

Disruptive Mood Dysregulation Disorder

(1 of 3)

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression towards people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.
- C. The temper outbursts occur, on average, three or more times per week.
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
- E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D

Disruptive Mood Dysregulation Disorder

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- F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
- H. By history or observation, the age at onset of Criteria A-E is before 10 years.
- I. There has never been a distinct period lasting more than 1 day during which the full symptoms criteria, except duration, for a manic or hypomanic episode have been met.
- J. (On next slide)
- K. The symptoms are not attributable to the physiological effects of a substance (e.g., alcohol, cocaine, a medication, etc.) or another medical or neurological condition (e.g., hyperthyroidism, brain tumor).

Disruptive Mood Dysregulation Disorder

(3 of 3)

- J. The behaviors do not occur exclusively during an episode of Major Depressive D/o and are not better explained by another mental disorder (e.g., Autism Spectrum Disorder, Posttraumatic Stress Disorder, Separation Anxiety Disorder, Persistent Depressive D/o [Dysthymia]).

Note: This diagnosis cannot coexist with Oppositional Defiant Disorder, Intermittent Explosive Disorder, or Bipolar Disorder, though it can coexist with others, including Major Depressive Disorder, Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, and Substance Use Disorders. Individuals whose symptoms meet criteria for both Disruptive Mood Dysregulation Disorder and Oppositional Defiant Disorder should only be given the diagnosis of Disruptive Mood Dysregulation Disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

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.

Major Depressive Disorder

- A. Criteria for a Major Depressive Episode have been met.
- B. The occurrence of the Major Depressive Episode is not better explained by Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or other specified and unspecified Schizophrenia-Spectrum and other Psychotic Disorders.
- C. There has never been a manic or hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Major Depressive Disorder

Specifiers:

- How many episodes: Single, Recurrent (anything more than one)
- Intensity of the 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 Melancholic Features
- With Atypical Features
- With Mood-Congruent Psychotic Features
- With Mood-Incongruent Psychotic Features
- With Catatonia
- With Peripartum Onset
- With Seasonal Pattern (recurrent episode only)

