drive), excessive or inappropriate guilt) and anhedonia (diminished interest or pleasure in activities). • The concept of 'melancholic' does seem to signify a severe type of depressive episode. • Melancholic depression appears more common in the elderly and responds more predictably to so-called somatic treatments - antidepressant medication and electroconvulsive therapy (ECT).
Catatonic features specifier:	Extremely rare muscular symptoms such as remaining in a still stupor, 'waxy' limbs that remain in place when manipulated, repetitive or purposeless movement. This specifier can be applied to major depressive episodes whether they occur in the context of a persistent depressive order or not, and even to manic episodes.

	Catatonia occurs across a range of neurological and psychiatric conditions and is characterised by ***grossly disturbed motor behaviour.*** • Catatonia involves grossly decreased movements with stupor. • In neurological disorders such as brain infection or epilepsy, it may present with excitability - a mixture of stupor and excitability may also occur. A common feature of catatonia is **catalepsy** • Catalepsy: *a state characterised by a gross paucity of movements and the maintenance of an often uncomfortable, rigid and fixed posture despite external stimulus or resistance and there may also be a decreased sensitivity to pain.* • It is a disturbance in motor behaviour characterized by paucity of movement and the assumption and maintenance of awkward postures. **Catalepsy is a manifestation of a catatonia.** Waxy flexibility (cerea flexibilitas) is an extension of the phenomenon of catalepsy where the examiner can manipulate the catatonic patient's limb into any arbitrary posture, which the patient then maintains, as if made of wax. • Catatonia was thought to be more commonly associated with schizophrenia, but some recent studies have suggested it may be more common in depression than in schizophrenia. This response may be a common 'end state' reaction to feelings of imminent doom and is found in many animals about to be attacked by a predator and after frenzied pursuit.
Atypical features specifier:	Presence of several symptoms less common in depression, including oversleeping and overeating. Atypical features are common. • Atypical means symptoms deviating from those typical, or classical, of depression. This specifier applies to both depressive episodes, whether in the context of persistent depressive disorder or not. • Individuals with this specifier consistently oversleep and overeat during their depression and therefore gain weight, leading to a higher incidence of diabetes. • They also have considerable anxiety, they can react with interest or pleasure to some things, unlike most depressed individuals. Depression with atypical features, compared to more typical depression, is associated with a greater percentage of women and an earlier of onset. • The atypical group also has more age symptoms, more severe symptoms, more suicide attempts, and higher rate of comorbid disorders, including alcohol abuse. • Atypical depression also points towards bipolar depression.
Peri-partum onset specifier:	Peri means **surrounding,** in this case the period of time just before and **just after birth (partum).** This specifier can apply to both major depressive and manic episodes. • Between 13% and 19% of all women giving birth (one in eight) meet criteria for a diagnosis of depression, referred to as peri-partum depression. • A somewhat higher incidence of depression is found postpartum (after the birth) than during the period of pregnancy itself. During the peri-partum period (pregnancy and the six-month period immediately following childbirth), early recognition of possible psychotic depressive (or manic) episodes is important, because in a few tragic cases a mother in the midst of an episode has killed her new-born child. • The phenomenon of infanticide is also associated with peri-partum psychosis and mood disorder.

	Fathers also do not entirely escape the emotional consequences of birth. • If you extend the period from the first trimester to one year after birth, the rate of depression is approximately 10% for fathers and as high as 40% for mothers. • Depression in fathers was associated with adverse emotional and behavioural outcomes in children three and a half years later. More minor reactions in adjustment to childbirth called the **baby blues** - typically last a few days and occur in 40-80% of women between one and five days after delivery: • During this period, new mothers may be tearful and have some temporary mood swings, but these are normal responses to the stresses of childbirth and they disappear quickly. ^^The peri-partum onset specifier does not apply to them. In peri-partum depression, most people, including the new mother herself, have difficulty understanding why she is depressed, because they assume this is a joyous time. • Many people forget that extreme stress can be brought on by physical exhaustion, new schedules, adjusting to nursing, and other changes that follow the birth. There is also evidence that women with a history of peri-partum depression meeting full criteria for an episode of major depression may be affected differently by the rapid decline in reproductive hormones that occurs after delivery or may have elevated corticotrophin-releasing hormone in the placenta and that these factors may contribute to peri-partum depression. • All women experience very substantial shifts in hormone levels after delivery, while only a few develop a depressive disorder. A close examination of women with peri-partum depression revealed no essential differences between the characteristics of this mood disorder and others • peri-partum depression did not require a separate category in DSM-5 and is simply a specifier for a depressive disorder. • Approaches to treatment for peri-partum depression do not differ from those for non-peri-partum depression.
Seasonal pattern specifier:	This temporal specifier applies to recurrent major depressive disorder (and also to bipolar disorders). • It accompanies episodes that occur during certain seasons **(example = winter depression).** • The most usual pattern is a depressive episode that begins in the late autumn and ends with the beginning of spring. In bipolar disorder, individuals become **depressed during the winter** and **manic during the summer.** • These episodes must have occurred for at least two years with no evidence of non-seasonal major depressive episodes occurring during that period of time. • May be treated effectively with light therapy. This condition is called seasonal affective disorder **(SAD).** • **Seasonal Affective Disorder (SAD):** *mood disorder involving cycling of episodes corresponding to the seasons of the year, typically with depression occurring during the winter.* Norman Rosenthal and Tom Wehr: Researching the effect of cellular light suppression by melatonin and its impact on circadian rhythms, developed the concept of **LIGHT THERAPY** as effective treatment for patients with SAD. • Many experienced clinicians remark about a spike in admissions of manic patients during spring

