

Mood Disorders

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I. Introduction

Mood disorders can be traced to our earliest times (indeed, to the Book of Genesis by some writers: Ostow, 1980) and across cultures (Al-Issa, 1982; Carson, et al., 1988). Many famous people apparently suffered from these disorders. Eg: Lincoln and Freud suffered from depression. They are among the most prevalent of psychological disorders (Reus, 1988).

The Mood Disorders are characterized by prolonged and persistent positive and/or negative emotions, which are of such intensity that they can color and interfere with all aspects of one's life. The key ingredient here is mood. Although thoughts may also be disturbed, thought disorder (i.e.: impairment of intellectual functioning - reflected by incoherence, unconnected, chaotic thoughts, bizarre speech and the like) is not a defining feature (Thought disorder is central to Schizophrenia, which we will be discussing in later lectures).

The emotions experienced in these disorders are typically thought to exist along a continuum with normal emotions (Beck, 1967; Reus, 1988). For example, we've all experienced sadness at some point in our lives. But such experiences do not warrant a diagnosis. As we shall see, clinical depression is very different from sadness. The emotions (or moods) we will be focusing on are excessively elevated moods and excessively depressed moods, or in other words, Mania and Depression.

A. **Manic States:** elevated, expansive, grandiose, or irritable mood.

A person in a manic state feels euphoric and high, eager to be involved with others and with life in general. This expansive and elevated mood may have an infectious quality for the uninvolved observer, but for those who know the person well, the mood is recognized as excessive.

Other characteristics:

- inflated self-esteem

- decreased need for sleep (eg: only 3 hours a night, or stays awake for 3 or 4 days at a time)

- talkative (e.g.: loud, difficult to interrupt, continuous flow of speech)

- racing ideas

- easily distracted

- nervous activity

- high degree of risk taking (often dangerous)

One patient who went on to write a book about his experiences (Custance, 1952), similarly describes mania:

intense sense of well-being
heightened sense of reality
release of inhibitions (sexual, moral)
delusions of grandeur and power

Others who have published personal accounts report similar experiences when in a manic state (see Lerner, 1980).

Case Study:

When experiencing manic symptoms, a 38 year old woman, periodically hospitalized because of her extreme moods, would become "overactive and exuberant in spirits and visited her friends, to whom she outlined her plans for reestablishing different forms of lucrative business. She purchased many clothes, bought furniture, pawned rings, and wrote checks without funds. (She) played her radio until late in the night, smoked excessively, took out insurance on a car that she had not yet bought. Contrary to her usual habits, she swore frequently and loudly, (and) created a disturbance in a club to which she did not belong. On the day prior to her second admission to the hospital, she purchased 57 hats" (Kolk, 1973, pp376-377).

These states of mania occur as discreet episodes: a distinct period of time during which the symptoms described above are predominant. Episodes typically begin suddenly, initially with a decreased need for sleep (Reus, 1988), and then escalate to last for a few days, or months in some cases (APA, 1987). Initially, the person's behavior may be quite creative and productive, and other people may enthusiastically join in with him or her. Such people can at first be quite engaging. But it soon becomes clear that little caution or judgment is being exercised, and the behavior deteriorates to socially inappropriate or self-destructive activities (esp. substance abuse) (Reus, 1988). Hospitalization often becomes necessary to prevent harm to self or others (APA, 1987).

In some cases, the person's thoughts and perceptions lose contact with reality - psychotic symptoms arise (these symptoms are not, however, a defining feature of mania). These include delusions and hallucinations.

Delusions: False beliefs based on an inaccurate inference or understanding of reality. For example: The person may believe he is being persecuted for his special or even divine powers

Hallucinations: Sensory perceptions (hearing, touch, sight, etc.) that seem real when in fact there is no external stimulation. So, for example, our person might hear the voice of alien beings instructing him to carry out some dangerous mission.

Usually these psychotic experiences are mood-congruent. That is, they are consistent with the extreme mood the person is experiencing. In rarer cases, the psychotic experiences are mood-incongruent: The content of the delusion or hallucination does not involve the themes typical in manic episodes (e.g.: delusions of being controlled, refusing to move or speak).

There is a milder form of mania, known as hypomania: In hypomania the extreme social and occupational impairments do not occur, and hospitalization is never required. Nor do psychotic features occur in hypomania.

B. Major Depression: depressed mood for most of the day, nearly every day, or loss of interest or pleasure in all, or almost all, activities, for a period of at least two weeks (APA, 1987). Note: It is not necessary for the person to report feeling depressed to be diagnosed with Major Depression. The presence of depressed mood

can be inferred from observing the person's behavior (see "Other features" listed below). Similarly, s/he may not complain of a loss of interest or pleasure, but withdrawal from once pleasurable activities and from friends has usually been observed by others (family, friends).

Other features include:

- often a diminished interest or pleasure in most activities.
- significant weight change
- appetite disturbance (especially loss of appetite)
- sleep disturbance (eg: insomnia)
- slowed movements and speech
- restlessness
- decreased feelings of energy
- feelings of worthlessness
- excessive or inappropriate guilt
- difficulty thinking, concentrating, attention &/or remembering
- indecisiveness
- thoughts of death and suicide
- suicide attempts

As a consequence, a person can end up unable to function even minimally (feeding, hygiene, etc.).