e.g. MDD, Recurrent, Moderate, With Atypical Features, With Peripartum Onset

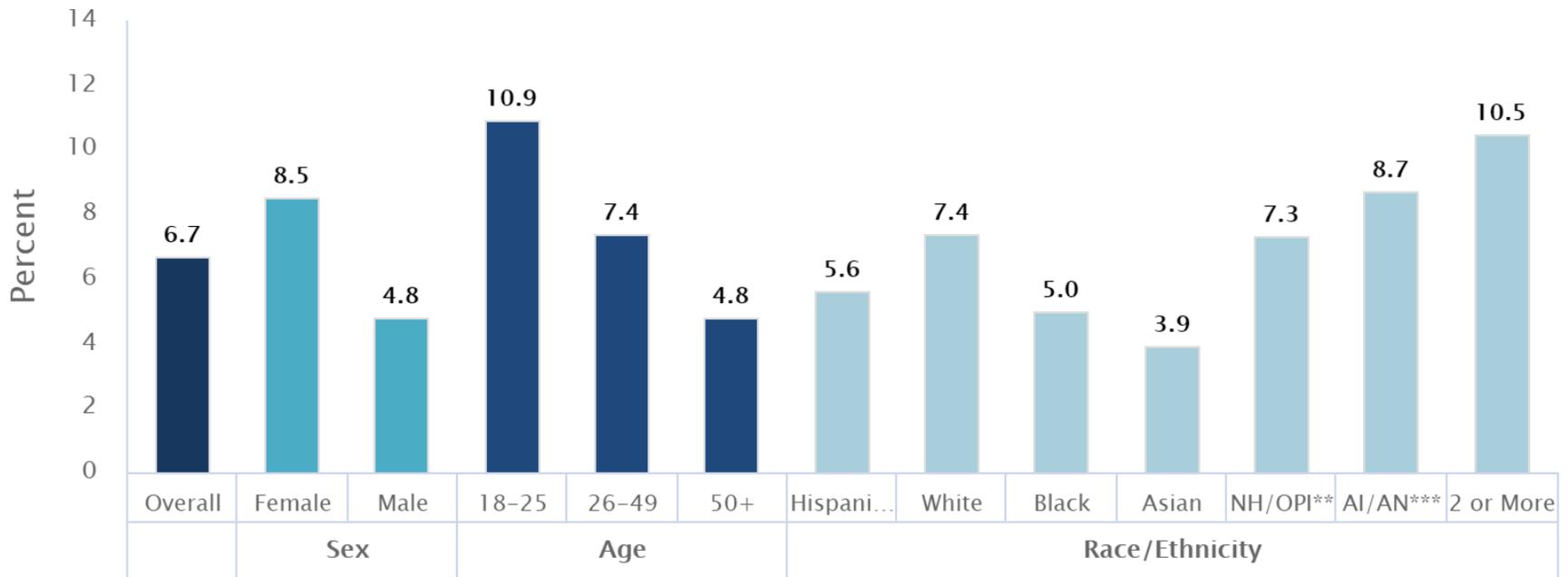
Major Depressive Disorder

- **Melancholic:** looks more vegetative (early morning awakening, appetite/weight loss); anhedonia (loss of pleasure); more hopelessness/guilt than sadness. Appears often in elderly.
- **Peripartum:** arises during pregnancy or within 4 weeks of giving birth; tends to reoccur
- **Atypical:** tends to be increased sleep, increased appetite, with some reactivity of mood brightening
- **Seasonal Pattern:** Onset associated with seasonal changes (darkness of late Fall or Winter; perhaps, heat of Summer) = Seasonal Affective Disorder (SAD); increased sleep and appetite
- **Psychotic Features:** 5-15% will experience hallucinations or delusions. The majority of these will go on to be diagnosed with a Psychotic Disorder (e.g., Schizoaffective Disorder).

Major Depressive Disorder - Prevalence

Past Year Prevalence of Major Depressive Episode Among U.S. Adults (2016)