	The majority of seasonal mood disorders involve winter depression • People with winter depressions tend toward excessive sleep (rather than decreased sleep) and increased appetite and weight gain (rather than decreased appetite and weight loss), symptoms shared with atypical depressive episodes. Emerging evidence suggests that SAD may be related to daily and seasonal changes in the production of melatonin (a hormone secreted by the pineal gland) • because exposure to light suppresses melatonin production, it is produced only at night. Melatonin production also tends to increase in winter, when there is less sunlight. • The amount of sunlight is what is important. One theory is that the increased production of melatonin might trigger depression in vulnerable people • Wehr and colleagues (2001) have shown that melatonin secretion does increase in winter but only in patients with SAD and not healthy controls. Another possibility is that **circadian rhythms,** which occur in approximately 24-hour periods, or cycles, and are thought to have some relationship to mood, are delayed in winter. Some clinicians reasoned that exposure to bright light might slow melatonin production in individuals with SAD: • In **phototherapy,** a current treatment, most patients are exposed to two hours of bright light immediately on waking. • If the light exposure is effective, the patient begins to notice a lifting of mood within three to four days and a remission of winter depression in one to two weeks. • Patients are also asked to avoid bright lights in the evening (from shopping malls and so on), so as not to interfere with the effects of the morning treatments. This treatment is not without side-effects • 19% of patients experience headaches, 17% have eyestrain, and 14% just feel 'wired'.

Onset and duration of Depressive Disorders:

- Rare in childhood.
- Risk increases in adolescence and young adulthood.
- Mean age of onset = 30 years.
- Earlier onset of Persistent Depression associated with worse outcome.
- Depressive episodes are variable in length usually last several months untreated, but many may last several years.

From Grief to Depression:

In previous editions of the DSM, depression could not be diagnosed during periods of mourning. It is now recognised that major depression may occur as part of the grieving process.

Acute Grief: *occurs immediately after loss.*

Integrated grief: *grief that evolves from acute grief into a condition in which the individual accepts the finality of a death and adjusts to the loss - eventually coming to terms with the meaning of loss.*

Integrated grief:

- In which the finality of death and its consequences are acknowledged and the individual adjusts to the loss.
- New, bittersweet, but mostly positive memories of the deceased person that are no longer dominating or interfering with functioning are then incorporated into memory.

Complicated grief: *grief characterized by debilitating feelings of loss and emotions so painful that a person has trouble resuming a normal life; designated for further study as a disorder by the DSM-5 □ persistent acute grief and inability to come to terms with the loss.*

Usually the normal grief process is about 6 months, although some grief longer.

Complicated grief:

- In children and young adults, the sudden loss of a parent makes them particularly vulnerable to severe depression beyond the normal time for grieving, suggesting the need for immediate intervention for some.
- In cases of complicated grief, the rituals intended to help us face and accept death were ineffective.

Other Depressive Disorders:

- **Premenstrual Dysphoric disorder (PMDD)**
- **Disruptive Mood Regulation disorder**

PREMENSTRUAL DYSPHORIC DISORDER:

Significant depressive symptoms occurring prior to menses during the majority of cycles, leading to distress or impairment.

Premenstrual Dysphoric Disorder: *condition characterized by mood disturbances, typically lability, and uncomfortable physical symptoms associated with the menses or female periods.*

*Controversial diagnosis:

- Advantage: Legitimises the difficulties some women face when symptoms are very severe.
- Disadvantage: Pathologies an experience many consider to be normal.

*NOTE: PMDD is not just your typical 'PMS' symptoms experienced by many women; rather, it is reserved for symptoms that are unusually severe; sometimes numerous; persistent; interfering and/or distressing.

Premenstrual Dysphoric Disorder

Diagnostic Criteria **625.4 (N94.3)**

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. One (or more) of the following symptoms must be present:

1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
2. Marked irritability or anger or increased interpersonal conflicts.
3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above.

1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
2. Subjective difficulty in concentration.
3. Lethargy, easy fatigability, or marked lack of energy.
4. Marked change in appetite; overeating; or specific food cravings.
5. Hypersomnia or insomnia.
6. A sense of being overwhelmed or out of control.
7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain.

Note: The symptoms in Criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (**Note:** The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

DISRUPTIVE MOOD DYREGULATION DISORDER

Disruptive Mood Dysregulation Disorder:

- Severe temper outbursts occurring frequently, against a backdrop of angry or irritable mood.
- Diagnosed only in children 6–18.
- Criteria for manic/hypomanic episode are not met.
- Designed in part to combat over diagnosis of bipolar disorder in youth.

Disruptive Mood Dysregulation Disorder: *condition in which a child has chronic negative moods such as anger and irritability without any accompanying mania.*

Disruptive Mood Dysregulation Disorder

Diagnostic Criteria **296.99 (F34.8)**

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
B. The temper outbursts are inconsistent with developmental level.
C. The temper outbursts occur, on average, three or more times per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.
F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
H. By history or observation, the age at onset of Criteria A–E is before 10 years.
I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).
Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.
K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Diagnostic Specifiers for Bipolar Disorders:

All of the specifiers for depressive disorders may also apply to bipolar disorders.

Additional specifier unique to bipolar disorders:

Rapid-cycling specifier (more characteristic of Bipolar II)

- Moving quickly in and out of mania and depression.
- Individual experiences at least four manic or depressive episodes within a year.
- Occurs in between 20–50% of cases.
- Associated with greater severity.

Prevalence of Mood Disorders:

- Worldwide lifetime prevalence of major depressive disorder: 16%.
- 6% have experienced major depression in last year.

Sex differences:

- Females are twice as likely to have major depression.
- Bipolar disorders affect males and females approximately equally.
- Women more likely to experience rapid cycling.
- Women more likely to be in depressive period.

Age:

- Occurs less often in pre-pubertal children.
- Rapid rise in adolescents.
- Adults over 65 have about 50% less prevalence than general population.
- Bipolar same occurrence in childhood, adolescence and adults.
- Prevalence of depression seems to be similar across subcultures.