Case Study:

"I was seized with an unspeakable physical weariness. There was a tired feeling in the muscles unlike anything I had ever experienced...My nights were sleepless. I lay with dry, staring eyes gazing into space...The most trivial duty became a formidable task. Finally mental and physical exercises were impossible; the tired muscles refused to respond, my "thinking apparatus" refused to work, ambition was gone. My general feeling might be summed up in the familiar saying "What's the use." I had tried so hard to make something of myself, but the struggle seemed useless. Life seemed utterly futile" (Reid, 1910, quoted in Davison & Neale, 1986, p.194).

The typical age of onset is between about 20 and 40 years, but can occur at any age (APA, 1987; Reus, 1988). The earlier the onset, the more likely the depression will recur later in life. Major Depression, like Mania, occurs in discreet episodes. These episodes develop gradually over many months, or sometimes more quickly, perhaps following some stressful event (although that isn't necessary). The symptoms will typically last six months or more (if untreated), and then subside, although there is some evidence that such recovery is not as common as once thought. Recent studies suggest that only about 50% of people suffering from Major Depression recover over a 12 month period (Reus, 1988). Relapse is much more likely if the episodes are brief and age of onset is early (Reus, 1988).

For some individuals, the depressive symptoms are chronic: they last for two years without a remission greater than two months.

As with mania, in certain cases the person's thoughts or perceptions may lose contact with reality, so that delusions, hallucinations or other psychotic features will be present. These can include mood-congruent delusions (eg: persecuted for moral transgressions, or otherwise self-deprecatory) and hallucinations (eg: berating voices blaming him/her for sins). Less common are mood-incongruent delusions and hallucinations (eg: belief in the ability to read minds).

There has been considerable interest in recent years in trying to identify sub-types of depression (different etiology, different responses to treatment methods). Thus, DSM-IV-TR requires specification as to whether or not the major depression is of the "melancholic type". This sub-type is characterized by

symptoms such as a loss of interest in almost all (or all) activities, an inability to experience pleasure, depression usually worse in the morning, early morning waking, good response to antidepressant medications. The hypothesis has been (although the DSM-IV-TR takes no explicit stand on this) that this type of depression is due to internal, perhaps biological processes, and is relatively unrelated to external events (we'll have more to say on this in the lectures on etiology).

Note: A person is not diagnosed with Major Depression if there are organic/biological causes or if the mood is the result of normal grieving over a death.

II. The DSM-IV-TR Mood Disorder Categories

The DSM-IV-TR divides the Mood Disorders into two major categories: Bipolar Disorders and Depressive Disorders. The Bipolar Disorders are characterized by alternating periods of mania and depression. The Depressive Disorders do not have periods of mania. These two classes of disorders are further sub-divided based on whether the disorder is chronic or episodic.

A. Bipolar Disorders

1. Bipolar Disorder: one or more Manic episodes usually accompanied by one or more Major Depressive episodes (this is the disorder sometimes known as "manic-depressive disorder").

Typically the mania and depression alternate, although in rare cases they may coexist. Although the DSM-IV-TR does not provide a category for this, there is some evidence that there may be a "unipolar" disorder: mania without any episodes of depression (Andreasen, 1982).

A Manic period is usually the reason the person comes to the attention of professionals.

Prevalence: .4% to 1.2% of the adult population.

Sex Ratio: Recent studies indicate this disorder to be equally common in males and females (APA, 1987).

According to the official U.S. definition as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, Bipolar II Disorder is "characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode." The key difference between Bipolar I and Bipolar II is that Bipolar II has hypomanic but not manic episodes. Also, while those with Bipolar I disorder may experience additional psychotic symptoms such as delusions and hallucinations, Bipolar II by definition cannot have psychotic features.

The indicators which would lead to a diagnosis of Bipolar II Disorder are:

- One or more Major Depressive Episodes
- At least one Hypomanic Episode
- There has never been a Manic or Mixed Episode
- Another disorder is not responsible for symptoms
- Symptoms cause distress or impair functioning

Symptoms and characteristics of depression include:

- Decreased energy
- Weight loss or gain
- Despair
- Irritability
- Uncontrollable crying

Symptoms and characteristics of hypomania include:

- Grandiosity – A symptom of mania or hypomania in bipolar disorder. In the APA DSM-IV, it is used in combination with several other symptoms to confirm a diagnosis of this disorder. This symptom also occurs in children with early onset bipolar disorder.
- Decreased need for sleep
- Pressured speech – A hallmark symptom of mania or hypomania in bipolar. In the APA DSM-IV, pressured speech is used in combination with several other symptoms to confirm a diagnosis of this disorder. It is a rapid, virtually non-stop, often loud and emphatic, seemingly driven, and usually hard to interrupt form of speech. It typically occurs in mania and in some drug-induced states as well as in severe anxiety states.
- Racing thoughts
- Distractibility
- Tendency to engage in behavior that could have serious consequences, such as spending recklessly or inappropriate sexual encounters
- Excess energy

It should be noted that the symptoms of hypomania are the same as for mania, but they are less severe.

