Mood Disorders & Suicide

PSYCH 239

WHAT ARE MOOD DISORDERS?

- As the name implies, mood disorders are a type of disorder characterized by disturbances of mood. They can take a variety of forms.

TYPES OF MOOD DISORDERS

- Mood Episodes
- Depressive Disorders
- Bipolar Disorders
- Other Mood Disorders

… Consider a continuum

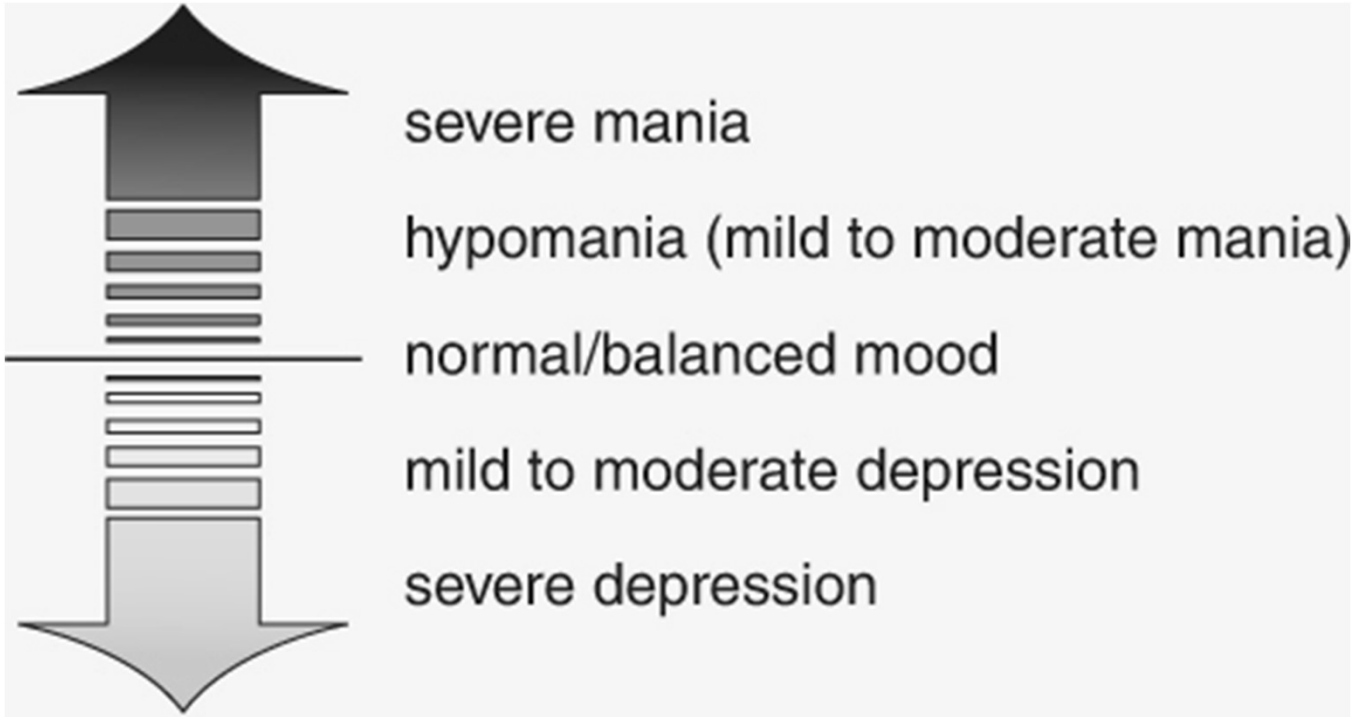


FIGURE 4.1 A mood thermometer.
Mood states can be conceptualized as varying along a spectrum or continuum. One end represents severe depression and the other end severe mania, which is a cardinal feature of bipolar I disorder. Mild or moderate depression is often called "the blues" but is classified as dysthymia when it becomes chronic. In the middle of the spectrum is normal or balanced mood. Mild mania is called *hypomania*.

Source: Based on National Institutes of Mental Health.

MAJOR DEPRESSIVE DISORDER

Major depressive disorder (MDD):

Severe mood disorder characterized by the occurrence of major depressive episodes *in the absence of a history of manic episodes*.

MAJOR DEPRESSIVE DISORDER

Major depressive disorder is characterized by a range of features:

- depressed mood
- lack of interest or pleasure in usual activities
- lack of energy or motivation
- changes in appetite or sleep patterns.

DSM-5 Criteria: Major Depressive Disorder

A. At least five 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.

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation made by others)

DSM-5 Criteria: Major Depressive Disorder

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

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)

DSM-5 Criteria: Major Depressive Disorder

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 specific plan for committing suicide

MAJOR DEPRESSIVE DISORDER

When are changes in mood considered abnormal?

