# Dysthymic Disorder

## A Depressed mood for at least 2 years for most days

## B Two or more of the following while depressed:

### Poor appetite or overeating

### Insomnia or hypersomnia

### Low energy

### Low self-esteem

### Poor concentration or difficulty making decisions

### Feelings of hopelessness

## C Symptoms absent for no more than 2 months total added up

## D No Major Depressive Disorder for first two years

## E Never Manic, Mixed, or Hypomanic Episode

Lifetime Prevelance: 3.6%

You can be diagnosed with dysthymic and major depressive episode

# Bipolar I Disorder (Manic History)

## Presence of a Manic, Hypomanic, or Major Depressive Episode

## .4% or 1.6% prevelance

Typically late asolecence onset

No racial or ethnic differences, same amount male to females

85% of people who have a depressive episode will have another depressive episode

90% of people who have had a manic episode wil have another manic episode

## If currently in a Hypomanic or Major Depressive Episode, history of a Manic Episode

## Significant distress or impairment

# Bipolar II Disorder (Hypomania + Depression)

## At least one or more Hypomanic Episodes, either past or present

## One or more Major Depressive Episodes, either past or present

## Never been a Manic or Mixed Episode

## Mood symptoms cause significant impairment

# Cyclothymic Disorder

## For at least 2 years, numerous periods of hypomanic symptoms and periods of depressive symptoms (not concurrent)

## Symptoms absent for no more than 2 months cumulatively

## No Major Depressive, Manic, or Mixed Episode

Onset during the teens

More common in females

## Mood disturbance causes significant impairment; Not due to substance or medical condition

# Specifiers

# Depressive

# Atypical – When they gain weight and/or sleep more when depressed. Retained ability to have interest in things

* Metancholic – When they report physical symptoms, loss of libido, lack of energy, losing weight, guilt feelings or loss of interests.
* Chronic - If you have major depressive episodes that last over 2 years continuously
* Bipolar I & Depressive
  + Catatonic (Bipolar I & Depressive) – Shows lack of movement, like gumby
  + Psychotic – Loss of reality, hear voices or delusions, only when in a mood episode. They can be mood congruent (neg. voices when depressed, great voices when in a manic episode).
  + With Postpartum Onset – Bipolar mood within one month of child birth. In DSM-V it will be within 6 months of childbirth

# DSM-V Changes

* MDD – no significant changes
* Dysthymic Disorder – Rename Chronic Depressive disorder and eliminate criteria D and E
  + Criteria D and E are
    - No major depressive disorder for first two years
    - Never manic, mixed, or hypomanic episode
* Bipolar I
  + Now diagnosed with one of 4 subtypes
    - Current or Most Recent Episode Hypomanic
    - Current or Most Recent Episode Manic
    - Current or Most Recent Episode Depressed
    - Current or Most Recent Episode Unspecified
* Bipolar II
  + Now diagnosed with one of 2 subtypes
    - Current or Most Recent Episode Hypomanic
    - Current or Most Recent Episode Depressed
* Mixed Episode
  + Downgraded to a specified “with mixed features”

# MDD – Behavioral Perspective

## Lewinsohn’s operant conditioning paradigm

## Behaviors we engage in are reinforced

## Two types of reinforcers (mastery vs. pleasure)

Mastery – Relate to a sense of achievement, tends to be instrinsicly motivating. Example: Learning to a ride a bike, a hard math problem, etc

Pleasure – Tend to be more extrinsic. They make us feel good, exercise, relaxing, watching tv, hanging out with friends, etc

## Depression occurs due to an absence of reinforcers, leading to extinction of behaviors

Mimics withdrawl part of depression

Fewer opportunities of reward

Works on mainting depression

## 3 reasons for lack of reinforcement (R)

### Environment produces loss of R (lost your job, divorce, death, etc)

### Skill deficit inhibits obtainment of R (socially unskilled and it’ll be hard to have a social encounter)

### R available but person cannot enjoy (Interfereing anxiety)

## Maintenance of depression

# MDD – Cognitive Perspective

## Learned helplessness

When they’re put in a situation where they can change the situation they will not even try. Depression is linked to a loss of control.

## Attribtutions

### Internal/external

### Global/specific

Applies to a wide range of events / only in that one circumstanc

### Stable/unstable

Always going to be that way / specific to just now

# Helplessness Attributions

Internal Global Stable is the worst to have

# Cognitive Perspective on MDD – Primary Model of Depression

## Beck’s cognitive theory of depression

Depression comes from negative thoughts

### Core of depression is distorted cognitions (things you think are true but may not be true), although emotions might be more obvious

### Develop maladaptive attitudes as children

Ideas on how the way the world works. If you start to think that your self worth is tied to you winning, you’re setting yourself up to feel bad when you lose

### Upsetting situations trigger negative thinking, shown by a “cognitive triad”

#### Negative view of self

#### Negative view of world

#### Negative view of future- important predictor of suicide (hopelessness)

# Types of Thoughts In MDD

## Automatic thoughts - beliefs about the moment-to-moment occurrences in life

### Attributions- explanations for events

### Expectancies- predictions about the future

## Basic beliefs – develop in childhood

### Assumptions-beliefs about the nature of the world on a basic level. If you believe the world is a dangerous place, things are out of control idea

### Schemas- basic beliefs about nature of self. “No one will love me”

# Development of MDD

## Person has vulnerabilities due to negative schemas and assumptions

## Negative life situation (extreme stress, loss or thwarting of goals, etc.) triggers schemas

## Activation of schemas leads to distorted automatic thoughts through logical errors

## Schemas also activate negative emotions related to cognitive schemas

## Negative emotions further energize schemas

# Major Depressive Disorder

## Why higher prevalence for women?

### Artifact theory

The difference we see is merely for the fact that men do not want to get treatment but women will. It’s just a fluke.

### Hormone theory

There are a number of hormonal changes in females during puberty and continually fluctuate. Men do not have such extreme fluctuation of hormones.

### Quality of life

If you look at the gender breakdown for poverty women are lower socioeconomically.

### Lack of control

Women are socialized to be submissive and subserveant.

### Attributions

Women are more likely to blame themselves when something goes wrong.

### Social creation

Women may be brought up or expected to be more expressive and bring up emotions. When upset they’re taught to cry, men are the opposite. It may be a function of that, that women are more likely to express dissatifaction.

### Reaction to stress

There is some evidence that women are more likely to reuinate problems and men are much more willing to do problem solving.

Biological Treatments for MDD

* + Antidepressants drugs
    - Monoamine Oxidase Inhibitors (MAO Inhibitors)
    - Tricyclics
      * Block reuptake of norepenephrine and serotonin
    - Selective Serotonin Reuptake Inhibitors (SSRIs)
  + Electroconvulsive Therapy (ECT)
    - May work for six months or so
    - Mimics the effects of having more serotonin
  + Transcranial Magnetic Stimulation (TMS)
    - Stimulating the brain with magnetic pulses
    - Dallas Brain Research