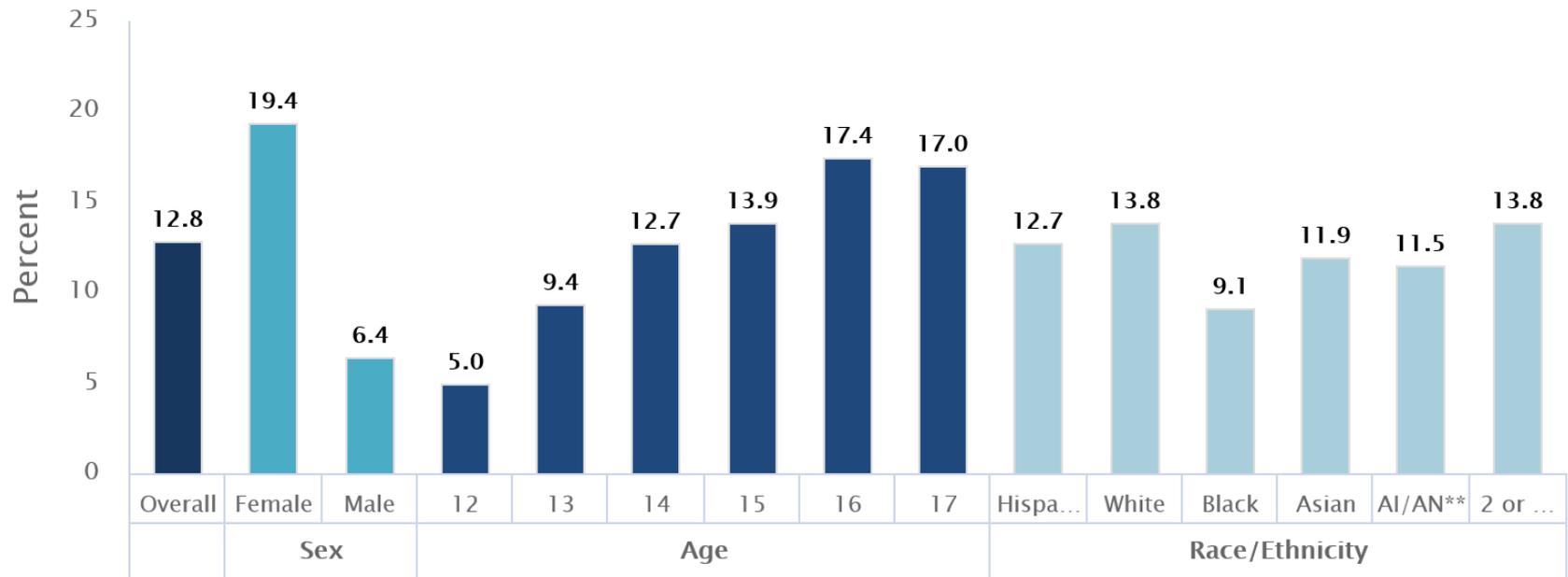
Data Courtesy of SAMHSA



Major Depressive Disorder - Prevalence

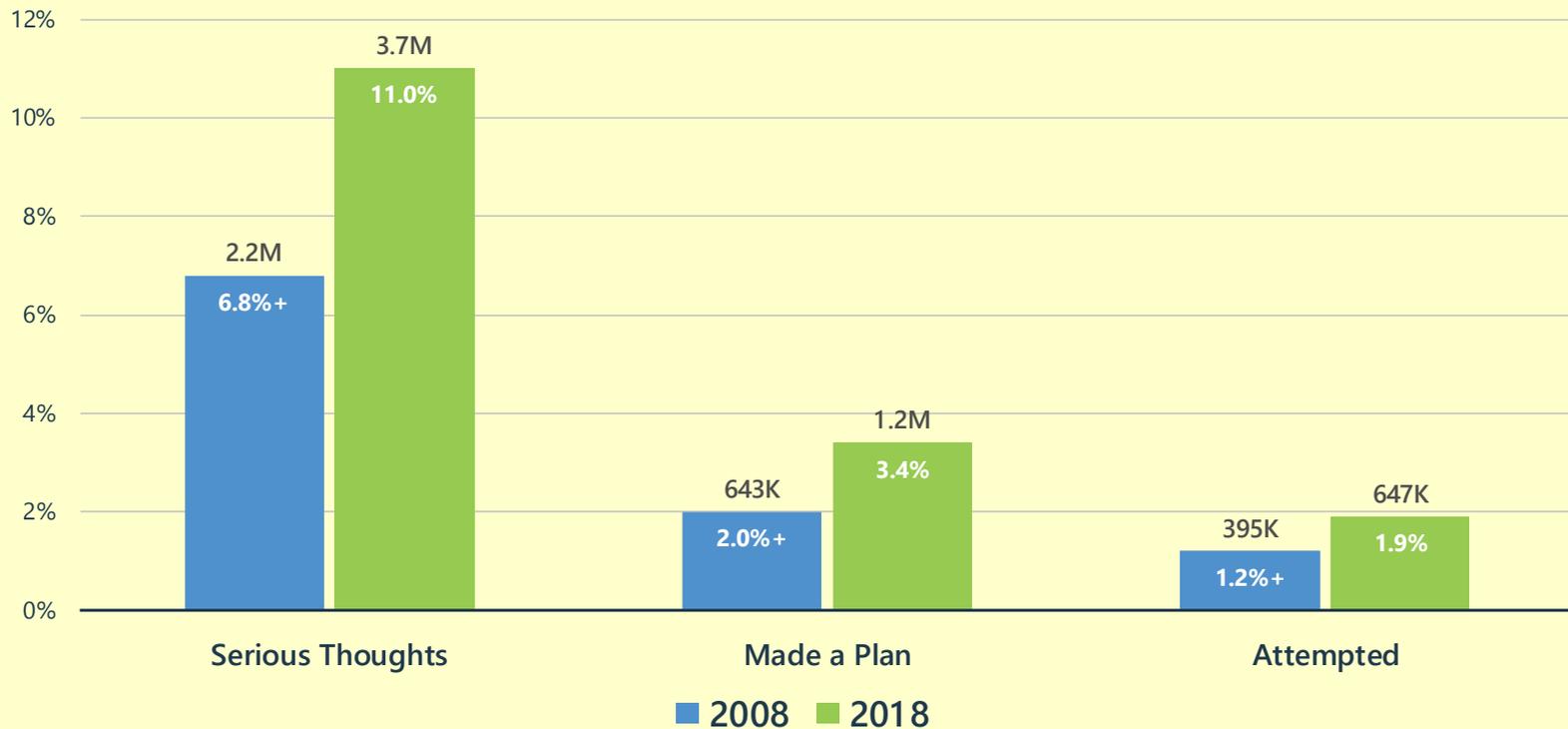
Past Year Prevalence of Major Depressive Episode Among U.S. Adolescents (2016)

Data Courtesy of SAMHSA



Suicidal Thoughts, Plans, and Attempts Increase for Young Adults (18-25 y.o)

PAST YEAR, 2008 and 2018 NSDUH, 18-25



+ Difference between this estimate and the 2018 estimate is statistically significant at the .05 level.

