
UNIT 1 MILD, MODERATE AND MAJOR DEPRESSIVE DISORDER

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1.0 INTRODUCTION

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorder (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. Mood disorders are emotional disturbances consisting of prolonged periods of excessive sadness, excessive joyousness, or both. Mood disorders are categorised as depressive or bipolar. A mood disorder is diagnosed when sadness or elation is overly intense and persistent and is accompanied by a requisite number of other mood disorder symptoms. In such cases, intense sadness is termed depression, and intense elation is termed mania. Depressive disorders are characterised by depression; bipolar disorders are characterised by varying combinations of depression and mania. In this unit we will discuss mild, moderate, and major depressive disorders. First we will deal with minor depressive disorders, then we will throw some light on moderate depressive disorders, and finally we will come across major depressive disorders.

1.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the different types of mood disorders;
- Describe the symptoms of mood disorder;
- Explain the symptoms of mild depressive disorder;

- Explain the symptoms and treatment of dysthymic disorder;
- Describe the adjustment disorder with depressed mood;
- Elucidate the types, causes and treatment of major depressive disorder; and
- Analyse the differences between mild and major depressive disorders.

1.2 DEPRESSIVE DISORDERS

We all go through ups and downs in our mood. Sadness is a normal reaction to life's struggles, setbacks, and disappointments. Many people use the word "depression" to explain these kinds of feelings, but depression is much more than just sadness. Depression is a form of what is known as a mood or affective, disorder, because it is primarily concerned with a change in mood.

On the basis of following symptoms depressive disorders are usually distinguished from other mental disorders:

- i) **Feelings of helplessness and hopelessness:** A bleak outlook—nothing will ever get better and there's nothing you can do to improve your situation.
- ii) **Loss of interest in daily activities:** No interest in former hobbies, pastimes, social activities, or sex. You've lost your ability to feel joy and pleasure.
- iii) **Appetite or weight changes:** Significant weight loss or weight gain—a change of more than 5% of body weight in a month.
- iv) **Sleep change:** Either insomnia, especially waking in the early hours of the morning, or oversleeping (also known as hypersomnia).
- v) **Irritability or restlessness:** Feeling agitated, restless, or on edge. Your tolerance level is low; everything and everyone gets on your nerves.
- vi) **Loss of energy:** Feeling fatigued, sluggish, and physically drained. Your whole body may feel heavy, and even small tasks are exhausting or take longer to complete.
- vii) **Self-loathing:** Strong feelings of worthlessness or guilt. You harshly criticize yourself for perceived faults and mistakes.
- viii) **Concentration problems:** Trouble focusing, making decisions, or remembering things.
- ix) **Unexplained aches and pains:** An increase in physical complaints such as headaches, back pain, aching muscles, and stomach pain.

Depression can be categorised in the following manner:

- 1) Depression that is originating from a bad or disturbing event in one's life
- 2) Depression which appears without apparent cause.

The first type of depression is easier for us to tackle because the cause is known. The first step is to deal with the event that triggered depression. It may have started as a result of death, an accident, a divorce or any other type of setback.

The second type of depression is more difficult to deal with as the source is unknown. It is the most common form of depression.

Mood disorders are also differentiated by

- 1) severity, that is the number of dysfunctions experienced in various areas of living and the relative degree of impairment evidenced in those areas and
- 2) duration, whether the disorder is acute, chronic, or intermittent (with periods of relatively normal functioning between the episodes of disorder).

There are several different diagnoses for depression, mostly determined by the intensity of the symptoms and the duration of the symptoms. The term depression is often used to refer to any of several depressive disorders.

Three are classified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Revision (DSM-IV-TR) by specific symptoms:

Major depressive disorder (often called major depression)

Dysthymia

Depressive disorder not otherwise specified

Two others are classified by etiology:

Depressive disorder due to a general physical condition

Substance-induced depressive disorder

- i) **Major Depression:** Major depression is a problem with mood in which there are severe and long lasting feelings of sadness or related symptoms that get in the way of a person's functioning.
- ii) **Dysthymic Disorder:** A less severe type of depression, dysthymic disorder, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good.

1.3 MILD DEPRESSIVE DISORDER

The term depression is often used to explain the feeling of sadness due to certain situations like failing an exam, having a row with a closed friend, losing a job, etc. However, this feeling of sadness cannot be exactly called depression because most likely it disappears in a day or two. However, for some people, the feeling of sorrow remains with them for a long time, so much so that it affects their daily life and activities. When such a situation arises, the person is said to be depressed. This mental condition of depression can be further divided into three forms which are mild, moderate and severe.

Among the three, moderate and severe forms of depression are talked about a lot and most do not know whether something like mild depression even exists. However, it is said that mild depression is a common phenomenon that many people experience. As people do not know about it, they are not able to recognise the signs that indicate a person to be suffering from mild depression. Though mild depression is not as serious as the other two versions of depression, if this condition is untreated, chances are there for the individual to go into severe depression. Therefore, it becomes important for people to know about what exactly happens when a person has mild depression and also about the ways one can adopt to treat this condition.

1.3.1 Symptoms of Mild Depression

The causes of mild depression is nothing different from the reasons that cause other types of depression. The difference is only in the impact that the situation has on that person. Hence, the focus is on the symptoms that can be observed when an individual is suffering from mild depression. Let us take a look at some of the symptoms of mild depression.

- i) **Reduced Concentration:** A person who is mildly depressed may feel very low, but still may continue with his daily activities like work related as well as household duties. However, he may have some difficulty in getting these things done. This is because individuals who are suffering from mild depression usually have problems like lack of concentration or reduced ability to think which hampers the activities that they used to execute easily.
- ii) **Fatigue and Sleeplessness:** Tiredness and fatigue is another symptom that affects a person who has mild depression. He may feel less energized, even after sleeping for a long time. This may happen because sometimes mild depression brings with it sleepless nights or insomnia.
- iii) **Physical Problems:** Along with the mental and emotional problems, a person experiencing mild depression may also have some physical problems. It is common to see people with depression suffer from pains and aches like headache, backache, etc. Often, people go to the physician to find a solution for their pain, however, no concrete cause is found out. In such cases, mild depression is one of the reasons that cause such kind of body ache. Apart from this, mild depression can also lead a person to lose interest in sexual intercourse. Change in eating habits is also one of the common symptoms of mild depression i.e. people may lose their appetite totally or may eat too much
- iv) **Loss of Interest:** Another sign of mild depression is loss of interest in any kind of activities. It is quite commonly seen that people no longer find enthusiasm in indulging in activities that they used to love earlier, when suffering from mild depression. This includes taking part in some kind of sports activities or may be indulging in one of their hobbies. Some people may feel uncomfortable meeting people and this may affect his social life.
- v) **Feeling of Guilt and Worthlessness:** People who are suffering from depression may experience the feeling of guilt and worthlessness as they are unable to perform their daily tasks and activities. They may feel frustrated the whole time and due to this are likely to cry or may experience anger bouts without any specific reason. This feeling of ineptitude may also trigger the thoughts of ending their life by committing suicide.

Dysthymic disorder is a form of mild depression. Many people are affected by it. It can be triggered by a specific incident or medical problem, or it can appear with no apparent cause. Often people don't realise that they're actually suffering from a medical condition because symptoms are mild and are easy to overlook until they start to affect your daily functioning.

1.3.2 Dysthymic Disorder

Mild or low level depressive symptoms that persist for two or more than two years are classified as dysthymia. Symptoms typically begin insidiously during adolescence and follow a low-grade course over many years or decades (diagnosis requires a course of ≥ 2 yr); dysthymia may intermittently be complicated by episodes of major

depression. Affected patients are habitually gloomy, pessimistic, humorless, passive, lethargic, introverted, and hypercritical of self and others, and complaining.

According to DSM-IV (TR) dysthymia is characterised by an overwhelming yet chronic state of depression, exhibited by a depressed mood for most of the days, for more days than not, for at least 2 years. (In children and adolescents, mood can be irritable and duration must be at least 1 year.)

In addition, no Major Depressive Episode has been present during the first two years (or one year in children and adolescents) and there has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder. Further, the symptoms cannot be due to the direct physiological effects of the use or abuse of a substance such as alcohol, drugs or medication or a general medical condition.

The symptoms must also cause significant distress or impairment in social, occupational, educational or other important areas of functioning. Dysthymia is a chronic long-lasting form of depression sharing many characteristic symptoms of major depressive disorder. These symptoms tend to be less severe but do fluctuate in intensity. To be diagnosed, an adult must experience 2 or more of the following symptoms for at least two years:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness
- Low sex drive
- Irritability

Symptoms exclude “manic, hypomanic or mixed episodes commonly associated with bipolar disorders. People with dysthymia have a higher than average chance of developing major depression. As dysthymia is a chronic disorder, a person may often experience symptoms for many years before it is diagnosed, if diagnosis occurs at all.

As a result, he or she tends to believe that depression is a part of their character. This, subsequently, may lead sufferers not to even discuss their symptoms with doctors, family members or friends.

Dysthymia, like major depression, tends to run in families. Some sufferers describe being under chronic stress. When treating diagnosed individuals, it is often difficult to tell whether they are under unusually high environmental stress or if the dysthymia causes them to be more psychologically stressed in a standard environment.

Treatment for Dysthymic Disorder

Psychotherapy is the treatment for choice for this psychological problem. Often, antidepressant medication is also recommended because of the chronic nature of the depression in Dysthymia. Psychotherapy is used to treat this depression in several ways. First, supportive counseling can help to ease the pain, and can address the

feelings of hopelessness. Second, cognitive therapy is used to change the pessimistic ideas, unrealistic expectations, and overly critical self-evaluations that create the depression and sustain it.

Cognitive therapy can help the depressed person recognise which life problems are critical, and which are minor. It also helps them to learn how to accept the life problems that cannot be changed. Third, problem solving therapy is usually needed to change the areas of the person's life that are creating significant stress, and contributing to the depression. Behavioural therapy can help to develop better coping skills, and interpersonal therapy can assist in resolving relationship conflicts.

Self Assessment Questions

1) What do you mean by mood disorder? Discuss its different types?

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2) Discuss the symptoms of mild depressive disorder.

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3) Describe the symptoms and treatment of dysthymic disorder.

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1.4 MODERATE DEPRESSIVE DISORDER

DSM-IV includes two main categories for depressions of mild to moderate severity: dysthymia and adjustment disorder with depressed mood. We have already discussed dysthymic disorder under mild depression category. Now we will turn to consider adjustment disorder with depressed mood under moderate depressive category.

1.4.1 Adjustment Disorder with Depressed Mood

This category describes depression that occurs in response to a major life stressor or crisis. This is also called a “reactive depression.” Basically adjustment disorder with depressed mood is behaviourally indistinguishable from dysthymia. It differs from dysthymia in that it does not exceed six months in duration, and it requires the existence of an identifiable (presumably precipitating) psychological stressors in the client's life. The justification of keeping it in a distinct clinical diagnosis is that the client is experiencing impaired social or occupational functioning.

The diagnosis of an adjustment disorder implies that specific psychological symptoms have developed in response to a specific and identifiable psychosocial stressor. However, this diagnostic group (adjustment disorders) is a “last resort” category. If the symptom picture suggests that the person meets the diagnostic criteria for another psychological disorder, then this diagnosis is not used. For example, if a person experiences a trauma, and develops the symptoms of a major depression, then the diagnosis of adjustment disorder is not used, even though the depression developed in response to a psychosocial stressor. So, adjustment disorder with depression is used to categorise mild to moderate depression, following a stressful event.