Across cultures:

- Similar prevalence among US subcultures, but experience of symptoms may vary
    - Example: some cultures more likely to express depression as somatic concern
- Higher prevalence among Native Americans: Four times the rate of the general population.
- There is a strong tendency of anxiety to take somatic (physical) forms in some cultures; instead of talking about fear, panic or general anxiety, many people describe stomach aches, chest pains or heart distress and headaches (same for mood disorders.)
- Feelings of weakness or tiredness particularly characterise depression that is accompanied by mental or physical slowing or retardation.
- Some cultures have their own idioms for depression; for instance, the Hopi, a Native American tribe, say they are 'heartbroken' whereas Aboriginal men in central Australia who are clearly depressed attribute it to weakness or injury of the spirit.
- Although the somatic symptoms that characterise mood disorders seem roughly equivalent across cultures, it is difficult to compare subjective feelings

- the way people think of depression may be influenced by the cultural view of the individual and the role of the individual in society.

- South Africa: the predominant view was that depression is rare amongst black Africans.

Many factors caused this erroneous view of which the most noteworthy are: racially segregated psychiatric hospitals and withdrawal from treatment because needs are not met under-investigation and under-reporting due to language barriers, cultural mistrust and stigmatisation, and a focus on reporting only the physical symptoms rather than the typical western cognitive and emotional approach to reporting symptoms (SADAG).

South African Depression and Anxiety group (SADAG) reports that 18% of black patients presenting to primary health care clinics suffer from depression.

- Another consideration is that access to treatment for a major depressive disorder is not guaranteed because of limited public health services, particularly in rural South Africa. Poverty also plays a role.
- It seems that the differences in the prevalence of depressive conditions across cultures in South Africa varies, depending on whether or not symptoms are reported, or, if reported, in the manner they are reported as well as access to healthcare

Life Span Developmental Influences on Mood Disorders:

- Three-month-olds can show depressive symptoms.
- Young children typically don't show classic mania or bipolar symptoms.
- Mood disorder may be misdiagnosed as ADHD.
- Children are being diagnosed with bipolar disorders at increasingly high rates.
- Depression in elderly between 14% and 42%.
- Co-occurrence with anxiety disorders.
- Less gender imbalance after 65 years of age.

CAUSES OF MOOD DISORDERS

Familial and Genetic Influences

Family studies:

- Risk is higher if relative has a mood disorder.
- Relatives of bipolar proband are more likely to have unipolar depression
- In family studies, we look at the prevalence of a given disorder in the first-degree relatives of an individual known to have the disorder (the proband).
- Despite wide variability, the rate in relatives of probands with mood disorders is consistently about two to three times greater than in relatives of controls who do not develop mood disorder Increasing severity, recurrence of major depression and earlier age of onset in the proband is associated with the highest rates of depression in relatives.
- Bipolar disorder gives close relatives an increased risk of developing some mood disorder, but not necessarily bipolar disorder this conclusion supports the assumption that bipolar disorder may simply be a more severe variant of mood disorders rather than a fundamentally different disorder.

Twin studies:

Concordance rates are high in identical twins:

- Two to three times more likely to present with mood disorders than a fraternal twin of a depressed co-twin
- Severe mood disorders have a strong genetic contribution.
- Heritability rates are higher for females compared to males.
- Some genetic factors confer risk for both anxiety and depression.

Neurobiological Influences:

Sleep disturbances:

- Hallmark of most mood disorders
- Depressed patients have quicker and more intense REM sleep
- Sleep deprivation may temporarily improve depressive symptoms in bipolar patients.
- Sleep disturbances demonstrable by EEG also predate mood disorder symptoms.

In depressed people:

- The period of REM latency (the time it takes from onset of sleep to the first epoch of rapid eye movement sleep) is shortened:
    - It takes less than the typical 90 minutes before REM-sleep sets in.
        - In addition to decreased REM latency, depressed patients experience REM activity that is more intense, and the stages of deepest sleep, called slow wave sleep, are delayed or absent altogether.

^^There is some conflicting data whether these changes are state-dependent (i.e. present only during a depressive episode) or a trait.

- But other evidence suggests that, at least in more severe cases with recurrent depression, disturbances in sleep continuity, as well as reduction of deep sleep, may be present even when the individual is not depressed.

Sleep pattern disturbances in depressed children are less pronounced than in adults, perhaps because children are very deep sleepers, illustrating once again the importance of developmental stage in psychopathology.

Sleep disturbances are most severe among the depressed elderly.
Insomnia: frequently experienced by older adults, is a risk factor for both the onset and persistence of depression.

Sleep disturbances also occur in bipolar patients, where they are particularly severe characterised BY:

- decreased REM latency
- severe insomnia and hypersomnia (excessive sleep)

Investigators discovered that the relationship between sleep and mood was bidirectional in both groups

- Negative mood predicted sleep disruptions and
- sleep disruptions subsequently resulted in negative mood

^^ this relationship may cut across different diagnoses and that treating sleep disruptions directly might positively affect mood not only in insomnia but also in mood disorders.

Another interesting finding is that depriving depressed patients of sleep, especially in the second half of the night, causes temporary improvement in their condition:

- this improvement was most prominent for patients with bipolar disorder in a depressive state
    - depression returned with restoration of the previous sleep pattern
        - this suggests that depression may be related to disturbances in circadian rhythms – round the clock biological rhythms.

Abnormal sleep profiles and, specifically, disturbances in REM sleep and poor sleep quality predict a somewhat poorer response to psychological treatment.

Psychological Dimensions (stress):

Stressful life events:

Stress is strongly related to mood disorders:

- Poorer response to treatment.
- Longer time before remission.
- Context of life events matters.

Gene–environment correlation: People who are vulnerable to depression might be more likely to enter situations that will lead to stress.

- The relationship between stress and bipolar is also strong.

Stressful life events: Stress and trauma are among the most striking unique contributions to the aetiology of all psychological disorders.

- This is reflected throughout psychopathology and is evident in the wide adoption of the diathesis.
- In seeking what activates this vulnerability (diathesis), we usually look for a stressful or traumatic life event.

Learned Helplessness:

The learnt helplessness theory of depression: *people become anxious and depressed when they make an attribution that they have no control over the stress in their lives (whether or not they do in reality)*

- Lack of perceived control over life events leads to decreased attempts to improve own situation.
- First demonstrated in research by Martin Seligman.
- Negative cognitive styles are a risk factor for depression.

