

Mood Disorders (DSM-4-TR)

- MUST cause clinically significant distress or impairment in social, occupational, or other areas of functioning
- Disruptions tend to occur across domains of
 - Emotion - euphoria, sadness, irritation, dejection
 - Cognition – racing or slowing of thought, flight of ideas, negative evaluations, expansiveness (everything is just wonderful!)
 - Motivation - interested in everything or loss of interest
 - Physical - changes in sleep, appetite, libido
 - Behavior - increased or decreased activity (may or may not be productive), reckless spending, risky sex, crying spells

Types of Mood Episodes

- **Major Depressive** - lasts 2 weeks or more
- **Manic** - lasts at least 1 week, or severe enough to require hospitalization
- **Hypomanic** – sub-Manic, lasts at least 4 days
- Rule-Outs:
 - The mood episode is directly caused by the physiological effects of a specific medical condition (e.g., Parkinson's Disease or a Cerebral Vascular Accident (CVA - aka stroke))
 - If the mood episode is directly caused by the physiological effects of substance use, the mood disturbances are beyond that which are typical of substance intoxication or withdrawal
 - If there are psychotic symptoms present, it will be important to determine whether the mood episode features or the psychotic features are more prominent

Manic Episode (1 of 3)

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

- B. During the period of disturbance and increased energy or activity, three (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
 1. Inflated self-esteem or grandiosity.
 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
 3. More talkative than usual or pressure to keep talking.
 4. Flight of ideas or subjective experience that thoughts are racing.

Manic Episode (2 of 3)

5. Distractibility (i.e., attention to or easily drawn to unimportant or irrelevant stimuli), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work, or school, or sexually) or psychomotor agitation. (purposeless non-goal directed activity).
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

Manic Episode (3 of 3)

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

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

Hypomanic Episode (1 of 3)

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

- B. During the period of disturbance and increased energy or activity, three (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
 1. Inflated self-esteem or grandiosity.
 2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
 3. More talkative than usual or pressure to keep talking.
 4. Flight of ideas or subjective experience that thoughts are racing.

Hypomanic Episode (2 of 3)

5. Distractibility (i.e., attention to or easily drawn to unimportant or irrelevant stimuli), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work, or school, or sexually) or psychomotor agitation. (purposeless non-goal directed activity).
 7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.

Hypomanic Episode (3 of 3)

- E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features present.
- F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

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

Major Depressive Episode (1 of 4)

- A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

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

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: in children and adolescents, can be irritable mood.)
2. Marked diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

Major Depressive Episode (2 of 4)

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% or body weight in a month) or increased/decrease in appetite. (Note: in children, considered failure to make expected weight gains.)
4. Insomnia or hypersomnia, nearly every day.
5. Psychomotor agitation or retardation, nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

Major Depressive Episode (3 of 4)

8. Diminished ability to think or concentrate or indecisiveness, nearly every day (either by subjective or as by observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

Major Depressive Episode (4 of 4)

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

Bipolar I Disorder (1 of 2)

- A. Criteria for at least one (1) Manic Episode in lifetime must be met
- B. The occurrence of the manic and major depressive episode(s) is not better explained by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or other specified or unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

Bipolar I Disorder (2 of 2)

Specifiers:

- The nature of the current episode (*specified as* Current or Most Recent Episode Manic, Hypomanic, Depressed, Unspecified)
- Intensity of the current episode: Mild, Moderate, Severe w/o Psychotic Features, Severe w/ Psychotic Features
- Remission specifiers: In Partial Remission, In Full Remission
- With Anxious Distress
- With Mixed Features
- With Rapid Cycling
- With Melancholic Features
- With Atypical Features
- With Mood-Congruent Psychotic Features
- With Mood-Incongruent Psychotic Features
- With Catatonia
- With Peripartum Onset
- With Seasonal Pattern (major depressive episode only)

e.g. Bipolar I Disorder, Most Recent Episode Depressed, Severe with Psychotic Features, With Mood-Congruent Psychotic Features

Bipolar I Disorder - Prevalence

Bipolar I is much rarer in population than Major Depressive Disorder – about 0.6% prevalence including those individuals whose illness starts with a depressive episode

Age of onset: typically late adolescence to early 20s, but can occur throughout the lifespan, including in the elderly.

Individuals with Bipolar I Disorder often become familiar with own course of illness and recurrence is common

Lots of problems when manic, including violence, abuse, tremendous spending. Loss of job and marriage common.

High levels of attempted and completed suicide

Bipolar II Disorder (1 of 2)

- A. Criteria have been met for at least one hypomanic episode and at least one major depressive episode.
- B. There has never been a manic episode in the lifetime.
- C. The occurrence of the hypomanic and major depressive episode(s) is not better explained by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or other specified or unspecified Schizophrenia Spectrum and Other Psychotic Disorder.
- D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Bipolar II Disorder (2 of 2)

Specifiers:

- The nature of the current episode (*specified as Current or Most Recent Episode Hypomanic or Depressed*)
- Intensity of the current episode: Mild, Moderate, Severe w/o Psychotic Features, Severe w/ Psychotic Features
- Remission specifiers: In Partial Remission, In Full Remission
- With Anxious Distress
- With Mixed Features
- With Rapid Cycling
- With Mood-Congruent Psychotic Features
- With Mood-Incongruent Psychotic Features
- With Catatonia
- With Peripartum Onset
- With Seasonal Pattern (major depressive episode only)

e.g. Bipolar II Disorder, Most Recent Episode Depressed, Severe without Psychotic Features, With Seasonal Pattern

Bipolar II Disorder - Prevalence

About 0.8% 1-year prevalence for Bipolar II Disorder, compared to 0.6% Bipolar I Disorder. Text notes that internationally, the 1-year prevalence rate is 0.3%.