Persistent or severe changes in mood or *cycles of extreme* elation and depression may suggest the presence of a mood disorder.

MAJOR DEPRESSIVE DISORDER

In Canada:

Depressive disorders are MOST common in adolescence and early adulthood (15-24 years of age)

Through adolescence and adulthood (15-64 years of age) WOMEN have a higher prevalence of depressive disorders compared to men

Older adults (65 and older) have the lowest prevalence of depressive disorders, and no significant difference between men and women

MDD Specifiers

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern (recurrent episode only)

MAJOR DEPRESSIVE DISORDER

RISK FACTORS FOR DEPRESSION:

- Age – more often starts in younger adulthood
  - –20s and 30s
- Socioeconomic status
- Marital status
- Women are nearly twice as likely as men to develop major depression
  - –Less pronounced difference in later years
  - –Greater array of life stressors?
- Coping styles

SEASONAL AFFECTIVE DISORDER

The features of SAD include:

Correctly called **MDD with seasonal pattern**

- fatigue
- excessive sleep
- craving for carbohydrates
- weight gain.

SEASONAL AFFECTIVE DISORDER

MDD with seasonal pattern :

- affects women more often than men
- is most common among young adults
- possibly occurs in children but not as commonly as in young adults

POSTPARTUM DEPRESSION

POSTPARTUM DEPRESSION:

- Correctly termed: **MDD with Peripartum Onset**
- Persistent and severe mood changes that occur following childbirth.
- In fact, about half begin in the late stages of pregnancy (hence the switch to *peri*partum)

-Prevalence: 10 to 15%

PERSISTENT DEPRESSIVE DISORDER

PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA):

- Previously called *Dysthymic Disorder*
- a milder form of depression, seems to follow a chronic course of development that often begins in childhood or adolescence

Persistent Depressive Disorder DSM-5 Criteria

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.

Premenstrual Dysphoric Disorder

Premenstrual Dysphoric Disorder:

Premenstrual Dysphoric Disorder is characterized by mood changes that revolve around a woman's menstrual cycle.

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 post menses.

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.

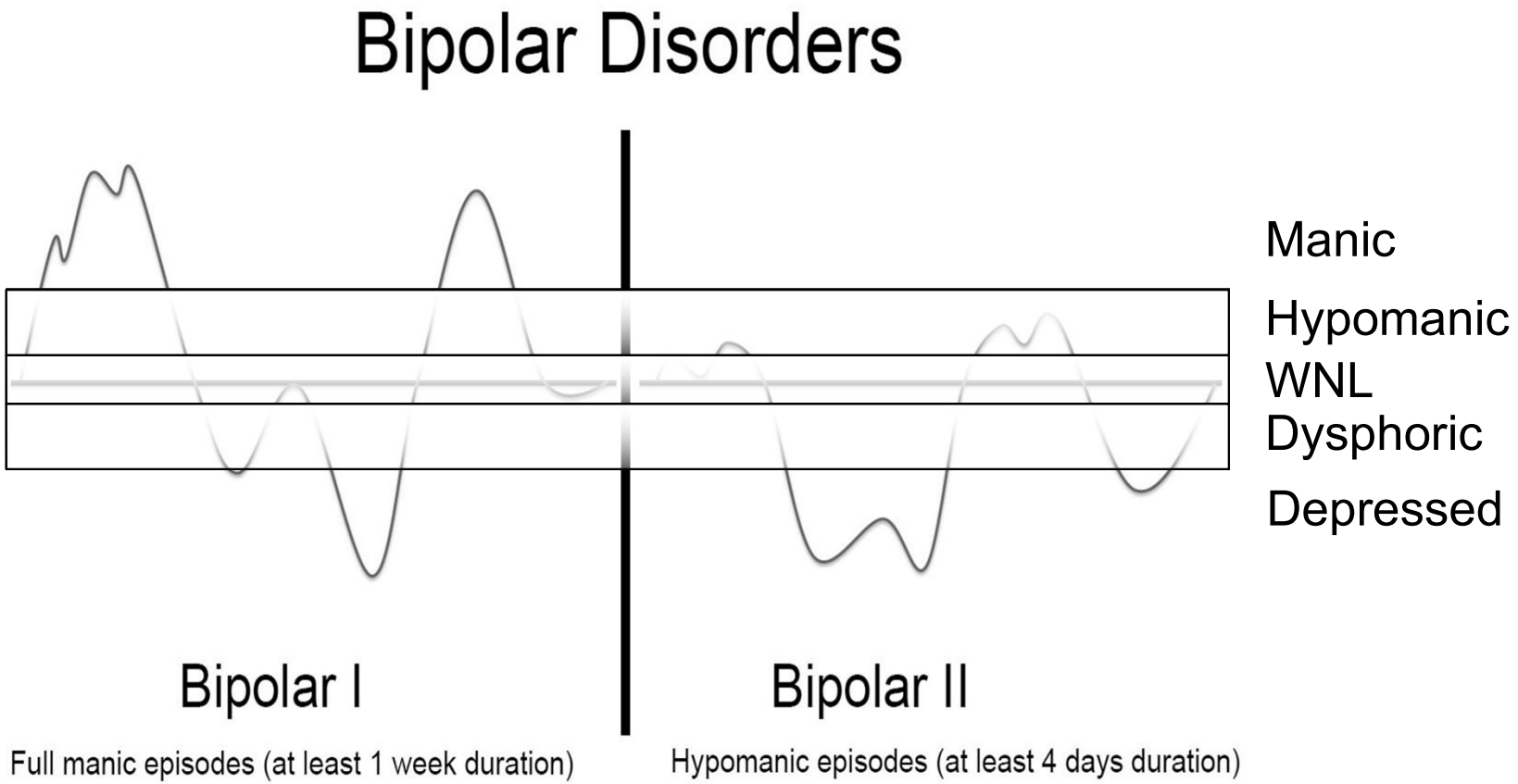
Premenstrual Dysphoric Disorder (cont.)