Martin Seligman:

Discovered that dogs and rats have an interesting emotional reaction to events over which they have no control.

➔ If rats receive occasional shocks, they can function reasonably well as long as they can cope with the shocks by doing something to avoid them, such as pressing a lever

- if they learn that nothing they do helps them avoid the shocks, they eventually become helpless, give up and manifest an animal equivalent of depression.

^^Do humans react the same way?

- Seligman suggests we do.
  - Just like the rats, they become anxious and depressed when they decide that they have no control over the stress in their lives

These findings have evolved into an important model called the learnt helplessness theory of depression.

- Often overlooked is Seligman's point that anxiety is the first response to a stressful situation.
- Depression may follow marked hopelessness about coping with the difficult life events.

The Depressive Attributional style is:

1. Internal: in that the individual attributes negative events to personal failings ('it is all my fault'),
2. Stable: in that, even after a particular negative event passes, the attribution that 'additional bad things will always be my fault' remains and
3. Global: in that the attributions extend across a variety of issues.

Example: You can see how these factors are applicable to Engela.
Early in her difficulties with attending school, she began to believe events were out of her control and that she was unable even to begin to cope. More important, in her eyes, the bad situation was all her fault: 'I could only blame myself…'. A downward spiral into a succession of major depressive episodes followed.

But a major question remains: Is learnt helplessness a cause of depression or an epiphenomenon of becoming depressed? If it were a cause, learnt helplessness would have to exist before the depressive episode:

Results from a classic five-year longitudinal study of children shed some light on this issue.

Nolen-Hoeksema, Girgus and Seligman (1992) reported that *Negative attributional style* did not predict later symptoms of depression in young children; rather, stressful life events seemed to be the major precipitant of symptoms.

- As children under stress grew older, however, they tended to develop more negative cognitive styles, which tended to predict symptoms of depression in reaction to additional negative events.
- Nolen-Hoeksema and colleagues speculate that meaningful negative events early in childhood may lead to negative attributional styles, making these children more vulnerable to future depressive episodes when stressful events occur.

Most studies support the finding that negative cognitive styles precede and are a risk factor for depression. This thinking recalls the types of psychological vulnerabilities theorised to contribute to the development of anxiety disorders:

- That is, in a person who has a non-specific genetic vulnerability to either anxiety or depression, stressful life events activate a psychological sense that life events are uncontrollable.
- Evidence suggests that negative attributional styles are not specific to depression but also characterise people with anxiety.

This may indicate that a psychological (cognitive) vulnerability is no more specific for mood disorders than a genetic vulnerability. Both types of vulnerabilities may underlie numerous disorders.

Abramson, Metalsky and Alloy (1989) revised the learnt helplessness theory to downplay the influence of negative attributions and highlight the development of a sense of hopelessness as a crucial cause of many forms of depression.

Attributions are important only to the extent that they contribute to a sense of hopelessness. This fits well with recent thinking on crucial differences between anxiety and depression. Both anxious and depressed individuals feel helpless and believe they lack control, but only in depression do they give up and become hopeless about ever regaining control.

Depressive Attributional Style:

1. Internal attributions

- Negative outcomes are one's own fault.

2. Stable attributions

- Believing future negative outcomes will be one's fault.

3. Global attribution

- Believing negative events will disrupt many life activities.

All three domains contribute to a sense of hopelessness.

Cognitive Theory:

Negative coping styles:

- Depressed persons engage in cognitive errors.
    - Tendency to interpret life events negatively.

Types of cognitive errors

1. **Arbitrary inference:** overemphasise the negative aspects of a mixed situation.
1. **Overgeneralisation:** negatives apply to all situations.

In 1967, Aaron T. Beck (1967, 1976) suggested that depression may result from a tendency to interpret everyday events in a negative way. According to Beck:

- people with depression make the worst of everything; for them, the smallest setbacks are major catastrophes.
    - Beck observed that all of his depressed patients thought this way, and he began classifying the types of 'cognitive errors' that characterised this style.

From the long list he compiled, two representative examples are arbitrary inference and overgeneralisation.

Arbitrary inference:

- E.g. A high school teacher may assume he is a terrible instructor because two students in his class fell asleep. He fails to consider other reasons they might be sleeping (up all night partying, perhaps) and 'infers' that his teaching style is at fault.

^^According to Beck, people who are depressed think like this all the time.

These individuals make errors in:

1. thinking negatively about themselves
2. their immediate world
3. their future

Three areas that together are called:
THE DEPRESSIVE COGNITIVE TRIAD.

After a series of negative events in childhood, people may develop a deep-seated negative schema, an enduring negative cognitive belief system about some aspect of life.

Self-blame schema: *individuals feel personally responsible for every bad thing that happens.*
Negative self-evaluation schema: *a person believes they can never do anything correctly.*

In Beck's view:

- These cognitive errors and schemas are automatic, that is, not necessarily conscious
    - an individual might not even be aware of thinking negatively and illogically
        - minor negative events can lead to a major depressive episode.

The thinking of depressed individuals is consistently more negative than that of non-depressed people in each dimension of the cognitive triad – the self, the world and the future.

- Depressive cognitions seem to emerge from distorted and probably automatic methods of processing information.
    - People prone to depression are more likely to recall negative events when they are depressed than when they are not depressed, and also more likely than non-depressed individuals.

The implications of this theory are important:

- By recognising cognitive errors and the underlying schemas, we can correct them and alleviate depression and related emotional disorders.
    - In developing ways to do this, Beck became the father of **cognitive therapy,** one of the most important developments in psychotherapy in the last 50 years.

Individuals with bipolar disorder also exhibit negative cognitive styles, but with a twist.

- *Cognitive styles in these individuals are characterised by ambitious striving for goals, perfectionism and self-criticism in addition to the more usual depressive cognitive styles.*

Cognitive errors and the depressive cognitive triad:

1. Think negatively about oneself
2. Think negatively about the world
3. Think negatively about the future

E.g.
Self: "I am too shy".
World: "people go for outgoing guys… guys like me don't get any attention".
Future: "I'll never find a life partner".