Also, the depressive symptoms related to an adjustment disorder should be treated and dissipate within six months following the end of the stress that produced the reaction. If the symptoms last longer, then the diagnosis of Depression, not otherwise specified, is probably more appropriate. There is an exception to this rule, as some stressors continue over a long period of time, rather than occurring as a single event. For example, if a person is harassed on the job, that can continue for months. In such a case, the depression may not be severe enough for a diagnosis of major depression, but it would continue for more than six months. But, since the stress is continuing, then the adjustment disorder diagnosis could still be used. Despite these problems with the formal diagnostic criteria, there are doubtless many cases of relatively brief but moderately serious depression.

The symptom picture is similar to other depressive disorders, and the recommended treatment is still cognitive-behavioural therapy and/or interpersonal therapy. However, because of the relationship between the symptoms and a specific stressor, there is more emphasis put on resolving the problem that created the stress. This may involve making concrete changes in the way the person manages his/her life, and may require specific action and decision making. (e.g. If job stress is resulting in depression, the person may need to decide whether changing jobs is the most appropriate solution.) Often people become depressed in reaction to psychosocial stressors when they don't believe a solution exists to their problem. In such cases, helping the person develop a reasonable solution is a key part of the treatment process.

Self Assessment Questions

- 1) Point out the symptoms and treatment of adjustment disorder with depressed mood.

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- 2) Differentiate between dysthymic disorder and adjustment disorder with depressed mood.

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1.5 MAJOR DEPRESSIVE DISORDER

Major Depressive disorder, commonly called major depression, unipolar depression, or clinical depression, where a person has one or more major depressive episode. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent). Depression without periods of mania is sometimes referred to as unipolar depression because the mood remains at one emotional state or “pole”. Major depression is a disabling condition which adversely affects a person’s family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who commit suicide had depression or another mood disorder.

The diagnosis of major depressive disorder is based on the patient’s self-reported experiences, behaviour reported by relatives or friends, and a mental status exam. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the persons physical health. The most common time of onset is between the ages of 20 and 30 years, with a later peak between 30 and 40 years.

Major depression significantly affects a person’s family and personal relationships, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.

A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. They develop feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. Insomnia is common among the depressed. Hypersomnia or oversleeping can also happen. A depressed person may also report multiple physical symptoms such as fatigue, headaches, or digestive problems.

The DSM-IV-TR recognises five further subtypes of MDD, called *specifiers*, in addition to noting the length, severity and presence of psychotic features:

Atypical Depression (AD) is characterised by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (“comfort eating”), excessive sleep or hypersomnia, a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.

Melancholic Depression is characterised by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss, or excessive Guilt.

Catatonic Depression is a rare and severe form of major depression involving disturbances of motor behaviour and other symptoms. Here the person is mute and almost stuporose, and either remains immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia or in manic episodes, or may be caused by neuroleptic malignant syndrome

Psychotic Major Depression (PMD), or simply psychotic depression, is the term for a major depressive episode, particularly of melancholic nature, where the patient

experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

Postpartum Depression (PPD) is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which has incidence rate of 10–15%, typically sets in within three months of labour and lasts as long as three months. It is quite common for women to experience a short term feeling of tiredness and sadness in the first few weeks after giving birth; however, postpartum depression is different because it can cause significant hardship and impaired functioning at home, work, or school as well as possibly difficulty in relationships with family members, spouses, friends, or even problems bonding with the newborn.

Seasonal Affective Disorder (SAD), also known as “winter depression” or “winter blues”, is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer. It is commonly hypothesized that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD, but the epidemiological support for this proposition is not strong (and latitude is not the only determinant of the amount of sunlight reaching the eyes in winter). SAD is also more prevalent in people who are younger and typically affects more females than males.

1.5.1 Causes of Major Depression

As far as etiology of major depressive disorder is concerned biological, psychological, and social factors all play a role in causing depression. Several models and approaches have been proposed by psychologists and psychiatrists to account for the causes of depression. For example Diathesis Model stresses that that depression results when a preexisting vulnerability, or diathesis, is activated by stressful life events.

The preexisting vulnerability can be either genetic, an interaction between nature and nurture, or schematic, resulting from views of the world learned in childhood. Family studies suggest that prevalence of mood disorder is higher among blood relatives of persons with clinically diagnosed mood disorder than in the population at large (e.g., Plomin, De Fries, Mc Cleary, & Rutter, 1997). Twin studies also suggested that there is a moderate genetic contribution to major depression. Plomin et.al. (1997) reviewed evidence from five different studies showing that monozygotic co-twins of a twin with major depression are about four to five times as likely to develop major depression as are dizygotic co-twins of a depressed twin.

Various aspects of personality and its development appear to be integral to the occurrence and persistence of depression with negative emotionality as a common precursor. Although depressive episodes are strongly correlated with adverse events, a person’s characteristic style of coping may be correlated with their resilience (Kessler, 1997). Additionally, low self-esteem and self-defeating or distorted thinking are related to depression.

Depressed people were found to have a distinctly negative view of themselves and the world around them (Beck, 1967), and their perception of stress may result, at least to some extent, from the cognitive symptoms of their disorder rather than causing their disorder (Kessler, 1997). Beck, following on from the earlier work of Kelly and Ellis, developed what is now known as a cognitive model of depression in the early 1960s.

He proposed that three concepts underlie depression: a triad of negative thoughts composed of cognitive errors about oneself, one's world, and one's future; recurrent patterns of depressive thinking, or *schemas*; and distorted information processing. According to American psychologist Seligman (1974, 1975) depression in humans is similar to learned helplessness in laboratory animals, who remain in unpleasant situations when they are able to escape, but do not because they initially learned they had no control.

Attachment theory, developed by Bowlby in the 1960s, predicts a relationship between depressive disorder in adulthood and the quality of the earlier bond between the infant and their adult caregiver. In particular, it is thought that "the experiences of early loss, separation and rejection by the parent or caregiver (conveying the message that the child is unlovable) may all lead to insecure internal working models.

Internal cognitive representations of the self as unlovable and of attachment figures as unloving [or] untrustworthy would be consistent with parts of Beck's cognitive triad" (Seligman, 1975). While a wide variety of studies has upheld the basic tenets of attachment theory, research has been inconclusive as to whether self-reported early attachment and later depression are demonstrably related.

According to Bandura (1978) depressed individuals have negative beliefs about themselves, based on experiences of failure, observing the failure of social models, a lack of social persuasion that they can succeed, and their own somatic and emotional states including tension and stress. These influences may result in a negative self-concept and a lack of self-efficacy; that is, they do not believe they can influence events or achieve personal goals. Depressed individuals often blame themselves for negative events, as shown in the study of Pinto and Francis (1993) on hospitalised adolescents with self-reported depression, those who blame themselves for negative occurrences may not take credit for positive outcomes. This tendency is characteristic of a depressive attributional or pessimistic explanatory style.

The studies conducted on depression in women indicates that vulnerability factors—such as early maternal loss, lack of a confiding relationship, responsibility for the care of several young children at home, and unemployment—can interact with life stressors to increase the risk of depression (Bandura, 1998). For older adults, the factors are often health problems, changes in relationships with a spouse or adult children due to the transition to a care-giving or care-needing role, the death of a significant other, or a change in the availability or quality of social relationships with older friends because of their own health-related life changes (Brown and Harris, 2001).

The understanding of depression has also received contributions from the psychoanalytic and humanistic psychology. From the classical psychoanalytic perspective of Freud depression or melancholia may be related to interpersonal loss and early life experiences (Hinrichsen and Emery, 2006). The founder of humanistic psychology, Abraham Maslow suggested that depression could arise when people are unable to attain their needs or to self-actualise (to realise their full potential).

Social: Poverty and social isolation associated with increased risk of mental health problems in general. Child abuse (physical, emotional, sexual, or neglect) is also associated with increased risk of developing depressive disorders later in life (Kessler, 1997). Abuse of the child by the caregiver is bound to distort the developing personality and create a much greater risk for depression and many other debilitating mental and emotional states. Disturbances in family functioning, such as parental (particularly maternal) depression, severe marital conflict or divorce, death of a

parent, or other disturbances in parenting are additional risk factors. In adulthood, stressful life events are strongly associated with the onset of major depressive episodes. In this context, life events connected to social rejection appear to be particularly related to depression (Kessler, 1997).

1.5.2 Treatment

Various psychological treatments are available for depressive disorders. Some of them are briefly listed below. In general, a combination of an antidepressant plus a psychological treatment is better than either treatment alone. Typically, most psychological treatments for depression last in the range of 12-20 weekly sessions of 1-2 hours per session.

Those most commonly used for moderate or severe depression are:

1.5.2.1 Cognitive Behavioural Therapy (CBT)

Briefly, cognitive behavioural therapy is based on the idea that certain ways of thinking can trigger, or fuel, certain mental health problems such as depression. The therapist helps the client to understand his thought patterns. In particular, to identify any harmful or unhelpful ideas or thoughts which the client has that can make him depressed. The aim is then to change his ways of thinking to avoid these ideas. Behavioural therapy aims to change such behaviours which are harmful or not helpful. CBT is a combination of cognitive therapy and behavioural therapy. In short, CBT helps people to achieve changes in the way that they think, feel and behave.

1.5.2.2 Interpersonal Psychotherapy (IPT)

Interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) focuses on resolving interpersonal problems and stresses in existing relationships and/or building the skills to form important new interpersonal relationship. IPT is based on the idea that our personal relationships may play a large role in affecting our mood and mental state. The therapist helps us to change our thinking and behaviour and improve our interaction with others. For example, IPT may focus on issues such as bereavement or disputes with others that may be contributing to the depression.

Self Assessment Questions

1) Discuss the symptoms and types of major depressive disorder.

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2) Explain the etiology and treatment of major depressive disorder.

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3) Differentiate between mild depressive disorder and major depressive disorder.

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1.6 LET US SUM UP

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorder (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. Depression is a form of what is known as a mood or affective, disorder, because it is primarily concerned with a change in mood.

There are several different diagnoses for depression, mostly determined by the intensity of the symptoms and the duration of the symptoms. The term depression is often used to refer to any of several depressive disorders. Depressive disorders may be classified as mild to moderate depressive disorder and major depressive disorder. DSM-IV includes two main categories for depressions of mild to moderate severity: dysthymia and adjustment disorder with depressed mood. To qualify for a diagnosis of dysthymia, a person must have a persistent depressed mood, more than not, for at least two years. In addition, dysthymics must have at least two of the following six symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. Adjustment disorder with depressed mood differs from dysthymia in that it does not exceed six months in duration, and it requires the existence of an identifiable (presumably precipitating) psychological stressors in the client's life. The diagnostic criteria for major depressive disorder require that the person exhibit more symptoms than are required for dysthymia and the symptoms be more persistent. A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. They develop feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred. In severe cases, depressed people may have symptoms of psychosis. Insomnia is common among the depressed. Hypersomnia or oversleeping can also happen. A depressed person may also report multiple physical symptoms such as fatigue, headaches, or digestive problems. As far as etiology of major depressive disorder is concerned biological, psychological, and social factors all play a role in causing depression. Cognitive behavioural therapy and interpersonal psychotherapy are most commonly used for the treatments of depressive disorders. In general, a combination of an antidepressant plus a psychological treatment is better than either treatment alone. Typically, most psychological treatments for depression last in the range of 12-20 weekly sessions of 1-2 hours per session.

1.7 UNIT END QUESTIONS

- 1) How does mood disorder differ from other types of mental disorders?
- 2) Describe different types of mood disorders.
- 3) Discuss the symptoms and treatment of mild mood disorder.
- 4) Explain the diagnosis and treatment of dysthymic disorder.