MDD – Prevalence

- **Lifetime Prevalence: 16.5%**
 - 7-21% lifetime for women, 3-13% lifetime for men
 - Mean: 16.5% (1 out of every 6 persons)
 - Non-Hispanic Whites: 10.4%
 - African-American: 7.5%
 - Mexican-American: 8.0%
 - Single, never married: 8.7%
 - Married, living with spouse: 8.8%
 - Separated, divorced, or widowed: 16.9%

MDD – Prevalence

Gender Differences:

Childhood: M > F

Adolescence-Early Adulthood, F > M, about 3:1

Middle Age: F > M, about 2:1

Old Age: F = M

Of individuals that have a Major Depressive Episode...

50-60% of them will have a second one

5-10% of them will have a manic episode

10-15% of them will have a hypomanic episode

- Median **age of onset** typically late twenties-early thirties

18-29: 5.0%

30-44: 7.5%

45-64: 4.0%

65+: 1.4%

Onset before 21 years of age correlated with greater chronicity and poorer treatment prognosis

Persistent Depressive Disorder (1 of 4)

- A. Depressed mood for most of the day, for more days than not, as indicated by either subjective report or observation by others for at least 2 years.

Note: in children and adolescents, mood can be irritable and duration must be at least 1 year.

- B. Presence, while depressed, of two (or more) of the following:
1. Poor appetite or over-reactive.
 2. Insomnia or hypersomnia
 3. Low energy or fatigue.
 4. Low self-esteem.
 5. Poor concentration or difficulty making decisions.
 6. Feelings of hopelessness.

Persistent Depressive Disorder (2 of 4)

- C. During the two year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. Criteria for a Major Depressive Disorder may be continuously present for 2 years.
- E. There has never been a Manic Episode or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.
- F. The disturbance is not better explained by a persistent Schizoaffective Disorder, Schizophrenia, Delusional Disorder, or other Specified or Unspecified Schizophrenia Spectrum And Other Psychotic Disorder.

Persistent Depressive Disorder (3 of 4)

- G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a Major Depressive Episode include four symptoms that are absent from the symptom list for Persistent Depressive Disorder (Dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for Persistent Depressive Disorder. If full criteria for a Major Depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of Major Depressive Disorder. Otherwise, a diagnosis of Other Specified Depressive Disorder or Unspecified Depressive Disorder is warranted.

Persistent Depressive Disorder (4 of 4)

Specifiers:

- With Anxious Distress
- With Mixed Features
- With Melancholic Features
- With Atypical Features
- With Mood-Congruent Psychotic Features
- With Mood-Incongruent Psychotic Features
- With Peripartum Onset
- Remission specifiers: In Partial Remission, In Full Remission
- Onset specifiers: Early Onset, Late Onset
- Severity specifiers: Mild, Moderate, Severe
- With Pure Dysthymic Syndrome
- With Persistent Major Depressive Episode
- With Intermittent Major Depressive Episodes, with Current Episode
- With Intermittent Major Depressive Episodes, without Current Episode

Persistent Depressive Disorder - Prevalence

- 1 year Prevalence – 1.5% for “Chronic Major Depressive Disorder
0.5% for Persistent Depressive Disorder
- Lifetime Prevalence – ranging from 1.3-3.7%
- M:F 1:2-3
- Tends to have an unclear, insidious onset
- Mean duration for adults is 5 years though for many, 20-30 year chronic course is unremarkable
- Early onset dysthymia is associated with presence of personality disorder

Premenstrual Dysphoric Disorder (1 of 3)

- A. In the majority of menstrual cycles. At least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week postmenses.
- B. One (or more) of the following symptoms must be present:
 1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
 2. Marked irritability or anger or increased interpersonal conflicts.
 3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
 4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

Premenstrual Dysphoric Disorder (2 of 3)

- C. One (or more) of the following symptoms must additionally be present, to reach a total of FIVE symptoms when combined with symptoms from Criterion B above.
1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
 2. Subjective difficulty in concentration.
 3. Lethargy, easy fatigability, or marked lack of energy.
 4. Marked change in appetite; overeating; or specific food cravings.
 5. Hypersomnia or insomnia.
 6. A sense of being overwhelmed or out of control.
 7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating” or weight gain.