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.

BIPOLAR DISORDER

- **Bipolar Disorder I**: features states of extreme elation (*manic episodes*); major depressive episodes are a common feature.
- **Bipolar Disorder II**: features states of abnormally elevated mood (*hypomania*) and major depressive episodes.



BIPOLAR DISORDER

MANIC EPISODE:

- Periods of unrealistically heightened euphoria, extreme restlessness, and excessive activity characterized by disorganized behaviour and impaired judgment.

BIPOLAR DISORDER

PRESSURED SPEECH:

Outpouring of speech in which words seem to surge urgently for expression, as in a manic state.

BIPOLAR DISORDER

RAPID FLIGHT OF IDEAS:

- A characteristic of manic behaviour involving rapid speech and changes of topics.

MANIC EPISODE – DSM-5 Criteria

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:

MANIC EPISODE – DSM-5 Criteria (cont.)

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).

BIPOLAR I DISORDER DSM-5 CRITERIA

A. Criteria have been met for at least one manic episode.

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.

- So really, Dx of a Manic Episode is usually tantamount to a Bipolar I Dx

HYPOMANIC EPISODE – DSM-5 Criteria

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 have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:

HYPOMANIC EPISODE – DSM-5 Criteria (cont.)

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. NOT severe enough to require hospitalization or cause major disruption.

BIPOLAR II DISORDER – DSM-5 Criteria

A. Criteria have been met for at least one hypomanic episode 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

Cyclothymic disorder:

- Mood disorder characterized by a chronic pattern of *mild mood swings* between depression and mania that are not of sufficient severity to be classified as bipolar disorder.

CYCLOTHYMIC DISORDER

- Numerous periods of hypomanic symptoms for at least two years that fail to meet the criteria for hypomanic episodes.
- Numerous periods of depressive symptoms that fail to meet the criteria for a major depressive episode.
- The person has experienced the periods mentioned above for at least half the time, and the person has not been without symptoms for longer than two months.
- The symptoms experienced are not due to another mental health condition.
- The symptoms experienced are not caused by a medical condition or substance.
- The symptoms experienced impair the person's ability to socialize, work, or function in other areas of his or her life.

THEORETICAL PERSPECTIVES

- Stress & Mood Disorders
  - Strong correlation
  - Even childhood experiences can later emerge as risk factors.
  - Symptoms of depression may lead to interpersonal conflict and job loss = more stress.
- Strong social supports and healthy coping style can be protective factors.

THEORETICAL PERSPECTIVES

Psychodynamic Perspective

- Anger at an internalized (*introjected)* love object is inwardly directed.
  - "I feel like I lost a part of myself…"
- Mourning (uncomplicated) is healthy and represents a form of psychological separation.
- Becomes pathological as a result of ambivalence (i.e., anger *and* guilt).
- Chronically depressed patients appear to engage in excessive *self-focusing* following loss or failure, but so do other clinical groups.

THEORETICAL PERSPECTIVES

Humanistic Perspective

What happens when we lose our sense of direction?
According to the humanistic-existential perspective, depression may result from the inability to find meaning and purpose in one's life.