Social and Cultural Dimensions

Marital relations:

- Marital dissatisfaction is strongly related to depression.
- This relation is particularly strong in males after divorce or separation.
- Another finding with considerable support is that depression and chronic depressive symptoms may erode marital relationships.

Conflict within a marriage seems to have different effects on men and women:

- Depression seems to cause men to withdraw or otherwise disrupt the relationship.
- For women, on the other hand, problems in the relationship most often cause depression.

Thus, for both men and women, depression and problems in marital relations are associated, but the causal direction is different.

- Given these factors, Beach, Jones and Franklin suggest that therapists treat disturbed marital relationships at the same time as the mood disorder to ensure the highest level of success for the patient and the best chance of preventing future relapses.
    - Individuals with bipolar disorder are less likely to be married at all, and more likely to get divorced if they do marry, although those who stay married have a somewhat better prognosis.

Social Support:

- Extent of social support is related to depression
    - Lack of social support predicts late onset depression
- Substantial social support predicts recovery from depression

Gender Difference in Mood Disorders:

- Women account for seven out of ten cases of major depressive disorder.
    - Recall that women also have higher rates of anxiety disorders.
- The mood disorders in which sex ratios are balanced are bipolar disorders.

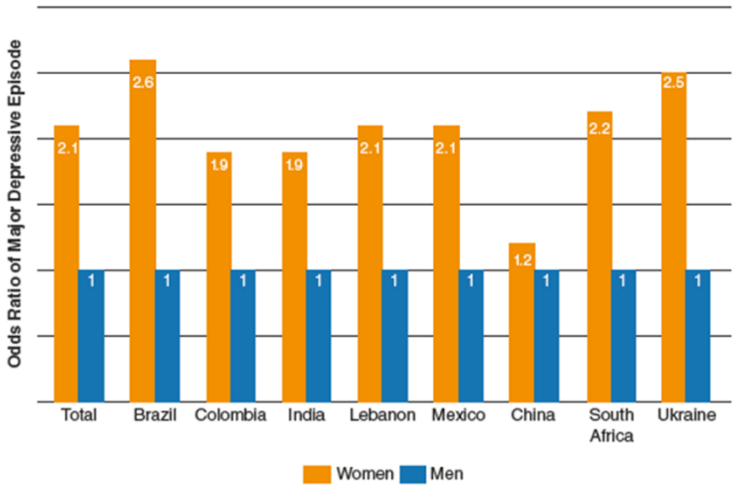


Figure 2: These numbers are expressed as odds ratios, or how many times as likely it is that a woman in that culture is will be diagnosed with depression, compared to a man.

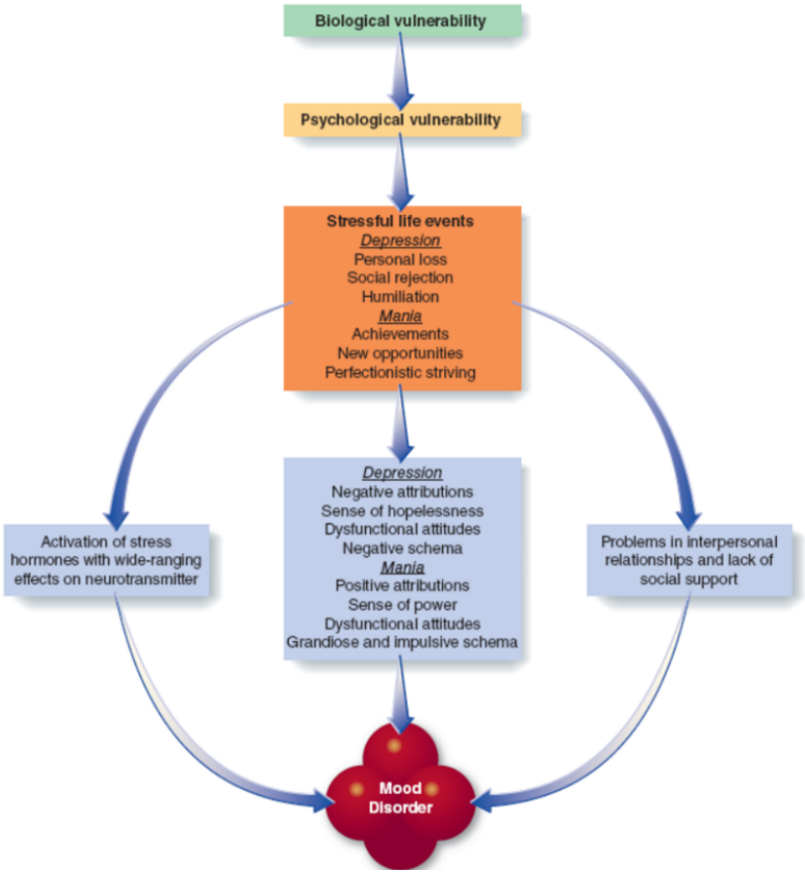
Possible explanations for gender disparity:

- Women are socialised to have stronger perception of uncontrollability.
- Parenting style makes girls less independent.
- Women more sensitive to relationship disruptions (e.g. Breakups, tension in friendships).
- Women ruminate more than men.

An Integrative Theory:

Biological and psychological vulnerabilities interact with stressful life events to cause depression.

- **Biological vulnerability:** overactive neurobiological response to stress.
- Psychological vulnerability: depressive cognitive style.



Management of Mood Disorders:

Medication:

Antidepressants:

1. **Selective serotonin reuptake inhibitors**
2. **Tricyclic antidepressants**
3. **Monoamine oxidase inhibitors**
4. **Mixed reuptake inhibitors (e.g. serotonin/noradrenaline reuptake inhibitors)**

Approximately equally effective:

- Only 50% of patients benefit.
- Only 25–30% achieve normal functioning.

Antidepressant agents are effective at treating the core symptoms of depression

- They are also effective with anxiety disorders and across a wide range of other neurological and medical conditions.