2. Cyclothymia: a mood disturbance characterized by alternating Hypomanic episodes with depressed mood; this mood disturbance having lasted for at least two years. Both ends of the "cycle" are never severe enough to be called Mania or Major Depression, and there are never any psychotic symptoms.

This is apparently a common disorder, possibly making up as much as 3 - 4% of the clinical population (Reus, 1988). Prevalence: .4 - 3.5%. Possibly more prevalent in women (APA, 1987, Reus, 1988).

People suffering from this disorder tend to be extroverted and sociable, appearing self-assured, energetic and impulsive and daring. Yet, they will also suddenly turn irritable and sensitive to rejection or loss. Substance abuse is a common complication (Reus, 1988).

There is a growing body of evidence that Cyclothymics are at risk to go to develop Bipolar Disorder and other Mood Disorders (Klein & Depue, 1984).

B. Depressive Disorders

1. Major Depression: one or more Major Depressive episodes as described above, without Mania or Hypomania. Episodes can be separated by years, or cluster around particular periods of time. Some fascinating recent work suggests that there may be a connection between the time of the year and the occurrence of a depressive episode. In other words, the occurrence of an episode may depend on the season. We will discuss this in an upcoming lecture.

Prevalence: 3% for men; 4 - 9% for women (Reus, 1988)

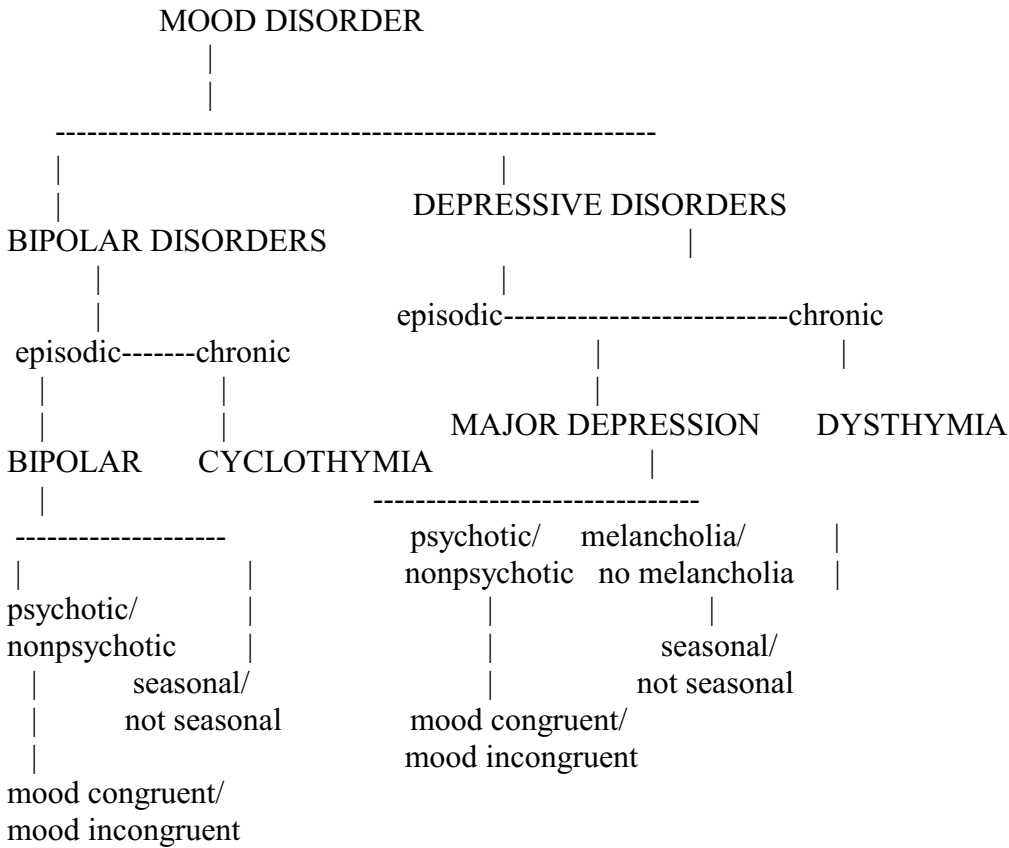
50% of sufferers will have more than one episode, and are at greater risk for developing Bipolar Disorder.

2. Dysthymia: chronic depressed mood for most of the day, more days than not, for at least two years. Often considered to be a "characterological" depression - the depression is the very core of how the person operates and thinks. These individuals experience chronic feelings of inadequacy and worthlessness. The symptoms are thus similar to Major Depression, just not as

severe. There is, however, no "loss of interest in pleasurable activities" nor an "inability to experience pleasure" which sometimes accompanies Major Depression.

The disorder is apparently common and somewhat more prevalent in women (APA, 1987).

The different categories of Mood Disorders and how they are related are summarized in the following:



(Adapted from Kupfer & Thase, 1987).