- 5) Discuss the symptoms and treatment of adjustment disorder with depressed mood.
- 6) Differentiate between dysthymic disorder and adjustment disorder with depressed mood.
- 7) Describe the diagnosis and types of major depressive disorder.
- 8) Explain the causes and treatment of major depressive disorder.
- 9) Differentiate between mild depressive disorder and major depressive disorder.

1.8 GLOSSARY

Adjustment disorder with depressed mood	: Moderately severe depressive disorder that occurs as a result of an identifiable life event and that is expected to disappear when the event's impact ceases, and not exceeding six months in duration.
Behaviour therapy	: Use of therapeutic procedures based on principles of classical and operant conditioning.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.
Cognitive Behaviour therapy	: Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
Depression	: Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
Depressive disorder	: Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
Dizygotic twins	: Twins that develop from two separate eggs.
Dysthymia	: A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
Episodic (disorder)	: Term used to describe a disorder that tends to abate and to recur.
Interpersonal psychotherapy	: A form of psychotherapy that focuses on increasing client's social effectiveness and the extent they feel cared about by others.
Learned helplessness	: Acquired belief in one's helplessness to deal with a situation or control one's environment. Concept has been applied to explain depression in humans.
Major depressive disorder	: A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts.

- Depressive episodes occur most of everyday for at least two weeks.
- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 2 BIPOLAR DISORDER

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2.0 INTRODUCTION

Bipolar disorder or manic-depressive disorder, which is also referred to as bipolar affective disorder or manic depression, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition and mood with or without one or more depressive episodes. The elevated moods are clinically referred to as mania or, if milder hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or mixed episode in which features of both mania and depression are present at the same time. These episodes are usually separated by periods of “normal” mood; but in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling. In the present unit we will first discuss the symptoms and types of bipolar disorder, after that we will explain the causes of bipolar disorder and finally we will come across to the treatment and prognosis of bipolar disorder.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of bipolar disorder;
- Describe the symptoms of bipolar disorder;
- Understand the different types of bipolar disorder;
- Explain the causes of bipolar disorder;
- Describe the treatment and prognosis of bipolar disorder; and
- Analyse the difference between bipolar disorder and other forms of depressive disorder.

2.2 BIPOLAR DISORDERS

Although recurrent cycles of mania and depression were recognised as early as sixth century, but it was Kraepelin in 1899 who first introduced the term manic-depressive insanity and to clarify the clinical picture. Kraepelin described the disorder as a series of attack of deletion and depression, with periods of relative normality in between, and a general favorable prognosis. Bipolar disorder has traditionally been thought to be much less common than depression.

Earlier it was opined that depressive disorders were four to five times more frequent than bipolar disorder. But recent studies disagree with this view and believe that depressive and bipolar disorder are really very similar (Bowden, 1993). The reason is that depression has traditionally been considered to be more common, and accordingly many individuals suffering from bipolar disorder are wrongly classified as suffering from unipolar disorder because a manic or hypomanic episode has not yet occurred. Sometimes, a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions.

The psychotic symptoms tend to reflect the person's extreme mood. For example, psychotic symptoms for a person having a manic episode may include believing he or she is famous, has a lot of money, or has special powers. In the same way, a person having a depressive episode may believe he or she is ruined and penniless, or has committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes wrongly diagnosed as having schizophrenia, another severe mental illness that is linked with hallucinations and delusions.

2.2.1 Symptoms of Bipolar Disorder

Bipolar disorder is distinguished from major depression by at least one episode of mania. Any given episode is classified as depressive, manic, or mixed, according to its predominant features. If individuals experience only one of these moods (for example, either mania or depression), they are said to suffer only Unipolar mood disorder. Since the experience of manic symptoms alone is extremely rare, almost all individuals with unipolar mood disorders suffer from unipolar depression.

If the individual alternates between experiences of depression and mania he/she is said to be suffering from a bipolar disorder. Bipolar disorder is a condition in which people experience abnormally elevated (manic or hypomanic) and, in many cases, abnormally depressed states for periods of time in a way that interferes with functioning.

2.2.1.1 Depressive Episode

A depressive episode has features typical of major depression, including depressed mood, anhedonia, psychomotor retardation, and feelings of pessimism and guilt. Sleeping and eating often increase. Delusions of guilt accompanied by self-loathings are common in psychotic depression, and some patients have hallucinations. Signs and symptoms of the depressive phase of bipolar disorder include persistent feelings of sadness, anxiety, guilt, anger, isolation, or hopelessness; disturbances in sleep and appetite; fatigue and loss of interest in usually enjoyable activities; problems in concentration, loneliness, self-loathing, apathy or indifference; loss of interest in sexual activity; shyness or social anxiety, irritability, chronic pain (with or without a known cause); lack of motivation; and morbid suicidal ideation. In severe cases, the individual may become psychotic – a condition also known as severe bipolar depression with psychotic features. Features of depressive form of bipolar disorders are usually clinically indistinguishable from those of major depression (Perris, 1992, American Psychiatric Association, 1994), although some studies report higher rates of psychomotor retardation, overeating, and oversleeping in the depressive phase of bipolar disorder (Cassano, et.al., 1992; Whybrow, 1997).

2.2.1.2 Manic Episode

A manic episode is defined as one or more than one week of a persistently elevated, expansive, or irritable mood plus three or more than three of the following additional symptoms:

Inflated self-esteem or grandiosity, decreased need for sleep, greater talkativeness than usual, persistent elevation of mood, flight of ideas or racing of thoughts, distractibility, and increased goal-directed activity.

People suffering from bipolar disorder commonly experience an increase in energy and a decreased need for sleep. A person's speech may be pressured, with thoughts experienced as racing. Attention span is low, and a person in a manic state may be easily distracted. Judgment may become impaired, and sufferers may go on spending sprees or engage in behaviour that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behaviour may become aggressive, intolerant, or intrusive. People may feel out of control or unstoppable. People may feel they have been "chosen" and are "on a special mission" or have other grandiose or delusional ideas. Sexual drive may increase.

Manic patients may inexhaustibly, excessively, and impulsively involved in various pleasurable, high-risk activities (e.g. gambling, dangerous sports, promiscuous sexual activity) without insight into possible harm. Symptoms are so severe that they impair functioning. Typically, patients in a manic episode are exuberant and flamboyantly or colorfully dressed; they have an authoritative manner with a rapid, unstoppable flow of speech. Patients may make clang associations (new thoughts that are triggered by word sounds rather than meaning). Easily distracted, patients may constantly shift from one theme or endeavor to another. However, they tend to believe they are in their best mental state. Lack of insight and an increased capacity for activity often lead to intrusive behaviour and can be a dangerous combination. Interpersonal friction results and may cause patients to feel that they are being unjustly treated or persecuted. As a result, patients may become a danger to themselves or to other people. Accelerated mental activity is experienced as racing thoughts by patients and is observed as flights of ideas by the physician.

2.2.1.3 Hypomanic Episode

A hypomanic episode is a less extreme variant of mania involving a distinct episode that lasts four or more than four days and is distinctly different from the patient's usual nondepressed mood. Hypomania is generally a mild to moderate level of mania, characterised by optimism, pressure of speech and activity, and decreased need for sleep. Generally, hypomania does not inhibit functioning like mania. Many people with hypomania are actually in fact more productive than usual. Some people have increased creativity while others demonstrate poor judgment and irritability. Many people experience hypersexuality. These persons generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. During the hypomanic period, mood brightens, the need for sleep decreases, and psychomotor activity accelerates. For some patients, hypomanic periods are adaptive because they produce high energy, creativity, confidence, and supernormal social functioning. Many do not wish to leave the pleasurable, euphoric state. Some function quite well, and in most, functioning is not markedly impaired. However, in some patients, hypomania manifests as distractibility, irritability, and labile mood, which the patient and others find less attractive.

2.2.1.4 Mixed Episode

A mixed episode blends depressive and manic or hypomanic features; the criteria for both mania and depression are met. For example, patients may momentarily switch to tearfulness during the height of mania, or their thoughts may race during a depressive period. Often, the switch follows circadian factors (e.g. going to bed depressed and waking early in the morning in a hypomanic state). In at least one third of people with bipolar disorder, the entire episode is mixed. A common presentation consists of a dysphorically excited mood, crying, curtailed sleep, racing thoughts, grandiosity, psychomotor restlessness, suicidal ideation, persecutory delusions, auditory hallucinations, indecisiveness, and confusion. This presentation is called dysphoric mania (i.e. prominent depressive symptoms superimposed on manic psychosis).

2.2.2 Classification of Bipolar Disorder

In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

- Bipolar I Disorder
- Bipolar I Disorder
- Cyclothymia
- Bipolar Disorder NOS (Not Otherwise Specified)

2.2.2.1 Bipolar I Disorder

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behaviour. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well. A very small number of people may experience one or more periods of mania without ever experiencing depression (Goodwin and Jamison, 1990).

2.2.2.2 Bipolar II Disorder

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make bipolar II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of successful high productivity and is reported less frequently than a distressing, crippling depression. Thus bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. People who experience a hypomanic episode may not see it as pathological, although those around them may be concerned about the erratic behaviour they see.

2.2.2.3 Cyclothymia

Cyclothymia, or Cyclothymic Disorder, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Symptoms of cyclothymic disorder are depressed mood for most of the day, for more days than not, for one year, including the presence of two of the following symptoms: poor appetite or overeating; insomnia/hypersomnia; low energy/fatigue; poor concentration; feelings of hopelessness. Symptoms are less severe than those of a major depressive episode but are more persistent. A history of hypomanic episodes with periods of depression that do not meet criteria for major depressive episodes. There is a low-grade cycling of mood which appears to the observer as a personality trait, and interferes with functioning.

2.2.2.4 Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour. This is a catchall category, diagnosed when the disorder does not fall within a specific subtype. Bipolar disorders NOS can still significantly impair and adversely affect the quality of life of the patient.

2.2.3 Causes of Bipolar Disorder

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder.

2.2.3.1 Biological Factors

Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder (Mitchell et.al., 1993). Results of studies indicated that about nine percent of the first degree relatives of a person with bipolar illness can also be expected to have bipolar disorder (nine times the rate of the disorder in the general population) (Katz and McGuffin 1993; Plomin et.al., 1997). Although family studies cannot by themselves establish a genetic basis for the disorder, results from twin studies also point to a

genetic basis. Twin studies have been limited by relatively small sample sizes but have indicated a substantial genetic contribution, as well as environmental influence.

The concordance rates for these disorders are much higher for identical twins than for fraternal twins (Kallman, 1958). The study of Bertelsen, Harvald, and Hauge (1977) estimated that monozygotic twins were three times more likely to be concordant (67 percent) for a diagnosis of bipolar disorder than were dizygotic twins (20 percent). About three-quarters of the affected cotwins had the same form of disorder (bipolar), but nearly one-quarter had unipolar disorder. This study further suggests that genes account for over 80 percent of the variance in the tendency to develop (that is liability for) bipolar depression. For bipolar I, the (probandwise) concordance rates in modern studies have been consistently put at around 40% in monozygotic twins (same genes), compared to 0 to 10% in dizygotic twins (Kieseppa et. al., 2004). A combination of bipolar I, II and cyclothymia produced concordance rates of 42% vs. 11%, with a relatively lower ratio for bipolar II that likely reflects heterogeneity.

The overall heritability of the bipolar spectrum have been put at 0.71 (Edvardsen et. al., 2008). There is overlap with unipolar disorder and if this is also counted in the co-twin the concordance with bipolar disorder rises to 67% (monozygotic) and 19% (dizygotic) (McGuffin et.al., 2003). The relatively low concordance between dizygotic twins brought up together suggests that shared family environmental effects are limited, although the ability to detect them has been limited by small sample sizes.