Currently, there are at least 15 different classes of antidepressant medications (thymoleptics, in the pharmacological literature):

1. **SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI)**
2. **SEROTONIN-NORADRENALINE REUPTAKE INHIBITORS (SNRI)**
3. **SEROTONIN MODULATORS AND STIMULATORS (SMS)**
4. **SEROTONIN PARTIAL AGONIST REUPTAKE INHIBITORS (SPARI)**
5. **SEROTONIN 2 ANTAGONIST REUPTAKE INHIBITORS (SARI)**
6. **NORADRENALINE REUPTAKE INHIBITORS**
7. **TRICYCLIC ANTIDEPRESSANTS (TCA)**
8. **TETRACYCLIC ANTIDEPRESSANTS**
9. **TETRACYCLIC ANALOGUES OF MIANSERIN (ALSO CALLED NORADRENARGIC AND SPECIFIC SEROTONERGIC ANTIDEPRESSANTS OR NASSA)**
10. **MELATONERGIC ANTIDEPRESSANTS**
11. **TRIAZALOPYRIDINE ANTIDEPRESSANTS**
12. **REVERSIBLE INHIBITORS OF MONOAMINE OXIDASE A (RIMA)**
13. **SELECTIVE MONOAMINE OXIDASE B INHIBITORS**
14. **CONVENTIONAL, IRREVERSIBLE MONOAMINE OXIDASE INHIBITORS (MAOI)**
15. **AMPHETAMINE-LIKE STIMULANTS**

Other unclassifiable agents such as **bupropion** (bupropion is actually understood to be an amphetamine-like inhibitor of the reuptake of noradrenaline and dopamine and exerts its pharmacological effect in the nucleus accumbens, or anterior terminal of the brain's reward system).

Selective Serotonin Reuptake Inhibitors:

Called SSRIs

- Specifically block reuptake of serotonin so more serotonin is available in the brain:
    - Fluoxetine (Prozac) is the most popular SSRI.
- SSRIs pose some risk of suicide, particularly in teenagers.
- Negative side effects are common.

Tricyclic Antidepressants:

- Include Tofranil
    - Negative side effects are common
        - drowsiness, weight gain
- Discontinuation is common.
- May be lethal in excessive doses.

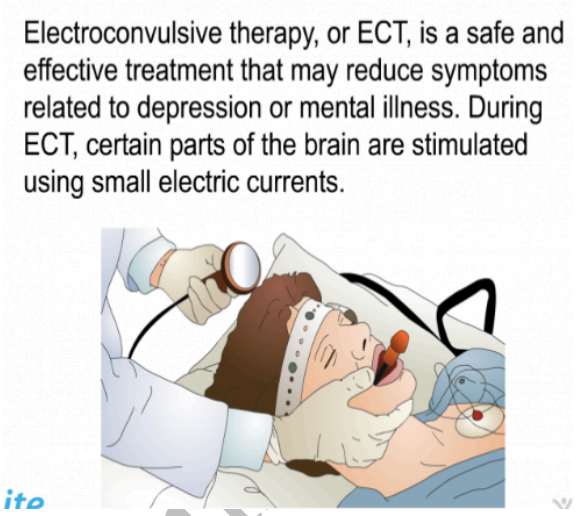
Mixed Reuptake Inhibitors:

- Block reuptake of noradrenaline as well as serotonin.
- Best known is venlafaxine (Effexor).
- Have similar side effects to SSRIs.

Lithium:

- Lithium carbonate = a common salt.
- Treatment of choice for bipolar disorder.
- Considered a mood stabiliser because it treats depressive and manic symptoms.
- Toxic in large amounts:
    - Dose must be carefully monitored.
- Effective for 50% of patients.
    - Why lithium works remains unclear.

Electroconvulsive Therapy (ECT):



- ECT: Biological or somatic treatment for sever and treatment refractory depression where a seizure is induced in an anaesthetisized patient by applying an electrical current to the head. It is safe in medically compromised patients and the elderly, where it is often the treatment of choice its mechanism of action is not fully understood.
    - Effective for medication-resistant depression.

The nature of ECT:

- Brief electrical current applied to the brain.
- Results in temporary seizures.
- Usually six to ten outpatient treatments are required.
- Side effects:
    - Short-term memory loss which is usually restored.
    - Some patients suffer long-term memory loss.

Mechanism is unclear

➔ In cases of extreme life-threatening depression, severe treatment refractoriness or, in frail patients, particularly the elderly where antidepressant medications are medically contraindicated, psychiatrists may consider electroconvulsive therapy (ECT).

ECT is the most controversial treatment for psychological disorders after psychosurgery.

Modern ECT is safe and effective.

After careful evaluation for the indication of ECT, it is administered thus:

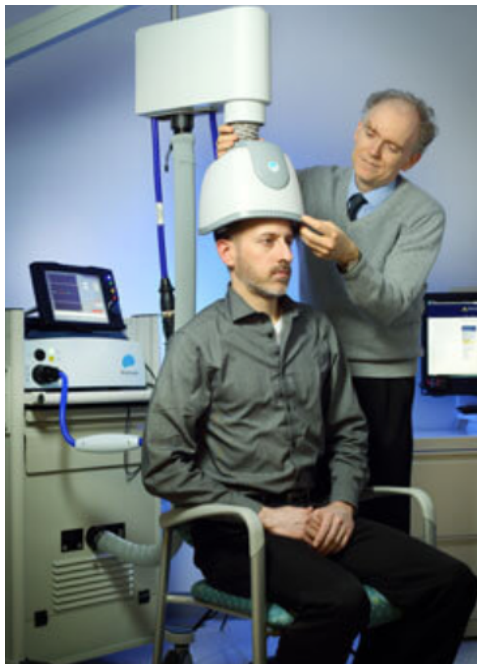
2. The patient is prepared for anaesthesia by remaining *nil per os* overnight (nothing by mouth and implies the patient consumes no food or drink after supper)
3. General anaesthesia is induced in the standard fashion, including pre-oxygenation and short acting muscle relaxation (to prevent generalised motor seizure and injury).
4. With EEG-electrodes on the scalp to confirm and monitor the occurrence and progression of a seizure, the paddles, or electrodes, of the ECT device are placed on two sites on the patient's scalp to deliver an electrical current to produce the seizure (There are different techniques in electrode placement aimed to balance efficacy with side-effects such as memory impairment.)
5. The electrical properties of the current are important, and the psychiatrist can modify the wave form, amplitude, frequency and energy of current.
6. Following an adequate seizure – regarded as more than 20 seconds of electrophysiological seizure activity, the patient is allowed to recover and regain consciousness, while being monitored according to acceptable anaesthetic standards.
7. In current practice, treatments are administered once every other day for a total of six to ten treatments (fewer if the patient's mood returns to normal).