THEORETICAL PERSPECTIVES

Learning Perspective

- Reinforcement & Depression
- Learned helplessness
- Interactional Theory (James Coyne, 1999)
  - Reciprocal interaction

SELIGMAN'S LEARNED HELPLESSNESS EXPERIMENTS

- Training phase: 3 groups
  1. No shocks
  2. Avoidable shock
  3. Non-avoidable shock
- Test Phase: All in shuttle Box (left)
  - Groups 1 & 2: Learned avoidance
  - Group 3: Failed to learn avoidance response
- Affective and behavioural differences
- Clinical implications?

THEORETICAL PERSPECTIVES

Cognitive (by extension) Perspective

- Learned Helplessness (Seligman)
  - Attributional Style
    - Internal Attribution
    - Stable vs. Unstable Attribution
    - Global vs. Specific Attribution

THEORETICAL PERSPECTIVES

Cognitive Perspective

- Aaron Beck's Cognitive Theory
  - Cognitive Distortions
  - Automatic Thoughts

THEORETICAL PERSPECTIVES

The Depressive Triad

Negative views of:

1. **Self**
2. **Environment**
3. **Future**

- Thinking positively toward any of these would likely lessen negative affect.

Cognitive Distortions

- All-or-nothing thinking
- Overgeneralization
- Mental filter
- Disqualifying the positive
- Jumping to conclusions
- Magnification/Minimization
- Emotional reasoning
- “Should” statements
- Labelling/Mislabelling
- Personalization

THEORETICAL PERSPECTIVES

Biological Perspective

- Genetic Factors
- Biochemical Factors & Brain Abnormalities in Depression

THEORETICAL PERSPECTIVES

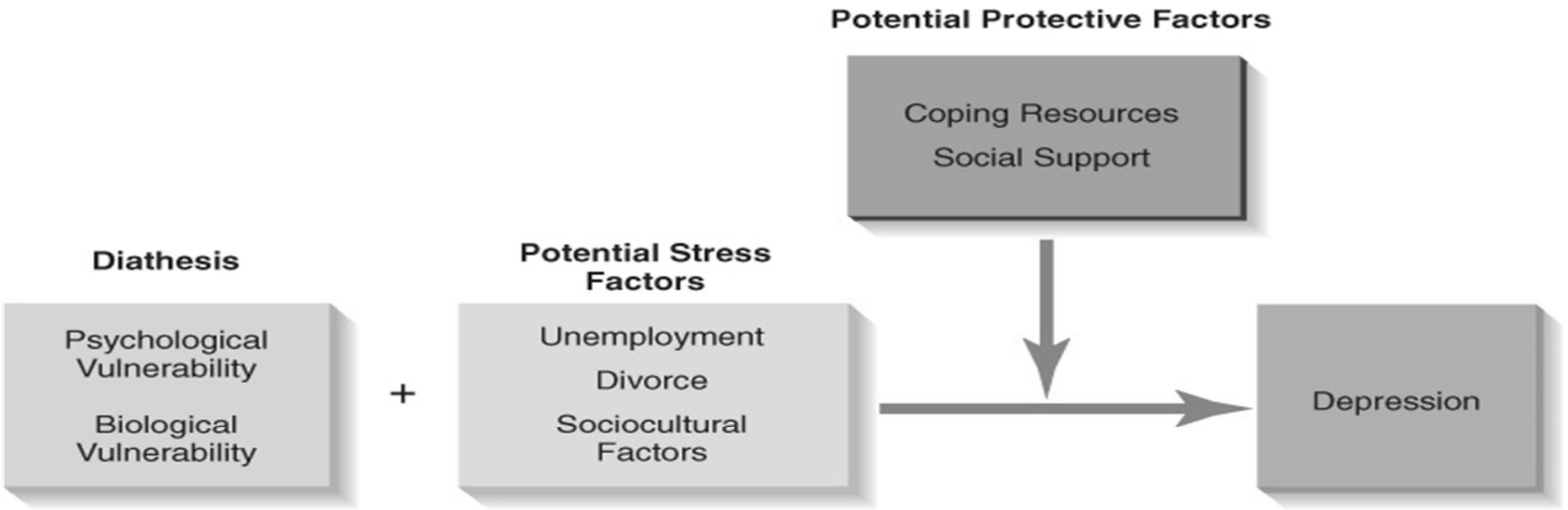


FIGURE 4.3 Diathesis-stress model of depression.

TREATMENT

- **Psychodynamic Approaches**
  - Interpersonal Therapy (IPT)
- **Behavioural Approaches**
  - "*Coping With Depression*" (CWD) Course
- **Cognitive Approaches**
  - Cognitive Therapy

TREATMENT

- **Biological Approaches**
  - Antidepressant Drugs
  - Lithium
  - Electroconvulsive Therapy (ECT)

Bottle cap and label from 1930s era.