Genetic studies of bipolar disorder have also used recombinant DNA technology in an attempt to locate genetic markers. The studies have suggested many chromosomal regions appearing to relate to the development of bipolar disorder, but the results are not consistent and often not replicated (Kato, 2007). Although the first genetic linkage finding for mania was in 1969 (Reich et. al., 1969), the linkage studies have been inconsistent (Burmeister et. al., 2008). Recent meta-analyses of linkage studies detected either no significant genome-wide findings or, using a different methodology, only two genome-wide significant peaks, on chromosome 6 and on chromosome 11.

Studies also suggest that abnormalities in the structure and/or function of certain brain circuits could underlie bipolar and other mood disorders. Imaging studies show how the brains of people with bipolar disorder may differ from the brains of healthy people or people with other mental disorders. For example, one study using MRI found that the pattern of brain development in children with bipolar disorder was similar to that in children with “multi-dimensional impairment,” a disorder that causes symptoms that overlap somewhat with bipolar disorder and schizophrenia (Gogtay, et. al. 2007). This suggests that the common pattern of brain development may be linked to general risk for unstable moods. Some studies have also found anatomical differences in areas such as the amygdale (Strakowski, 1999), prefrontal cortex and hippocampus (Kempton et. al., 2008). However, despite 25 years of research involving more than 7,000 MRI scans, studies continue to report conflicting findings and there remains considerable debate over the neuroscientific findings. Two fairly consistent abnormalities found in a meta-analysis of 98 MRI or CT neuroimaging studies were that groups with bipolar disorder had lateral ventricles which were on average 17% larger than control groups, and were 2.5 times more likely to have deep white matter hyperintensities.

Studies on conducted on the causes of mood disorder suggest that neurotransmitter also play important role in the development of bipolar disorder. As we know that neurotransmitter is brain chemical which helps in the transmission of information from one neuron to other at synapse. Neurobiological investigations suggest that norepinephrine and serotonin are such two transmitters which are associated with

depression. For example, Joseph and Schildkraut (1965) suggested that at least some forms of depressions are associated with low levels of norepinephrine. Conversely he suggested that elation or mania was associated with an excess of this neurotransmitter, which is called noradrenalin. This hypothesis, called *catecholamine hypothesis*, was developed after researcher had observed an unexpected drug effect. The drug reduced the levels of norepinephrine, which caused the people to become very depressed.

A second theory, known as *indolamine hypothesis*, suggests that low levels of serotonin (one of the indolamines) were associated with and perhaps caused depression (Glossman and Platman, 1969). It has also been observed that neurotransmitter system has many subtypes and interact in many complex ways with other neurotransmitters and neuromodulators (products of endocrine system). For example reserpine (used to reduce blood pressure) also affects dopamine, and in turn, causes to produce depression. Like reserpine, serotonin was also found to reduce levels of neurotransmitter and thus causes to increase the depression. Researchers also became interested in the endocrine system when they found that patients with such diseases which affect the endocrine system became depressed. Hypothyroidism, or Crushing's disease, affecting the adrenal cortex, leads to excessive secretion of cortisol and, often, depression.

It has been suggested that a hypersensitivity of the melatonin receptors in the eye could be a reliable indicator of bipolar disorder, in studies called a trait marker, as it is not dependent on state (mood, time, etc.). In studies, patients diagnosed as bipolar reliably showed a melatonin-receptor hypersensitivity to light during sleep, causing a rapid drop in sleep time melatonin levels compared to controls (Lewy et. al., 1985)). Another study showed that drug-free, recovered, bipolar patients exhibited no hypersensitivity to light (Whalley et.al , 1991). It has also been shown in humans that valproic acid, a mood stabiliser, increases transcription of melatonin receptors and decreases eye melatonin-receptor sensitivity in healthy volunteers while low-dose lithium, another mood stabiliser, in healthy volunteers, decreases sensitivity to light when sleeping, but doesn't alter melatonin synthesis (Hallam et al., 2005). The extents to which melatonin alterations may be a cause or effect of bipolar disorder are not fully known.

2.2.3.2 Psychological Factors

Evidence suggests that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions (Serretti & Mandelli, 2008). There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression (Alloy et. al., 2005). Environmental stressors can sometimes be important in setting off either an initial or additional manic episode.

Two-thirds of manic episodes experienced by patients in one study were preceded by a life related stress of some kind (Ambelas, 1987). Stressful events can also cause a manic episode in people with a past history of manic episodes or bipolar disorder. For example, when a major hurricane struck Long Island, New York, in 1985, there was a dramatic increase in manic episodes among patients with bipolar disorder who were being treated with lithium (Aronson and Shukla, 1987). All the people who relapsed already had a high level of stress in their lives and most lacked social support from a close, confiding relationship.

For each of these people the hurricane resulted in additional stress besides that from the storm itself. Findings of the studies also suggest that between a third and a half of adults diagnosed with bipolar disorder report traumatic/abusive experiences in childhood, which is associated on average with earlier onset, a worse course, and more co-occurring disorders (Gabriele et.al. 2006). The total number of reported stressful events in childhood is higher in those with an adult diagnosis of bipolar spectrum disorder compared to those without, particularly events stemming from a harsh environment rather than from the child's own behaviour (Louisa et. al., 2007).

Early experiences of adversity and conflict are likely to make subsequent developmental challenges in adolescence more difficult, and are likely a potentiating factor in those at risk of developing bipolar disorder (Miklowitz et. al., 2008).

2.2.4 Treatment

There are a number of pharmacological and psychotherapeutic techniques used to treat Bipolar Disorder. Hospitalisation may be required especially with the manic episodes present in Bipolar I.

Because bipolar disorder is a lifelong and recurrent illness, people with the disorder need long term treatment to maintain control of bipolar symptoms. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

2.2.4.1 Medications

Some of the types of medications generally used to treat bipolar disorder are listed below:

2.2.4.1.1 Mood Stabilising Medications

These are usually the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilisers for years. The following medications are commonly used as mood stabilisers in bipolar disorder:

Lithium (sometimes known as Eskalith or Lithobid) was the first mood-stabilising medication approved by the U.S. Food and Drug Administration (FDA) in the 1970s for treatment of mania. It is often very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes.

Valproic acid or divalproex sodium (Depakote), approved by the FDA in 1995 for treating mania, is a popular alternative to lithium for bipolar disorder. It is generally as effective as lithium for treating bipolar disorder.

More recently, the anticonvulsant lamotrigine (Lamictal) received FDA approval for maintenance treatment of bipolar disorder.

Other anticonvulsant medications, including gabapentin (Neurontin), topiramate (Topamax), and oxcarbazepine (Trileptal) are sometimes prescribed. No large studies have shown that these medications are more effective than mood stabilisers.

2.2.4.1.2 Atypical Antipsychotic Medications

These are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. Atypical antipsychotic medications are called "atypical" to set them apart from earlier medications, which are called "conventional" or "first-generation" antipsychotics.

Olanzapine (Zyprexa), when given with an antidepressant medication, may help relieve symptoms of severe mania or psychosis. Olanzapine can be used for maintenance treatment of bipolar disorder as well, even when a person does not have psychotic symptoms.

Aripiprazole (Abilify), like olanzapine, is approved for treatment of a manic or mixed episode.

Aripiprazole is also used for maintenance treatment after a severe or sudden episode. As with olanzapine, aripiprazole also can be injected for urgent treatment of symptoms of manic or mixed episodes of bipolar disorder.

Quetiapine (Seroquel) relieves the symptoms of severe and sudden manic episodes. In that way, quetiapine is like almost all antipsychotics. In 2006, it became the first atypical antipsychotic to also receive FDA approval for the treatment of bipolar depressive episodes.

Risperidone (Risperdal) and ziprasidone (Geodon) are other atypical antipsychotics that may also be prescribed for controlling manic or mixed episodes.

2.2.4.1.3 Antidepressant Medications

These are sometimes used to treat symptoms of depression in bipolar disorder. People with bipolar disorder who take antidepressants often take a mood stabiliser too, because taking only an antidepressant can increase a person's risk of switching to mania or hypomania, or of developing rapid cycling symptoms.

2.2.4.2 Psychotherapy

In addition to medication, psychotherapy, or “talk” therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families. Some psychotherapy treatments used to treat bipolar disorder include:

Cognitive behavioural therapy (CBT) helps people with bipolar disorder learn to change harmful or negative thought patterns and behaviours.

Family-focused therapy includes family members. It helps enhance family coping strategies, such as recognising new episodes early and helping their loved one. This therapy also improves communication and problem-solving.

Interpersonal and social rhythm therapy helps people with bipolar disorder improve their relationships with others and manage their daily routines. Regular daily routines and sleep schedules may help protect against manic episodes.

Psychoeducation teaches people with bipolar disorder about the illness and its treatment. This treatment helps people recognise signs of relapse so they can seek treatment early, before a full-blown episode occurs. It is usually done in a group. Psychoeducation may also be helpful for family members and caregivers.

2.2.5 Prognosis

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this. Persons with bipolar disorder may have periods of normal or near normal functioning

between episodes. Ultimately one's prognosis depends on many factors, several of which are within the control of the individual. Such factors may include: the right medicines, with the right dose of each; comprehensive knowledge of the disease and its effects; a positive relationship with a competent medical doctor and therapist; and good physical health, which includes exercise, nutrition, and a regulated stress level.

A naturalistic study from first admission for mania or mixed episode (representing the hospitalised and therefore most severe cases) found that 50% achieved syndromal recovery (no longer meeting criteria for the diagnosis) within six weeks and 98% within two years. 72% achieved symptomatic recovery (no symptoms at all) and 43% achieved functional recovery (regaining of prior occupational and residential status). However, 40% went on to experience a new episode of mania or depression within 2 years of syndromal recovery, and 19% switched phases without recovery (Tohen et. al., 2003).

2.3 LET US SUM UP

The characteristic feature of bipolar disorders, sometimes referred to as manic-depressive disorders, or bipolar affective disorders, is that the person experiences episodes of both depression and mania or hypomania. Mania is a state of elevated mood flight of ideas, and increased psychomotor activity. A hypomanic episode is referred to a period of manic behaviour that is not extreme enough to greatly impair function. In DSM-IV-TR and ICD-10 bipolar disorder is conceptualised as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists three specific subtypes and one for non-specified:

Bipolar I Disorder

Bipolar I Disorder

Cyclothymia

Bipolar Disorder NOS (Not Otherwise Specified)

Bipolar I Disorder is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. A person with bipolar disorder experiences episodes of mania and, usually, major depressive episodes as well.

Bipolar II Disorder is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes. Hypomanic episodes do not go to the full extremes of mania (*i.e.*, do not usually cause severe social or occupational impairment, and are without psychosis), and this can make Bipolar II more difficult to diagnose. Bipolar II disorder differs from Bipolar I in that – rather than experiencing one or more florid, dramatic manic episodes – the manic behaviour is present to a lesser degree. Cyclothymic disorder is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years.

However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder. Bipolar Disorder Not Otherwise Specified (BP-NOS) is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II.

The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with Bipolar I or II. However, the symptoms are clearly out of the person's normal range of behaviour

Although causes of bipolar disorder likely vary between individuals. But studies suggest that both biological and psychological factors seem to play a role in determining whether a person will develop symptoms of bipolar disorder. Studies conducted on the families of people diagnosed with bipolar disorder show that there is strong tendency for other family members also to have higher than expected risk for a mood disorder of some type including bipolar disorder. Twin studies have indicated a substantial genetic contribution, as well as environmental influence. The concordance rates for these disorders are much higher for identical twins than for fraternal twins. Evidence suggested that psychological factors play a significant role in the development and course of bipolar disorder, and that individual psychosocial variable may interact with genetic dispositions. There is fairly consistent evidence from prospective studies that recent life events and interpersonal relationships contribute to the likelihood of onsets and recurrences of bipolar mood episodes, as they do for onsets and recurrences of unipolar depression.