5-15% will experience a manic episode, changing diagnosis to Bipolar I Disorder.

High levels of attempted suicide.

Cyclothymic Disorder (1 of 2)

- A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that DO NOT meet criteria for a hypomanic episode and numerous periods with depressive symptoms that DO NOT meet criteria for a major depressive episode.
- B. During the above 2 year period (1 year in children and adolescents) the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.
- C. Criteria for a manic, hypomanic, or major depressive episode have NEVER been met.

Cyclothymic Disorder (2 of 2)

- D. The symptoms in Criterion A are not better explained by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or other specified or unspecified Schizophrenia Spectrum and Other Psychotic Disorder.
- E. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Only one specifier:

- With Anxious Distress

Cylcothymic Disorder - Prevalence

Lifetime prevalence rates range from 0.4-1.0%

1-year prevalence rates unknown but 3-5% in mood disorder clinics (therefore less in outpatient clinics)

M:F supposedly 1:1

Need to differentiate this from “moodiness” and personality disorders, particularly as 15-50% risk of becoming more severe Bipolar-Related Disorder (I or II)

Substance/Medication-Induced Bipolar and Related Disorder (1 of 3)

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.

- B. There is evidence from the history, physical examination, or laboratory findings of both (1) AND (2):
 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A.

Substance/Medication-Induced Bipolar and Related Disorder (2 of 3)

- C. The disturbance is not better explained by a bipolar or related disorder that is not substance/medication-induced. Such evidence of an independent bipolar or related disorder could include the following:
 - The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication or there is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history or recurrent non-substance/medication-related episodes)
- D. The disturbance does not occur exclusively during the course of a delirium.

Substance/Medication-Induced Bipolar and Related Disorder (3 of 3)

- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers:

With Onset During Intoxication

With Onset During Withdrawal

Other Specified and Unspecified Bipolar and Related Disorder

These diagnoses are used for disorders with predominantly Bipolar and Related Disorder features that do not meet the criteria for any other named Bipolar and Related Disorder.

Examples of Specified (or Unspecified) Bipolar and Related Disorders include:

1. Short-duration hypomanic episodes and major depressive episodes.
2. Hypomanic episodes with insufficient symptoms and major depressive episodes
3. Hypomanic episode without prior major depressive episode
4. Short-duration cyclothymia

Differentiation between Specified Bipolar and Related Disorder and Unspecified Bipolar and Related Disorder is clinical judgment (practitioners professional opinion).

Bipolar and Related Disorders - Etiology

- Biological Theories
 - Genetics – 12-22% of individuals with a Bipolar Disorder have another first degree relative with a Bipolar Disorder
 - If one sibling has it, another sibling has a 11% chance of having it vs. a 2% chance in the general population
 - Monozygotic twins: 72% concordance, dizygotic: 14%
 - Excess neurotransmitters – too much Serotonin, Dopamine, and Norepinephrine
- Cognitive-Behavioral Theories
 - Positive reinforcement for discharge of anger without significant consequences (low pain)
- Interactional Theory
 - Diathesis-Stress

Bipolar I Disorder - Treatment

- Biological Treatment
 - Medication – Mood stabilizers: Lithium, Depakote, Lamictal
- Therapy Alone
 - Not effective in preventing Mania and recommending therapy alone without medication is regarded as unethical and not the “standard of care”. Also, untreated ongoing Manic episodes can result in kindling – where subsequent manic episodes have faster onset and more psychotic features
- Integrative Treatment
 - Meds and therapy to address illness-related thoughts, dynamics, resistance (i.e., why not experience hypomania, more gets done, feels great, medication non-compliance)

Bipolar II Disorder - Treatment

- Biological Treatment
 - Depending on the course of the hypomanic symptoms/episodes, medication may involve antidepressants and/or mood stabilizers.
- Therapy Alone
 - After a medication consultation has been performed and the patient declines a medication regimen, therapy may be continued but careful monitoring is needed as onset of mood symptoms may reflect episode onset. High risk for both patient and therapist.
- Integrative Treatment
 - Meds and therapy to address any illness-related thoughts, as well as recognize the signs of symptom onset or their worsening and having a treatment plan in place.

Cyclothymic Disorder - Treatment

- Biological Treatment
 - Depending on the level of distress, a medication consultation may be warranted.
- Therapy
 - After a medication consultation has been performed and the patient declines a medication regimen, therapy may be continued but careful monitoring is needed as onset of mood symptoms may reflect worsening of the condition to Bipolar I or Bipolar II Disorder.
 - Therapy should include recognition of the onset and worsening of symptoms with clear course of action in place and understood by the client.