- ECT may be administered to outpatients, particularly if used as maintenance treatment in difficult cases. The medical risks of ECT are few and, overall, less than those for antidepressant and other psychotropic medications.
- Adverse effects of ECT are mild memory impairment and occasional confusion during recovery. Some patients may have long-term memory problems.
- For severely depressed inpatients with psychotic features, controlled studies indicate that approximately 50% of those not responding to medication will benefit from ECT.
- The antidepressant effects of ECT are, unfortunately transient continued treatment with medication or psychotherapy is then necessary because the relapse rate approaches 60% or higher follow-up treatment with antidepressants or psychological treatments is necessary, but relapse is still high.
- It might not be in the best interests of psychotically depressed and acutely suicidal inpatients to wait three to six weeks to determine whether medication or psychological treatment is working; in these cases, immediate ECT may be appropriate – and life-saving.
- Repeated seizures induce massive functional and perhaps structural changes in the brain, which seems to be therapeutic.

How it works:

- ECT appears to alter the permeability of the blood brain barrier and to allow the passage into the neural milieu of precursor molecules necessary for the synthesis of neurotransmitters.
- There is some evidence that ECT increases levels of serotonin, blocks stress hormones and promotes neurogenesis in the hippocampus.
- Declined use since 1980s and 1970s.

Transcranial magnetic stimulation (TMS):



Another method for altering electrical activity in the brain by setting up a strong magnetic field has been introduced:

- It works by placing a magnetic coil over the individual's head to generate a precisely localised electromagnetic pulse
    - uses magnets to generate a precise localised electromagnetic
- TMS exploits a fundamental physical property of electromagnetism – the movement of a magnetic field induces an electrical current.
- This current affects the state of polarisation of neuronal systems, altering signalling and transmitter release.
- Anaesthesia is not required and TMS can be administered to outpatients.
- The side-effects are usually:
    - limited to headaches
    - some patients experience strange sparkles or flashes in their visual fields due to the activation of retinal cells by the magnetic field.

    - Patients undergoing magnetic resonance imaging also report these flashes, as do astronauts who pass through dense regions of the Earth's magnetic field.
- Less effective than ECT for medication-resistant depression.
- May be combined with medication.

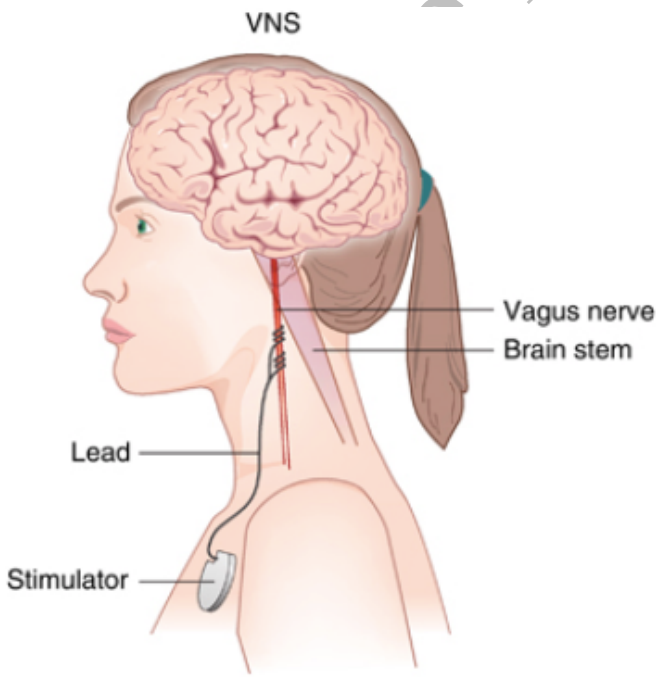
Results from several important clinical trials with severe or treatment-resistant psychotic depression reported ECT to be clearly more effective than TMS

- TMS is more comparable to antidepressant medication than to ECT, and one recent study reported a slight advantage for combining TMS and medication compared to using either treatment alone.

Electrical stimulation of the vagus nerve:

The tenth cranial nerve that courses widely throughout the body, from intracranial structures to the colon involves implanting a pacemaker-like device that generates pulses to the vagus nerve in the neck, which, in turn, is thought to influence neurotransmitter production in the brain stem and limbic system.

- Sufficient evidence has accumulated so that the FDA has approved this procedure, but results are generally weak and it has been little-used.