There are a number of pharmacological and psychotherapeutic techniques used to treat bipolar disorder. An effective maintenance treatment plan includes medication and psychotherapy for preventing relapse and reducing symptom severity.

Some of the types of medications generally used to treat bipolar disorder are:

(1) Mood stabilising medications are usually the first choice to treat bipolar disorder. Lithium, valproic acid or divalproex sodium are commonly used as mood stabilisers in bipolar disorder. (2) Atypical antipsychotic medications are sometimes used to treat symptoms of bipolar disorder. Often, these medications are taken with other medications. (3) Antidepressant medications are also used to treat symptoms of depression in bipolar disorder.

In addition to medication, psychotherapy, or “talk” therapy, can be an effective treatment for bipolar disorder. It can provide support, education, and guidance to people with bipolar disorder and their families.

For many individuals with bipolar disorder a good prognosis results from good treatment, which, in turn, results from an accurate diagnosis. Bipolar disorder can be a severely disabling medical condition. However, many individuals with bipolar disorder can live full and satisfying lives. Quite often, medication is needed to enable this.

2.4 UNIT END QUESTIONS

- 1) What do you mean by bipolar disorder? How does it differ from other mood disorders?
- 2) Discuss the symptoms of bipolar disorders in detail.
- 3) What is manic episode? Differentiate between manic and hypomanic episode.
- 4) Discuss the types of bipolar disorder. Differentiate between bipolar I disorder and bipolar II disorder.
- 5) Explain the causes of bipolar disorder.
- 6) Describe the treatment and prognosis of bipolar disorder.
- 7) Differentiate between bipolar disorder and other forms of depressive disorder.

2.5 GLOSSARY

Antidepressant medication	: General term for a number of drugs used to relieve depression and to elevate mood.
Antipsychotic medication	: Group of drugs used to treat patients who show severely disturbed behaviour and thought processes.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.
Cognitive Behaviour therapy	: Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
Cyclothymic disorder	: A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
Depression	: Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
Depressive disorder	: Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
Dizygotic twins	: Twins that develop from two separate eggs.
Episodic (disorder)	: Term used to describe a disorder that tends to abate and to recur.
Major depressive disorder	: A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
Mania	: Euphoric, hyperactive state in which an individual's judgment is impaired.
Hypomania	: A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
Hypomanic episode	: A distinct period of elevated expansive or irritable mood and other manic behaviours that is not severe enough to greatly impair social or occupational functioning and does not require hospitalisation.
Lithium	: Chemical salt used in the treatment of bipolar disorder.

Monozygotic twins	: Identical twins developed from one fertilised egg.
Mood disorder	: One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
Psychotherapy	: Treatment of mental disorders by psychological methods.
Stress	: Effects created within an organism by the application of a stressor.
Unipolar disorder	: Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 3 OTHER MOOD DISORDERS: MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

Structure

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3.0 INTRODUCTION

The depressive disorders are grouped under a category in the DSM-IV-TR called Mood Disorders. Included in this category are major depressive disorder, dysthymic disorder, bipolar disorder, cyclothymic disorder, mood disorder due a general medical condition and substance induced mood disorder. Two subtypes of mood disorders include seasonal affective disorder and postpartum depression, while premenstrual dysphoric disorder has been proposed as a diagnosis for further study. For each of these mood disorders there are specific criteria that a person's symptoms must meet in order to receive a diagnosis. Major depressive disorder, dysthymic disorder, bipolar disorder and cyclothymic disorder have been discussed in previous units. These disorders reflect a disturbance in mood or emotional reaction that is not due to any other physical or mental disorder. In the present unit we will discuss mood disorders that occur due to general medical condition such as cancer, diabetes, or a recent heart attack.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of mood disorder due to general medical condition;
- Describe the diagnostic criteria for mood disorder due to a general medical condition;

- Analyse the differences between mood disorder due to general medical condition and major depressive disorder; and
- Explain the some of the major medical conditions that induce mood disorder.

3.2 MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

It has been estimated that approximately one of every ten major depressive episodes is caused by medical illness, substance abuse, or medication used to treat another disorder (Clinton, 1993). Almost one of every four hospitalised medical patients has depressive symptoms (Moldin, et. al. 1993). Approximately 27–57% of patients with certain neurologic conditions (e.g., Parkinson’s disease, multiple sclerosis, Huntington’s disease, and epilepsy) develop symptoms of severe depression at some point during their illness. For medical conditions that do not directly affect the brain, prevalence rates appear to be more variable, ranging from less than 8% (for chronic renal disease), to 19% (for coronary artery disease, to 40% (for primary hypothyroidism).

The diagnostic criteria for mood disorder due to a general medical condition are less vigorous than those for the primarily psychiatric mood disorders and require only the presence of depressed mood/diminished enjoyment or elevated, expansive, or irritable mood (manic symptoms). Regarding the medical illness, the required signs, symptoms, and laboratory findings are simply those that, in conjunction with the clinical history, yield the medical diagnosis.

According to Diagnostic of Statistical Manual of Mental Disorders- Fourth Edition-Text Revised the diagnosis of mood disorder due to general medical condition is done when:

- a) the person has significant disturbance in mood that includes either (or both) of depressed mood or significantly reduced level of interest or pleasure in most or all activities, mood that is euphoric, heightened, or irritable,
- b) the person’s symptoms are directly related to the presence of a medical condition,
- c) another disorder does not better explain the mood disturbance,
- d) the mood condition is not present only when a person is delirious
- e) the symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) further specifies that the psychiatric presentation of a medical illness is classified as “the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition.”

Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of utmost importance. Failure to identify these underlying causal medical conditions can be potentially dangerous because serious and frequently reversible conditions can be overlooked. Major Depressive, Manic, Mixed, and Hypomanic Episodes in Bipolar I Disorder must be distinguished from episodes of a Mood Disorder Due to a General Medical Condition.

The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are judged to be the direct physiological consequence of a specific general

medical condition (e.g., multiple sclerosis, stroke, hypothyroidism). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is diagnosed.

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve

- depressed mood
- markedly diminished interest or pleasure
- elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met.

The predominant symptom type may be indicated by using one of the following subtypes:

- With Depressive Features,
- With Major Depressive–Like Episode,
- With Manic Features, or
- With Mixed Features.

There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition. The mood disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder with Depressed Mood that occurs in response to the psychosocial stress of having the general medical condition).

The diagnosis is also not made if the mood disturbance occurs only during the course of a delirium. The mood disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort. In determining whether the mood disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition.

Further, the clinician must establish that the mood disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the mood disturbance and the general medical condition is etiological, several considerations provide some guidance in this area.

One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the mood disturbance.

A second consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at onset or course or absence of family history).

Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of mood symptoms can provide a useful context in the assessment of a particular situation.

In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Mood Disorder, a Substance-Induced Mood Disorder, or other primary mental disorders (e.g., Adjustment Disorder).

The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions...sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide.

The manic symptoms experienced during mood disorder due to a general medical condition are the same as those experienced during other manic episodes...elevation, confidence, delusional thinking, high level of energy, increased activity, productivity, loud and rapid speech, racing thoughts, risky behaviour, impulsive behaviour, increased sexual behaviour, over spending, fast reckless driving, wild business schemes, overeating, drinking too much, irritability, anger, and agitation.

There are a large number of medical conditions which can cause mood disorder due to a general medical condition. Some of the major medical conditions which can cause a mood disorder due to a general medical condition are discussed below:

3.2.1 Parkinson's Disease

Parkinson's disease (PD) is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra. It is estimated that Parkinson disease affects approximately 1% of the population older than 50 years and up to 2.5% of the population older than 70 years (National Institute of Neurological Disorders and Stroke, 2001). The hallmark clinical signs of the motor triad include (1) tremor (2) rigidity, and (3) bradykinesia/akinesia.

The classic motor signs may not be obvious early in the disease, and patients may initially present with only clinical signs of depression. Thus, PD may be misdiagnosed as a primary depressive illness, and concomitant depression may remain undiagnosed in a patient with PD. Similarities in the symptoms common to major depression and PD include impaired memory/concentration, slowed psychomotor activity, restricted affect, and fatigue or decreased energy.

The true prevalence of depression among people with Parkinson's disease is difficult to determine because there are no standardised assessment tools designed to evaluate depressive symptoms in the context of this illness. However, it is estimated to be quite common as many as half of people with Parkinson's may suffer from depression (Working Group Meeting of National Institute of Neurological Disorders and Stroke, National Institute on Aging, and National Institute of Mental Health 2001).

Most treatments are aimed at patients' specific symptoms. PD must be considered in the differential diagnosis of an elderly person presenting with first-time depression/anxiety symptoms, especially when the patient appears depressed but denies experiencing a depressed mood. In addition, treatment of symptoms can be complicated in patients with PD because antiparkinsonian drugs may exacerbate psychiatric symptoms and vice versa. Consultation with both neurologists and psychiatrists can be helpful when treating these patients.

3.2.2 Multiple Sclerosis

Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system. Prevalence is estimated to be approximately 50 cases per 100,000 people. It is more common in women than in men and usually manifests in persons aged 20-40 years. This disorder is a highly variable illness, with differences among patients and changes within a patient over time.

Behavioural symptoms in multiple sclerosis include personality changes and feelings of euphoria and/or depression. Approximately 25% of patients experience euphoria that is different from hypomania and is characterised by an unusually cheerful mood. One study showed a 2-fold increase in the lifetime risk of bipolar disease in MS patients. Major depression is very common in individuals with MS; indeed, 25-50% of patients experience major depression after the onset of multiple sclerosis. Suicide attempts are common in patients with multiple sclerosis who are depressed. For treating the depression a combination of psychotherapy and medication is found to be useful.

3.2.3 Seizure Disorder

Epilepsy is one of the most common chronic neurologic diseases, affecting approximately 1% of the US population. Approximately 30-50% of patients with a seizure disorder have psychiatric symptoms sometime during the course of their illness. Psychiatric symptoms can be viewed in the context of their time relationship with the seizures as preictal, ictal, postictal, and interictal. Two major categories of seizures are partial and generalised. Increased psychopathology has been associated with different features (eg, seizure phenomenology, brain pathology, antiepileptic drug use, psychosocial factors). Generalised seizures simultaneously involve both cerebral hemispheres, with classic symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours. Partial seizures have focal signs and symptoms resulting from electrical discharge in a limited site in one brain hemisphere. Simple partial seizures occur without any impairment of consciousness and usually stem from primary motor, sensory, or visual cortical regions. Complex partial seizures are associated with impairment of consciousness and usually originate from a focus in the temporal lobe. In such seizures, psychiatric signs abound, with memory dysfunction, affective auras, perceptual changes (eg, hallucinations), and depersonalisation.

An estimated average, 10% of patients with complex partial epilepsy have psychotic symptoms such as paranoid ideation, thought disorder, and hallucinations. Mood disorder symptoms occur most often with foci in the temporal lobe. Statistically, 30% of patients with epilepsy have a history of suicide attempts, which attests to the importance of diagnosing depression in these patients. Fear and anxiety are the most common ictal affective states. As far as treatment of depression of patients suffering from seizure disorder is concerned psychotherapy such as cognitive behavioural therapy is generally recommended.