Note: The symptoms in Criteria A-C must have been met for most menstrual cycles that occurred in the preceding year.

Premenstrual Dysphoric Disorder (3 of 3)

- D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).
- E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Persistent Depressive Disorder (Dysthymia), or a personality disorder (although it may co-occur with any of these disorders).
- F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles (Note: The diagnosis may be made provisionally prior to this confirmation).
- G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

Premenstrual Dysphoric Disorder - Prevalence

Despite the complaints of many women and their husbands/
boyfriends (and maybe girlfriends/wives), 1-year Prevalence rates
have been 1.8-5.8% of menstruating women.

Obviously, the disorder is only diagnosable for females.

Any thoughts about this?

Substance/Medication-Induced Depressive Disorder (1 of 3)

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by 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 is 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 Depressive Disorder (2 of 3)

- C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive 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 depressive 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.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Substance/Medication-Induced Depressive Disorder (3 of 3)

Specifiers:

With Onset During Intoxication

With Onset During Withdrawal

Lifetime Prevalence rate is 0.26% - RARE.

(e.g., compare with lifetime prevalence rate of Schizophrenia of ~0.5%)

Other Specified and Unspecified Depressive Disorder

These diagnoses are used for disorders with predominantly depressive features that do not meet the criteria for MDD, PDD, Adjustment Disorders with Depressed Mood, or any other named Depressive Disorder.

Examples of Specified (or Unspecified) Depressive Disorders include:

1. Recurrent Brief Depression.
2. Short-Duration Depressive Episode.
3. Depressive Episode with Insufficient Symptoms (what used to be thought of as “Minor depressive disorder”)
4. Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to another medical condition, or substance induced.

Differentiation between Specified Depressive Disorder and Unspecified Depressive Disorder is clinical judgment (practitioners professional opinion). This will probably result in decreased reliability of Specified Depressive Disorder (and hence validity, but that will remain to be seen).

Depressive Disorders – Etiology

- Biological Theories
 - Not enough serotonin in the brain
 - Not enough norepinephrine in the brain
- Cognitive Theories
 - Maladaptive Automatic Thoughts (Beck, 1979)
 - Cognitive Triad (Internal, Stable, Global)
 - Schemas (Young, 1990)
- Psychodynamic Theories
 - Anaclitic Depression (early separation and loss)
- Systemic Theories
 - Unmourned losses passed on generationally
 - Sensitive member of a family being made the scapegoat for family's problems (“YOU'RE the reason why...”)
- Interpersonal Theories
 - Lack of emotionally meaningful and supportive relationships
 - Marital discord/High marital dissatisfaction

Depressive Disorders – Etiology

- Behavioral Theories
 - Learned helplessness (Seligman, 1975) (perceived non-control)
- Psychospiritual Theories
 - From the fall (brokenness in original creation)
 - From rebellion (Jonah)
 - From sin, from our own ideals/belief in our power to control and be happy (misplaced identity)
 - Amish Study (England & Hostetter, 1983)
- Interactional Theory

MDD – Treatment

- Biological
 - SSRIs (Paxil, Prozac, Lexapro), Wellbutrin, Effexor
 - Tricyclic Antidepressants (Anafranil, Pamelor) and MAO Inhibitors
 - Electroconvulsive Treatment (ECT)
- Cognitive Therapy
 - Cognitive restructuring (Beck, 1979; Young, 1990)
 - thought level
 - to address Cognitive Triad
 - to address underlying schemas
- Psychodynamic Therapy
 - (Object relations) address impaired self-object representations and provide a different self-introject
- Systemic Theories
 - Help family grieve healthily vs. keeping things unmourned
 - Redistribute responsibility to all family members

MDD – Treatment

- Interpersonal Therapy
 - Address grief reactions, interpersonal disputes, role transitions, interpersonal deficits
 - Marital Therapy to improve communication and emotional satisfaction through improved meeting of emotional/relational/sexual needs
- Behavioral Therapy
 - Increase frequency of pleasurable activities and mastery
- Psychospiritual Therapy
 - Increase connection to God and revise identity in relationship with God
- Integrative Therapy

Grief/Bereavement

- Bereavement following a death is normal
- Culture significantly influences grieving practices
- Avoidance of grieving is clinically significant
- Anniversary reactions are common and normal
- Grief > 2 months may be reflective of what used to be called **pathological grieving but is now being considered for a possible disorder called, “Persistent Complex Bereavement Disorder”**
 - Preoccupation with the deceased/death of the deceased lasting more than 12 months (6 for children)
 - Clinically significant disruption to identity or social functioning.