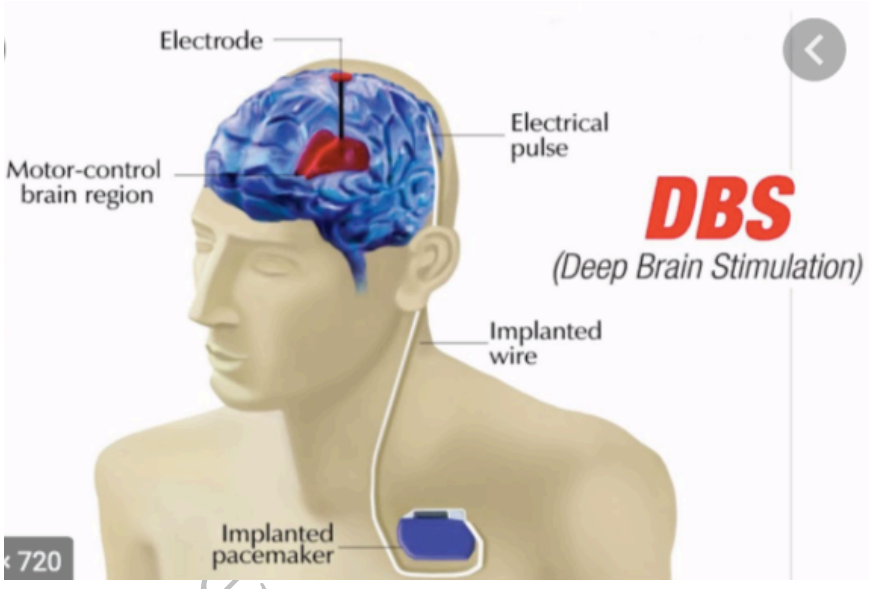


Deep brain stimulation: (https://www.youtube.com/watch?v=2wvj7XJrQW4)

- Has been used to treat Parkinsonism since the 1960s.
- Deep brain stimulation has been used on severely depressed patients.

In this procedure, electrodes are surgically implanted into structures of the limbic system.

- Like vagal stimulation, the electrodes are connected to a pacemaker-like device.



Initial results show some promise in treatment resistant patients, but time will tell if this is a useful treatment.

Both vagal stimulation and deep brain stimulation have proved efficacious in the management of intractable seizures in complex epilepsy syndromes.

Psychological Treatments for Depression:

Cognitive-behavioural therapy:

- Addresses cognitive errors in thinking
- Also includes behavioural components including behavioural activation (scheduling valued activities).

Interpersonal psychotherapy:

- *Brief treatment approach that emphasizes resolution of interpersonal problems and stressors, such as role disputes, in marital conflit or forming relationships in marriage or a new job, it has demonstrated effectoeness for such problems as depression.*

Focus: Improving problematic relationships.

Prevention:

- Pre-emptive psychosocial care for people at risk.
- Has longer-lasting effectiveness than medication.

Preventing Relapse:

- Research on relapse prevention is relatively less common.
- Psychosocial and pharmacological treatments are both used.
- Psychosocial interventions generally more effective at preventing relapse.

Treatments for Bipolar Disorders:

1. Medication (usually lithium) is still first line of defence.
2. Psychotherapy helpful in managing the problems (e.g. interpersonal, occupational) that accompany bipolar disorder.
3. Family therapy can be helpful.

SUICIDE

Facts and Statistics:

- Eleventh leading cause of death in USA
- Underreported; actual rate may be two to three times higher

Gender differences:

- Females attempt suicide more often than males
- Males complete more suicides than females
- Disparity is due to males using more lethal methods
- Exception: Suicide more common among women in China
- May reflect cultural acceptability; suicide is seen as an honourable solution to problems.

Many of these unreported suicides occur when people deliberately drive off a cliff or into a bridge column and in the past it was not uncommon to attribute deaths by suicide to medical causes out of respect to the deceased.

South African research consistently demonstrates unequal age distribution of suicide.

Racial and Ethnic differences:

- Historically, data in South Africa suggested that suicide is more common among white than black South Africans.
- The utility of racially-based data on suicide appears unclear whether race is a useful variable.
- Race may well be too crude a parameter and other variables, such as socioeconomic status, education, unemployment, poverty, general health and access to medical care might be more meaningful

In addition to completed suicides, three other important indices of suicidal behaviour are:

1. suicidal ideation (thinking seriously about suicide)
2. suicidal plans (the formulation of a specific method for killing oneself)
3. suicide attempts (when the person survives)

Nock and Kessler distinguish:

- **Attempters:** *self-injurers with the intent to die.*
- **Gesturers:** *self-injurers who intend not to die but to influence or manipulate somebody or communicate a cry for help.*

Risk Factors:

- ➔ Suicide in the family.
- ➔ Low serotonin levels.
- ➔ Pre-existing psychological disorder.
- ➔ Alcohol use and abuse.
- ➔ Stressful life event, especially humiliation.
- ➔ Past suicidal behaviour.
- ➔ Plan and access to lethal methods.

Suicide Contagion:

Some research indicates that a person is more likely to commit suicide after hearing about someone else committing suicide.

Media accounts may worsen the problem by:

- Sensationalising/romanticising suicide.
- Describing lethal methods of committing suicide
    - providing a guide on how to commit the suicide.

Most people react to hearing the news of a suicide with sadness and curiosity. Some people, however, react by attempting suicide themselves, often by the same method they have just heard about:

Gould (1990) reported an increase in suicides during a nine-day period after widespread publicity about a suicide, and a recent review found a positive relationship between suicidal behaviour and exposure to media coverage related to suicide.

- Clusters of suicides (several people copying one person) seem to predominate among teenagers, with as many as 5% of all teenage suicides reflecting an imitation.

Little is reported about the paralysis, brain damage and other tragic consequences of the incomplete or failed suicide, or about how suicide is almost always associated with a severe psychological disorder.

To prevent these tragedies, mental health professionals must intervene immediately in schools and other locations with people who might be depressed or otherwise vulnerable to the contagion of suicide.

- ➢ The stress of a friend's suicide or some other major stress may affect several individuals who are vulnerable because of existing psychological disorders.

Suicide Prevention:

<u>In professional mental health:</u>

1. Clinician does risk assessment (ideation, plans, intent, means, etc.).
2. Clinician and patient develop safety plan (e.g. who to call, strategies for coping with suicidal thoughts).
3. In some cases, sign no-suicide contract.

<u>Preventative programmes for at-risk groups</u>:

- CBT can reduce suicide risk

Important: Removing access to lethal methods

NB: If you think someone is at risk, talk to them and ensure they're getting needed support:

- Talking to someone about suicide is not likely place them at greater risk or 'plant the idea'.
    - In contrast, the risk of not providing support to someone in need is huge.

The South African Suicide and Anxiety Prevention Group (SADAG)

For a suicidal Emergency contact us on 0800 567 567

24hr Helpline 0800 456 789