3.2.4 Diabetes

Diabetes is a disorder that impairs the way the body uses digested food for growth and energy. Most of the food we eat is broken down into glucose, a form of sugar that provides the main source of fuel for the body. After digestion, glucose passes into the bloodstream. Insulin helps glucose get into cells and converts glucose to

energy. Without insulin, glucose builds up in the blood, and the body loses its main source of fuel.

In **type 1 diabetes**, the immune system destroys the insulin-producing beta cells of the pancreas. This form of diabetes usually strikes children and young adults, who require daily or more frequent insulin injections or using an insulin pump for the rest of their lives.

Type 2 diabetes, which accounts for about 90 percent of diabetes cases in the United States, is most common in adults over age 40. Affecting about 6 percent of the U.S. population, this form of diabetes is strongly linked with obesity (more than 80 percent of people with type 2 diabetes are overweight), inactivity, and a family history of diabetes. People with type 2 diabetes first develop insulin resistance, a disorder in which muscle, fat, and liver cells do not use insulin properly. At first, the pancreas produces more insulin, but gradually its capacity to secrete insulin falters, and the timing of insulin secretion becomes abnormal. After diabetes develops, insulin production continues to decline.

Studies suggest that individuals with depression may be at greater risk for developing diabetes. Treatment for depression helps people manage symptoms of both diseases, thus improving the quality of their lives. Studies further suggest that diabetes doubles the risk of depression compared to those without the disorder (Anderson, Lustman, & Clouse, 2000). The chances of becoming depressed increase as diabetes complications worsen. Research shows that depression leads to poorer physical and mental functioning, so a person is less likely to follow a required diet or medication plan. Treating depression with psychotherapy, medication, or a combination of these treatments can improve a patient's well-being and ability to manage diabetes.

3.2.5 Parathyroid Disorder

Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia. Hyperparathyroidism is more common in women than in men. Annual incidence is in the 0.1% range and affects up to 0.2% of the population older than 60 years.

Hyperparathyroidism is frequently associated with significant psychiatric symptoms, which are caused by the resultant hypercalcemia and can precede other somatic manifestations of the illness. Patients can experience delirium, sudden dementia, depression, anxiety, psychosis, apathy, stupor, and coma.

Hypomagnesemia also occurs in association with hyperparathyroidism, usually after surgical removal of a parathyroid adenoma.

In hypoparathyroidism, expect to find low serum levels of calcium and magnesium. Patients most commonly experience delirium but may also experience psychosis, depression, or anxiety

3.2.6 Thyroid Disorders

Hyperthyroidism is a common clinical condition caused by excess thyroid hormone. Because this disorder is so common, a high index of clinical awareness for thyroid disease and its complications is needed in any patient who presents with psychiatric symptoms. Always include evaluations of thyroid-stimulating hormone (TSH [thyrotropin]) and free thyroxine (T4) levels in the medical workup of patients presenting with psychiatric symptoms for the first time. Graves disease is the most common

cause in the population. Some evidence indicates that stress can precipitate Graves disease and aggravate treated disease. Toxic nodular goiter is most prevalent in the elderly population.

Similar to patients with hyperthyroidism, those with hypothyroidism often develop symptoms of depression and anxiety. The usual clinical features include apathy, psychomotor retardation, depression, and poor memory. However, when hypothyroidism develops rapidly, the psychiatric features are usually delirium and psychosis, which has also been termed myxedema madness. Subclinical hypothyroidism can have either mild or no symptoms of thyroid hormone deficiency. It is fairly common and affects 5-10% of the population, mainly women, and occurs in 15-20% of women older than 45 years.

3.2.7 Heart Disease

Heart disease includes two conditions called angina pectoris and acute myocardial infarction (“heart attack”). Like any muscle, the heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease. If not enough oxygen-carrying blood reaches the heart, the heart may respond with pain called angina. When the blood supply is cut off completely, the result is a heart attack. The part of the heart that does not receive oxygen begins to die, and some of the heart muscle may be permanently damaged.

Research over the past two decades has shown that people with heart disease are more likely to suffer from depression than otherwise healthy people, and conversely, that people with depression are at greater risk for developing heart disease. (Nemeroff, Musselman, & Evans, 1998). Furthermore, people with heart disease who are depressed have an increased risk of death after a heart attack compared to those who are not depressed (Frasure-Smith, Lesperance, & Talajic, 1995). Depression may make it harder to take the medications needed and to carry out the treatment for heart disease. Treatment for depression helps people manage both diseases, thus enhancing survival and quality of life.

Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and alter blood clotting. They can also lead to elevated insulin and cholesterol levels. These risk factors, with obesity, form a group of signs and symptoms that often serve as both a predictor of and a response to heart disease. Furthermore, depression or anxiety may result in chronically elevated levels of stress hormones, such as cortisol and adrenaline. As high levels of stress hormones are signaling a “fight or flight” reaction, the body’s metabolism is diverted away from the type of tissue repair needed in heart disease.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. Persons with heart disease, their families and friends, and even their physicians and cardiologists (physicians specialising in heart disease treatment) may misinterpret depression’s warning signs, mistaking them for inevitable accompaniments to heart disease. Symptoms of depression may overlap with those of heart disease and other physical illnesses.

Effective treatment for depression is extremely important, as the combination of depression and heart disease is associated with increased sickness and death. Specific types of psychotherapy can relieve depression. Exercise is another potential pathway to reducing both depression and risk of heart disease.

Treatment for depression in the context of heart disease should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the heart disease treatment. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy.

3.2.8 HIV/AIDS

AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. HIV is spread most commonly by having sex with an infected partner. HIV also is spread through contact with infected blood, which frequently occurs among injection drug users who share needles or syringes contaminated with blood from someone infected with the virus. Women with HIV can transmit the virus to their babies during pregnancy. Many people do not develop any symptoms when they first become infected with HIV. As the immune system deteriorates, a variety of complications start to take over. For many people, their first sign of infection is large lymph nodes or "swollen glands" that may be enlarged for more than three months.

Although as many as one in three persons with HIV may suffer from depression (Bing, Burnam, & Longshore, 2010) the warning signs of depression are often misinterpreted. People with HIV, their families and friends, and even their physicians may assume that depressive symptoms are an inevitable reaction to being diagnosed with HIV. But depression is a separate illness that can and should be treated, even when a person is undergoing treatment for HIV or AIDS. Some of the symptoms of depression could be related to HIV, specific HIV-related disorders, or medication side effects. However, a skilled health professional will recognise the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

3.2.9 Cancer

Development of different varieties of cancer is subject of psychological influences. This has resulted in the development of a new field called psychoncology (Anderson, 1992; Antoni and Goodkin, 1991). Oncology means study of cancer. Cancer can develop in any organ or tissue of the body. Normally, cells grow and divide to produce more cells only when the body needs them. But sometimes cells keep dividing when new cells are not needed. These extra cells may form a mass of tissue, called a tumor. Tumors can be either benign (not cancerous) or malignant (cancerous).

Cells in malignant tumors are abnormal and divide without control or order, resulting in damage to the organs or tissues they invade. Cancer cells can break away from a malignant tumor and enter the bloodstream or the lymphatic system. This is how cancer spreads, or "metastasizes," from the original cancer site to form new tumors in other organs. The original tumor, called the primary cancer or primary tumor, is usually named for the part of the body in which it begins. Research has enabled many men, women, and young people with cancer to survive.

About 9 million Americans of all ages are living with a current or past diagnosis of cancer. People who face a cancer diagnosis will experience many stresses and emotional upheavals. Fear of death, interruption of life plans, changes in body image and self-esteem. Still, not everyone with cancer becomes depressed. Depression can exist before the diagnosis of cancer or may develop after the cancer is identified. While there is no evidence to support a causal role for depression in cancer, depression may impact the course of the disease and a person's ability to participate in treatment.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. While studies generally indicate that about 25 percent of people with cancer have depression, only 2 percent of cancer patients in one study were receiving antidepressant medication (Regier, Narrow, & Rae, (1993).

Treatment for depression can help people feel better and cope better with the cancer treatment process. There is evidence that the lifting of a depressed mood can help enhance survival (McDaniel, Musselman, & Porter, 1995). Treatment for depression in the context of cancer should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the cancer treatment. This is especially important when antidepressant medication is needed or prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as cancer may be available.

3.2.10 Stroke

A stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells. Stroke can occur in all age groups and can happen even to fetuses still in the womb; but three-fourths of strokes occur in people 65 years of age and over, making stroke a leading cause of disability in older persons. Of the 600,000 American men and women who experience a first or recurrent stroke each year, an estimated 10 to 27 percent experience major depression. An additional 15 to 40 percent experience some symptoms of depression within two months following a stroke (Depression Guideline Panel, 1993).

The average duration of major depression in people who have suffered a stroke is just under a year. Among the factors that affect the likelihood and severity of depression following a stroke are the location of the brain lesion, previous or family history of depression, and pre-stroke social functioning. Stroke survivors who are also depressed, particularly those with major depressive disorder, may be less compliant with rehabilitation, more irritable, and may experience personality change.

Treatment for depression in stroke survivors should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the post-stroke rehabilitation and treatment. This is especially important when antidepressant medication is prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as stroke may be available.

3.3 LET US SUM UP

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. This is diagnosed when: the patient is depressed or has lost interest in activities, there is significant impairment in important areas of functioning, the patient's mood is elevated, expansive or irritable, or a combination of these, there is medical evidence to support the diagnosis, the change in mood is not due to stress of the medical condition. the change in mood doesn't occur only in delirium.

Mood disorder due to a general medical condition is characterised by depressions or manic episodes which are caused by a medical condition. The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions...sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide. The manic symptoms experienced during mood disorder due to a general medical condition are the same as those experienced during other manic episodes...elation, confidence, delusional thinking, high level of energy, increased activity, productivity, loud and rapid speech, racing thoughts, risky behaviour, impulsive behaviour, increased sexual behaviour, over spending, fast reckless driving, wild business schemes, overeating, drinking too much, irritability, anger, and agitation.

Depressive disorder due to a general medical condition affects a lot of people. There are many medical conditions which can cause mood disorder due to a general medical condition. These include:

- 1) Parkinson disease
- 2) Multiple sclerosis
- 3) Seizure disorder
- 4) Diabetes
- 5) Parathyroid disorder
- 6) Thyroid disorders
- 7) Heart disease
- 8) HIV/AIDS
- 9) Cancer
- 10) Stroke

Treatment for mood disorder due to a general medical condition must include treatment of the medical condition causing the depression or manic disorder. Psychiatric and psychological treatment of the mood disorder is also often needed. Psychiatric treatment will include medication to reduce the depressive or manic symptoms. Psychological treatment will provide the person with emotional support and help him develop coping skills.

3.4 UNIT END QUESTIONS

- 1) Explain the nature of mood disorder due to general medical condition.
- 2) Discuss the diagnostic criteria for mood disorder due to a general medical condition.
- 3) Differentiate between mood disorder due to general medical condition and major depressive disorder.
- 4) Explain the etiology of bipolar disorder.
- 5) Discuss any three of the major medical conditions which may cause mood disorder.

3.5 GLOSSARY

Antidepressant medication	: General term for a number of drugs used to relieve depression and to elevate mood.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.
Cognitive Behaviour therapy	: Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
Cyclothymic disorder	: A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
Depression	: Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
Depressive disorder	: Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
Diabetes	: Diabetes is a disorder that impairs the way the body uses digested food, especially glucose (a form of sugar), for growth and energy.
Dizygotic twins	: Twins that develop from two separate eggs.
Dysthymia	: A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
Episodic (disorder)	: Term used to describe a disorder that tends to abate and to recur.
HIV/AIDS	: AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers.
Heart Disease	: Heart disease includes two conditions called angina pectoris and acute myocardial infarction ("heart attack"). Heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease.
Hypomania	: A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
Major depressive disorder	: A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of

energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.