Suicide

- About 15% of individuals with severe Major Depressive Disorder commit suicide
- The US suicide rate is approximately 11 out of 100,000 people.
- Suicide: Intentional, self-inflicted death
- Parasuicide: Non-lethal suicide attempt, suicidal gestures
- Suicidal Ideation: Thoughts about suicide/death. Can be active or passive
- Suicidal Intent: Intent to die/commit suicide, typically involves plan

Suicide - Statistics

- **Age**

Middle Age > Old > Young

3rd leading cause of death: 10-24 yo (2001)

2nd leading cause of death: 25-34 yo Males (2001)

- **Gender**

Attempts: 3:1 F:M

Completed/Committed: 3.5-4:1 M:F

- **Marital Status**

Divorced > Widowed > Single > Married

2-3:1 Divorced Males:Married Males

9-17:1 Young widowed males (20-34 y.o.):Married males

- **Nationality**

Low (< 5/100K) – Egypt, Mexico, Greece, Spain

Medium (8-12/100K) – England, USA, Canada

High – Russia, Germany, Scandinavia, China, Japan

Suicide – Triggers

1. Mental Disorders

- 50% of suicide attempters & 90% of completed suicides have at least one diagnosable DSM5 disorder
- hopelessness about disorder, future (severe MDD, Anorexia, Schizophrenia, Bipolar I Disorder, Alcoholism)

2. Stressful Events & Situations

- shame, failure, loss of job/chronic unemployment, arrest, rejection by/loss of loved one, natural disaster, bullying (including online)

3. Mood and Thought Changes

- increased emotional pain, hopelessness
- pessimistic belief that one's present circumstances or problems will not change
- loss of perspective (seeing all as negative)
- dichotomous thinking (viewing problems and solutions in rigid "either/or" terms)

Suicide – Triggers

4. Alcohol Use

- 60% of suicide attempts are preceded by drinking
- 25-50% of actual suicides occur while under intoxication
(33% of adolescent suicides)
- due to both depression of physiology and disinhibiting effects on judgment

5. Contagion

- When suicide is reported in the news media, rates tend to go up by 10-20% over the next 6 months
- When a student commits suicide, this increases chances of others following suit

Myths about Suicide

1. People who talk a great deal about suicide don't actually make attempts

FACT: > 60% of all completed suicides occur among people who make a definitive statement to another person about their intention.

2. People who fail to commit suicide will not attempt suicide again

FACT: 15-20% of people who fail in an attempt will eventually go on to complete suicide.

3. Once people decide to kill themselves nothing can stop them; they will feel that way forever

FACT: Most individuals commit suicide during limited periods of vulnerability, e.g., while drunk, enraged, etc. The period of vulnerability is estimated at 24-72 hours.

Myths about Suicide

4. Mentioning suicide to a suicidal person will “give them ideas”

FACT: There is no evidence that mention of suicide increases motivation for someone to act. It may, indeed, decrease motivation.

5. People who commit suicide leave notes

FACT: < 25% of persons committing suicide actually leave a note.

6. Suicide happens without warning

FACT: Many suicides occur after a great deal of warning or hints which go unacknowledged. Suicidal persons often verbalize and behave differently.

7. Religious people don't kill themselves

FACT: This is simply NOT true. Though most religions consider suicide wrong, religious people are not less likely to commit suicide than non-religious persons.

Myths about Suicide

8. You have to be crazy to kill yourself

FACT: Only about 10% of suicide victims are psychotic.

9. If a person has been very depressed for a time and says there's nothing to live for and then begins to act relaxed and cheerful, one can safely assume that his or her suicidal thoughts have passed

FACT: The individual may have made the decision to commit suicide and now is relaxed before doing the act.

10. Suicidal people really want to kill themselves.

FACT: Most suicidal persons are ambivalent about living and dying. They are hopeless about finding a solution to their problems. They often rely upon another person to rescue them from their intention.