1955 print advertisement.

1948 ruling to remove Lithium from all soft drinks

Treatment (3 of 3)

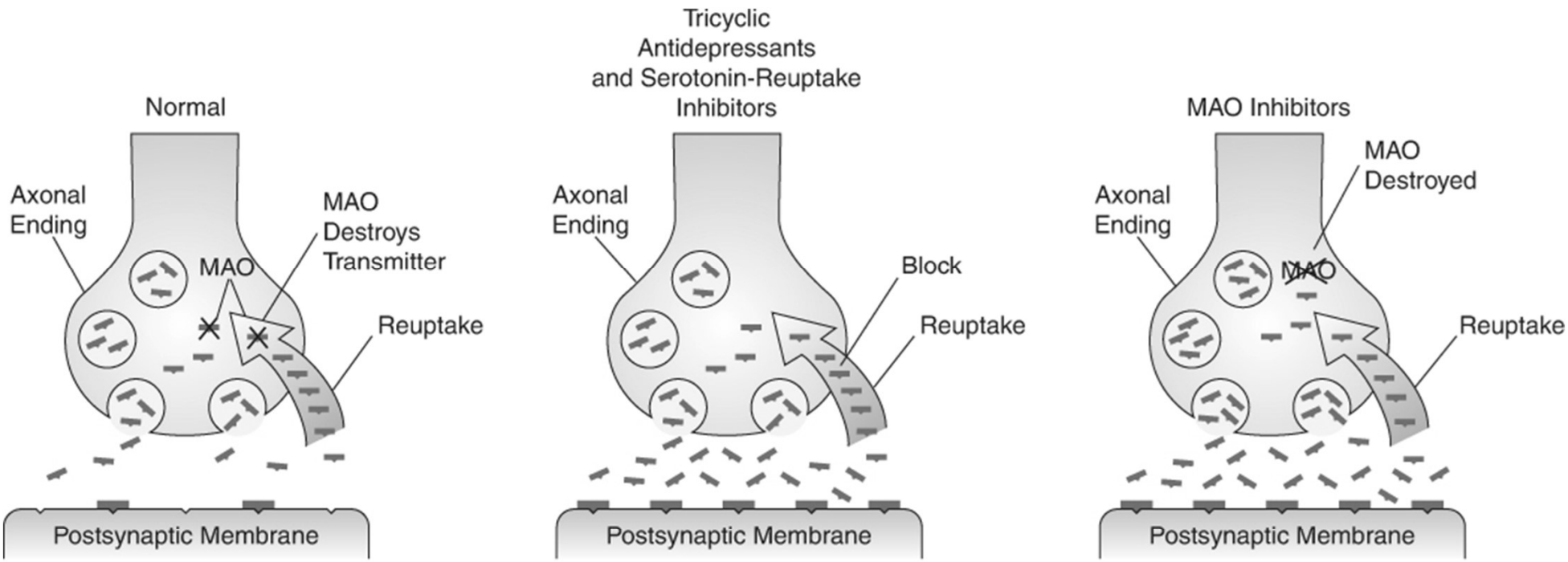


FIGURE 4.4 The actions of various types of antidepressants at the synapse.
Tricyclic antidepressants and selective reuptake inhibitors (SSRIs and SNRIs) increase the availability of neurotransmitters by preventing their reuptake by the presynaptic neuron. MAO inhibitors work by inhibiting the action of monoamine oxidase, an enzyme that normally breaks down neurotransmitters in the synaptic cleft.

TREATMENT: St. John's Wort

- *Hypericum perforatum.* Used for centuries to heal wounds.
- Early small-scale studies supported benefits of St. John's Wort with few reported side effects in cases of mild to moderate depression.
- Unclear as to whether it is effective in treating severe depression.
  - Continues to be evaluated

SUICIDE

Who Commits Suicide?

- 24% of deaths in Canada for 15-24 year olds.
- Suicide is one of the leading causes of death in both men and women from adolescence to middle age

SUICIDE

- Why Do People Commit Suicide?
- Theoretical Perspectives on Suicide
- Predicting Suicide (concussions)

SUICIDE PREVENTION

1. Draw the person out.

2. Be sympathetic.

3. Suggest that means other than suicide can be discovered to work out their problems.

SUICIDE PREVENTION

4. Inquire as to how the person expects to commit suicide.

5. Propose that the person accompany you to see a professional right now.

6. Don’t degrade the individual (“You’re talking crazy…”)