Mania	: Euphoric, hyperactive state in which an individual's judgment is impaired.
Monozygotic twins	: Identical twins developed from one fertilised egg.
Mood disorder	: One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
Multiple sclerosis	: Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system.
Parathyroid disorder	: Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia.
Parkinson disease	: Parkinson disease is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra.
Psychotherapy	: Treatment of mental disorders by psychological methods.
Seizure disorder	: A neurological disorder with symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours.
Stress	: Effects created within an organism by the application of a stressor.
Stroke	: Stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells.
Thyroid disorders	: Hyperthyroidism is a clinical condition caused by excess thyroid hormone
Unipolar disorder	: Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

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UNIT 4 SUBSTANCE INDUCED MOOD DISORDER

Structure

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4.0 INTRODUCTION

When taking a drug or stopping a drug causes days or weeks of mood changes, the problem is called substance-induced mood disorder. Many medicines and illegal drugs can cause you to be depressed. The drugs make you feel sad, uninterested in daily events, and hopeless. You may also get manic symptoms. When you are manic you are overexcited, have too much energy, and have difficulty controlling your actions. If you were depressed or manic before beginning drug use and it worsens with drug use, it is not called substance-induced mood disorder. A Substance-Induced Mood Disorder is distinguished from Major Depressive, Manic, or Mixed Episodes by the fact that a substance (e.g., a drug of abuse, a medication, or

exposure to a toxin) is judged to be etiologically related to the mood disturbance. In the present unit we will discuss the etiology and symptoms substance-induced mood disorder. We will also discuss different types of substances and how these substances induce mood disorders during intoxication (i.e., while the individual is under the influence of the drug) or during withdrawal (i.e., after an individual stops using the drug).

4.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of substance induced mood disorder;
- Describe the diagnostic criteria of substance induced mood disorder;
- Elucidate the differences between due substance induced mood disorder and mood disorder due to general medical condition;
- Delineate the types of psychoactive drugs that may induce mood disorder; and
- Analyse the differences between substance induced mood disorders from a primary mood disorder.

4.2 SUBSTANCE INDUCED MOOD DISORDER

According to the Diagnostic and Statistical Manual of Mental Disorders- Forth Edition, Text Revised (DSM-IV- TR) substance induced mood disorder is diagnosed when

A: A person has significant disturbance in mood that includes either (or both)

Depressed mood or significantly reduced level of interest or pleasure in most or all activities.

Mood that is euphoric, heightened, or irritable.

B: The person's symptoms develop during (or within four weeks of) intoxication or withdrawal, or are caused by medication use.

C: Another disorder does not better explain the mood disturbance.

D: The mood condition is not present only when a person is delirious.

E: The symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Before we start our discussion about the substance induced mood disorder, it is important to explain what we mean by psychoactive substance and also the level of involvement, that is which are substance use, intoxication, abuse and dependence.

4.2.1 Psychoactive Substances and Level of Involvement

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category, as the safe drugs also affect mood and behaviour: they can be addictive, and they account for more health problems than those of illegal drugs (Durand & Barlow, 2000).

Substance use is the ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning.

Substance intoxication refers to the physiological reaction to ingested substances—drunkenness, or getting high. Intoxication depends on which drug is taken, how much is ingested, and the person's individual biological reaction. Intoxication may cause impaired judgment, mood changes, and lowered motor ability.

Substance abuse is defined in terms of how significantly the substances interfere with the user's life. If substances disrupt user's education, job, or relationship with others, and put him in physically dangerous conditions, he would be considered a drug abuser.

As far as *substance dependence* is concerned the term substance dependence or "addiction" is generally used to describe people who seem to be enslaved by drugs. Substance dependence is the person is dependent on drug or drugs, requires greater and greater amounts to experience the same effect (tolerance), and will respond physically in a negative way when the substance is no longer ingested (withdrawal) (Kalant, 1989).

Depending on their effect, psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens.

Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion).

Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the *opiates* group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in *hallucinogens* category. These substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and amount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders. Substance induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Moreover, substance induced mood disorders, most notably acute depression lasting from hours to days, can result from sedative-hypnotic intoxication. Similarly, prolonged or sub-acute withdrawal, lasting from weeks to months, can cause episodes of depression, sometimes accompanied by suicidal ideation or attempts.

Also, stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Overall, the process of addiction per se can result in bio-psychosocial disintegration, leading to chronic dysthymia or depression often lasting from months to years.

Since symptoms of mood disorders that accompany acute withdrawal syndromes are often the result of the withdrawal, adequate time should elapse before a definitive diagnosis of an independent mood disorder is made. Conditions that most frequently cause and mimic mood disorders and symptoms must be differentiated from substance

induced conditions. When symptoms persist or intensify, they may represent substance induced mood disorders.

Transient dysphoria following the cessation of stimulants can mimic a depressive episode. According to the DSM-IV, if symptoms are intense and persist for more than a month after acute withdrawal, a depressive episode can be diagnosed. Symptoms of shorter duration can be diagnosed as a substance-induced mood disorder.

4.2.2 Diagnostic Features of Substance Induced Mood Disorder

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Alternately, an individual may have a mood disorder coexisting with a substance abuse disorder.

Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse. It is diagnosed as a Substance Induced Mood Disorder (e.g., euphoric mood that occurs only in the context of intoxication with cocaine would be diagnosed as Cocaine-Induced Mood Disorder, with Manic Features, with Onset During Intoxication).

Symptoms like those seen in a manic or mixed episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy, such episodes are also diagnosed as Substance Induced Mood Disorder. The essential feature of Substance Induced Mood Disorder is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a substance.

Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a major depressive, manic, mixed, or hypomanic episode, the full criteria for one of these episodes need not be met. The predominant symptom type may be indicated by using one of the following subtypes: (i) With Depressive Features (ii) With Manic Features (iii) With Mixed Features.

The diagnosis is not made if the mood disturbance occurs only during the course of a delirium. The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort.

A Substance Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal.

Substance-Induced Mood Disorders arise only in association with intoxication or

withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

4.2.3 Substances and Accompanying Psychiatric Symptoms

Following is an overview of the most common classes of substances of abuse and the accompanying psychiatric symptoms seen in intoxication, withdrawal, or chronic use.

4.2.3.1 Depressants

Depressants decrease the activities of central nervous system. Their principal effect is to reduce the levels of physiological arousal and help us relax. Some of the most commonly used depressants are discussed below:

4.2.3.1.1 Alcohol

Alcohol is a depressant, but its initial effect is an apparent stimulation. The chronic abuse of alcohol can be associated with significant depression that may, by symptoms alone, be indistinguishable from idiopathic major depression.

However, of patients with depressive disorder from alcohol dependence who are monitored for 2-4 weeks without alcohol, more than 50% have full remission of symptoms without additional intervention for the depressive symptoms. A minority of patients, usually those with more severe symptoms, has a continued depressive syndrome despite sobriety and requires additional treatment (Schuckit, Smith, Danko, 2007).

In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Such symptoms might even appear “hypomanic.” However these often are followed with next-day mild fatigue, nausea, and dysphoria (i.e., a hangover). In a person who has many life stresses, losses, and struggles, which is often the case as addiction to alcohol proceeds, the mood lability and lowered impulse control can lead to increased rates of violence toward others and self. Prolonged drinking increases the incidence of dysphoria, anxiety, and such violence potential. Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heartbeat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions.

Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks, so called “protracted withdrawal.” Differentiating protracted withdrawal from a major depression or anxiety disorder is often difficult. More severe withdrawal is characterised by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures. The best predictor of whether this type of withdrawal may happen again is if it happened before. Alcohol-induced deliriums after high-dose drinking are characterised by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone, while by definition, alcohol dementias are associated with brain damage and are not entirely reversible even with sobriety.

4.2.3.1.2 Sedative, Hypnotic, and Anxiolytic Substances

Acute intoxication with sedative, hypnotic, and anxiolytic drugs like barbiturates (which include Amytal, Seconal, and Nembutal) and benzodiazepines (which include

Valium, Xanax, Rohypnol, and Halcion) is similar to what is experienced with alcohol. The DSM-IV criteria for sedative, hypnotic, and anxiolytic drug use disorder do not differ substantially from those alcohol disorders.

Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety and/or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterised by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealisation and depersonalisation, and impaired concentration.

Most symptoms resolve within weeks, though some symptoms, such as anxiety, depression, tinnitus (ringing in the ears), and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal in rare cases. No chronic dementia-type syndromes have been characterised with chronic use; however, many people who use sedatives chronically seem to experience difficulty with anxiety symptoms, which respond poorly to other anxiety treatments.

4.2.3.2 Stimulants

Stimulants are the most commonly used psychoactive substances. Included in this group are caffeine (in coffee, chocolate, and many soft drinks), nicotine (in tobacco products) amphetamines, and cocaine. In contrast to depressant substances, stimulants make us more alert and energetic. Several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. Some of the common stimulant substances are given below:

4.2.3.2.1 Amphetamine

Amphetamines are CNS stimulants and initially cause feelings of increased well-being, energy, and concentration. However, amphetamine abuse can cause development of psychotic symptoms. A low dose of amphetamines can induce feelings of elation and vigor and can reduce fatigue. We literally feel “up”. However, after a period of elation we come back down and “Crash”, Feeling depressed and tired. DSM-IV diagnostic criteria for amphetamine intoxication include significant behavioural symptoms, such as euphoria or affective blunting, changes in sociability, interpersonal sensitivity, anxiety, tension, anger, stereotyped behaviours, impaired judgment, and impaired social or occupational functioning.

Ecstasy (methylenedioxymethamphetamine [MDMA]), a designer drug synthetically derived from amphetamine, is often used in the context of large and energetic parties (raves) and at nightclubs. Initially, it causes mild euphoria, increased energy, and increased libido. Tolerance develops rapidly. Depression, anxiety, and psychosis have also been described with regular use, and some of the symptoms persist for months after cessation of use.

4.2.3.2.2 Caffeine

Caffeine is the most common psychoactive substances. It is used nearly by all people. It is called “gentleman stimulant” because it is thought to be the least harmful of all the addictive drugs. This drug is found in tea, coffee, many cola drinks, and in cocoa products. As with other stimulants, regular use of caffeine can result in

tolerance and dependence on the drug (Strain, Mumford, Silverman, & Griffiths, 1992). When denied the morning tea or coffee the person experiences headaches, drowsiness, and a general unpleasant mood characterised by withdrawal symptoms. When consumed in large quantities, caffeine can cause mild to moderate anxiety, though the amount of caffeine that leads to anxiety varies. Caffeine is also associated with an increase in the number of panic attacks in individuals who are predisposed to them.

4.2.3.2.3 Cocaine

Cocaine is derived from the leaves of coca plant. Cocaine is a powerful stimulant initially causing euphoria and increased alertness and energy. Cocaine can also make the heart beat more rapidly and irregularly, and it can have fatal consequences, depending on the person's physical condition and the amount of drug ingested. As the high wears off, the user may develop symptoms of anxiety and depression, often with drug craving. With continued regular use, symptoms of psychosis develop with hallucinations and frank paranoid delusions. The psychiatric presentation can appear similar to that observed in patients with chronic amphetamine abuse.

4.2.3.2.4 Nicotine

Clients who are dependent on nicotine are more likely to experience depression than people who are not addicted to it; however, it is unclear how much this is cause or effect. In some cases, the client may use nicotine to regulate mood. Whether there is a causal relationship between nicotine use and the symptoms of depression remains to be seen. At present, it can be said that many persons who quit smoking do experience both craving and depressive symptoms to varying degrees, which are relieved by resumption of nicotine use.

Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with attention deficit disorders and even in people who do not have attention deficit disorders. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease. As dosage of increases cocaine and methamphetamines, the chances of impulsive dangerous behaviours, which may involve violence, promiscuous sexual activity, and others, also increases. Many who become chronic heavy users go on to experience temporary paranoid delusional states.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression. These anhedonic states can persist for weeks. As mentioned above, heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms. Month-long methamphetamine binges followed by week- or month-long alcohol binges, a not uncommon pattern, might appear to be "bipolar" disorder if the drug use is not discovered.

4.2.3.3 Opioids

The word opiate refers to the natural chemicals in the opium poppy that have a narcotic effect (they relieve pain and induce sleep). The broader term opioids refer

to the family of substances that include natural opiates, synthetic variations, and the comparable substances that occur naturally in brain (Jaffe, Knapp, & Ciraulo, 1997). Morphine, codeine, and heroin are produced from opium poppies. Opiates are analgesics (relieve pain). It also induces euphoria, drowsiness, and slowed breathing. Opioid intoxication is characterised by intense euphoria and well-being. Withdrawal results in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids.

Symptoms during withdrawal vary, that is, some will become acutely anxious and agitated, while others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist for weeks as a protracted withdrawal syndrome. Again, differentiating this from major depression or anxiety is difficult and many clinicians may just treat the ongoing symptom cluster. For many people who become opioid dependent, and then try abstinence, these ongoing withdrawal symptoms are so powerful that relapse occurs even with the best of treatments and client motivation. For these clients, opioid replacement therapy (methadone, suboxone, etc.) becomes necessary and many times life saving. There are reports of an atypical opioid withdrawal syndrome characterised by delirium after abrupt cessation of methadone. Such clients do not appear to have the autonomic symptoms typically seen in opioid withdrawal. Long-term use of opioids is commonly associated with moderate to severe depression.

4.2.3.4 Hallucinogens

Hallucinogens are the substances that can lead to hallucinogen use disorder. Ingestion of these substances change the way the user perceives the world. Sight, sound feelings, taste, and even smell are distorted. They produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalisation.

Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared to schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). The hallucinogens can cause a state of intoxication called hallucinosis, which has several features in common with psychotic disorders and a few in common with mood disorders.

4.2.3.4.1 Marijuana

Marijuana is an important drug of hallucinogens category. It is the name given to the dried parts of the Cannabis or hemp plant. Cannabis grows wild throughout the tropical and temperate regions of the world, which accounts for one of its nicknames, “weed.” Marijuana, which has sedative and psychedelic properties, can cause a variety of mood-related effects. In the individual who has not developed tolerance for the drug’s effects, high doses of marijuana can cause acute marijuana intoxication with euphoria or agitation, grandiosity, and “profound thoughts.” Together, these symptoms can mimic mania. Because marijuana is only slowly eliminated from the body, chronic use results in relatively constant marijuana levels. Thus, daily marijuana use can be, in effect, a chronic marijuana intoxication. This state may include symptoms of chronic, low-grade lethargy and depression, perhaps accompanied by anxiety and memory loss. Phencyclidine (PCP) intoxication can include symptoms of euphoria, mania, or depression, in addition to sensory dissociation, hallucinations, delusions, psychotic thinking, altered body image, and disorientation.

Other hallucinogens such as LSD (lysergic acid diethylamide) and drugs such as MDMA (methylenedioxy-methamphetamine, or Ecstasy) and MDA (methylenedioxyamphetamine) may precipitate intense emotional experiences that may be perceived as positive or negative mood states by the drug user. These experiences are affected greatly by personality, preexisting mood state, personal expectations, drug dosage, and environmental surroundings.

While many users will experience sensory and perceptual distortions, some will experience euphoric religious or spiritual experiences that may resemble aspects of a manic or psychotic episode. Others may have a deeply troubling introspective experience, causing symptoms of depression.

4.2.4 Prognosis

Depressive or manic symptoms induced by substance intoxication usually subside once the substance responsible is eliminated. Symptoms persist depending on the half-life of the substances (i.e., how long it takes the before the substance is no longer present in an individual's system). Symptoms, therefore, can persist for hours, days, or weeks after a substance is last used. Mood disorder symptoms induced by substances sometimes do not disappear, even although the substance inducing them has been eliminated. More intensive treatment for the mood disorder symptoms would be necessary and should include a combination of medication and behavioural therapy.

4.2.5 Treatment

A multidisciplinary approach to the treatment of substance induced mood disorder appears to be most effective because the problems are often complex, requiring flexibility and individualisation of treatment procedures (Margolis and Zweben, 1998). Treatment programme objectives usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.2.5.1 Psychotherapy

Substance-induced mood disorder can be successfully treated with either group or individual psychotherapy. Therapy in a group with other people having substance abuse problems is often very helpful. Groups have the benefit of connecting with others having similar problems, thereby overcoming feelings of isolation. Groups provide clients with an opportunity to learn from, and give support to, each other. They can instill hope, encourage information sharing and provide role models. The group allows clients to find new ways to express themselves, or to review old conflicts in a supportive environment. In some cases, medicines for depression or anxiety may help the client to stop substance abuse. Following therapies have been found effective to cure substance induced mood disorder:

4.2.5.1.2 Aversion Therapy

Aversion therapy is based on conditioning model. In aversion therapy substance use is paired with something extremely unpleasant, such as brief electric shock or feelings of nausea. For example, a person might be offered a drink of alcohol, and receive a painful shock when the glass reaches his lips.

4.2.5.1.2 Covert Sensitisation

In covert sensitisation therapy a negative association is to be made by imagining unpleasant scenes. The Client might picture himself to snort cocaine and then becoming violently ill.

4.2.5.1.3 Contingency Management

In contingency management therapy the clinician and client together select the behaviour that the client needs to change and decide on the reinforcers that will reward reaching certain goals. In a study of cocaine abusers, clients received things like lottery tickets for having cocaine-negative urine specimens (Higgins et.al., 1993).

4.2.5.1.4 Biofeedback

Through biofeedback the client learns to control body functions such as muscle tension or brain wave patterns. Biofeedback can help with tension, anxiety, and concentration, and indirectly may help to avoid a return to substance abuse. Biofeedback should be done only in addition to psychotherapy.

4.2.5.1.5 Relaxation Therapies

Learning special relaxation methods can help with mood problems or substance abuse, along with psychotherapy. Yoga and meditation may also be helpful.

4.2.5.1.6 Art and Music Therapies

Some people find art and music therapy, along with psychotherapy, to be helpful.

4.3 LET US SUM UP

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiological effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. When the symptoms like those seen in a manic, mixed, or hypomanic episode may be part of an intoxication with or withdrawal from a drug of abuse, it is diagnosed as a Substance-Induced Mood Disorder.

Psychoactive substances are chemical compounds that are ingested to alter mood or behaviour. Thus all types of drugs, illegal (e.g. cocaine and heroin) as well as legal and safe drugs (e.g. alcohol, nicotine, and the caffeine in the coffee, soft drinks, and chocolate) are included in this category. There are four levels of substance involvement: Substance use, Substance intoxication, substance abuse, and substance dependence or intoxication

Depending on their effect psychoactive substances are grouped into four categories as depressants, stimulants, opiates, and hallucinogens. Depressant are those substances which result in behavioural sedation. They include alcohol and the sedative (calming), hypnotic (sleep-inducing), and anxiolytic (anxiety-reducing) drugs in the families of barbiturates (e.g., seconal) and benzodiazepines (e.g., valium and halcion). Stimulant substances are the substances which cause the person to be more active and alert, and can elevate mood. Amphetamines, cocaine, nicotine, and caffeine are included in this group. Heroin, opium, codeine, and morphine are included in the opiates group. Their major effect is to temporarily produce analgesia (reduce pain) and euphoria, while marijuana and LSD are included in hallucinogens category. These

substances alter sensory perception and can produce delusions, paranoia, and hallucinations.

A Substance-Induced Mood Disorder is distinguished from a primary Mood Disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of dependence, abuse, intoxication, or withdrawal. Substance-Induced Mood Disorders arise only in association with intoxication or withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence.

Treatment of substance induced mood disorder usually include detoxification, physical rehabilitation, control over drug-abuse behaviour, and development of an individual's realisation that he /she can cope with the problems of living and lead a much more rewarding life without drugs. Psychotherapy along with some medications is effectively used for treating substance induced mood disorder.

4.4 UNIT END QUESTIONS

- 1) What do you mean by substance-induced mood disorder? Explain in the light of DSM-IV-TR.
- 2) Explain the diagnostic criteria of substance-induced mood disorder.
- 3) Differentiate between mood disorder due substance-induced mood disorder and mood disorder due to general medical condition.
- 4) What do you mean by psychoactive drugs? Discuss the types of psychoactive drugs.
- 5) Distinguish substance induced mood disorder from a primary mood disorder.

4.5 GLOSSARY

Abstinence	: Refraining altogether from the use of an addictive substance.
Addiction	: Pathological need for a substance. It may also involve the abuse of substance or the excessive ingestion of high caloric food, or gambling.
Alcoholism	: Dependence on alcohol that seriously interferes with life adjustment.
Amphetamine	: Drug that produces a psychologically stimulating and energizing effect.
Anhedonia	: Inability to experience pleasure or joy.
Barbiturates	: Synthetic drugs that act as depressants to calm induce sleep.
Biofeedback	: Treatment technique in which a person is taught to control his/her own physiological processes formerly thought to be involuntary.
Bipolar disorder	: Mood disorder in which a person experiences both manic and depressive episodes.

Caffeine	: Most common psychoactive drug of dependence found in many commonly available drinks and foods.
Cocaine	: Stimulating and pain reducing psychoactive drug.
Cyclothymic disorder	: A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
Delirium	: Condition characterised by a confused mental state, usually resulting from shock or fever, accompanied by alterations in attention and by hallucinations, delusions, and incoherence.
Depressants	: Psychoactive drugs that decrease the activities of central nervous system.
Depression	: Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
Depressive disorder	: Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
Detoxification	: Treatment directed toward ridding the body of alcohol or other drugs.
Drug Abuse	: Use of a drug to the extent that it interferes with health and/or occupation or adjustment.
Drug addiction (Dependence)	: Physiological and/or psychological dependence on a drug.
Dysthymia	: A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
Episodic (disorder)	: Term used to describe a disorder that tends to abate and to recur.
Hallucination	: False perception; things seen or heard that are not real or present.
Hallucinogens	: Drugs which cause to induce hallucinations.
Heroin	: Psychoactive drug derived from morphine, that relieves pain but more intense and addictive than morphine.
Hypomania	: A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
Lability	: Instability, particularly with regard to affect.

LSD (Lysergic acid diethylamide)	: The most potent of hallucinogens. It is so strong that it can produce intoxication with an amount smaller than that a grain of salt.
Major depressive disorder	: A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.
Mania	: Euphoric, hyperactive state in which an individual's judgment is impaired.
Marijuana	: Mild hallucinogenic substance derived from hemp plant.
Mood disorder	: One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
Nicotine	: Addictive alkaloid that is the chief active ingredient in tobacco and a drug of dependence.
Opium	: Narcotic drug that leads to physiological dependence and the development of tolerance, derivatives are morphine, heroin, and codeine.
Psychoactive drugs	: Drugs that affect mental functioning.
Psychotherapy	: Treatment of mental disorders by psychological methods.
Stimulants	: Drugs that tend to increase feelings of alertness, reduce feelings of fatigue, and enable a person to stay awake over sustained periods of time.
Unipolar disorder	: Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

4.6 SUGGESTED READINGS

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