Forty years ago, there was little awareness of the psychological factors associated with unipolar depression. Interest in the psychological factors associated with bipolar disorder is even more recent. However, in recent decades, there has been increasing awareness of the critical role psychological science plays in the understanding and treatment of mood disorders. Psychological innovations have influenced the recognition of mood disorders in both general practice and mental health settings and have led to the development and delivery of effective psychological treatments. There has also been an exciting growth in research, with new psychological treatments being developed and evaluated. Throughout this process, the importance of understanding and addressing the interaction of biological, psychological and social factors in assessing and treating mood disorders has been underscored.

The current chapter on disorders of mood comprises two main sections focusing on unipolar depression and bipolar disorder respectively. Each section will provide a brief overview regarding historical approaches to these disorders, a description of the diagnostic criteria for key mood disorders, information regarding epidemiology and a discussion of current biopsychosocial understandings regarding aetiology and treatment.

Unipolar depression

LO 3.1

HISTORICAL AND CURRENT APPROACHES TO THE CLASSIFICATION OF UNIPOLAR DEPRESSION

There have been many historical references to the existence of a pathologically depressed mood state in both Western and Eastern literature (Jackson, 1986). For example, in ancient Greece, the term 'melancholia' was used to denote a mental condition characterised by fear and depression. Over the centuries, the term melancholia came to encompass broader concepts and was used to refer not only to a state of illness but also to a depressed personality style.

During the late nineteenth century the German psychiatrist Emil Kraepelin (1896) identified 'manic depressive insanity' as one of the major categories of mental illness. Manic depressive insanity encompassed the conditions that are currently categorised as mood disorders. However, there was controversy surrounding Kraepelin's concept as it classified all mood disorders together rather than distinguishing between those individuals who experience depressive episodes alone and those who experience both depressive and manic episodes (currently termed unipolar and bipolar disorders, respectively). A distinction between unipolar depression and bipolar disorder was eventually made by the German psychiatrist Karl Leonhard (1957) and has remained in the current classification system.

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association [APA], 2013) includes a chapter entitled 'Depressive Disorders'. Among these conditions is **major depressive disorder** (commonly referred to as 'major depression'), which is characterised by a continuous period of at least two weeks during which the person feels depressed, sad, empty or hopeless, or has lost interest in nearly all his/her activities (referred to as **anhedonia**). In children the mood can be irritable rather than sad. This period of low mood must represent a change in the person's functioning and be accompanied by at least four of the following symptoms:

- significant weight loss when not dieting or weight gain, or a decrease or increase in appetite nearly every day
- insomnia or hypersomnia nearly every day
- loss of energy or fatigue nearly every day

major depressive disorder Depressive disorder involving one or more major depressive episodes.

anhedonia Inability to experience pleasure for previously pleasurable activities.

specifier An extension to the diagnosis that further clarifies the course, severity or special features of the disorder

anorexia Loss of appetite.

major depressive episode State characterised by at least five depressive symptoms, one of which must be either sad mood or a loss of pleasure/interest in usual activities. Additional depressive symptoms include an increase or decrease in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or severe guilt, difficulty concentrating and suicidal ideation. These symptoms must be present for at least two weeks.

- motor restlessness ('psychomotor agitation') or slowed movements ('psychomotor retardation') nearly every day and observable to others
- diminished concentration or ability to think, or indecisiveness nearly every day
- feelings of worthlessness or excessive or inappropriate guilt nearly every day
- recurrent thoughts of death, recurrent suicidal ideation without a plan or a suicide attempt or a specific plan for committing suicide.

To be considered an episode of major depression, these symptoms also need to cause significant distress and impairment in the person's life—impacting on their social, occupational and other important roles—and not be attributable to the physiological effect of a substance or other medical condition.

The *DSM-5* also attempts to consider the great deal of variability in the clinical presentation of major depressive disorder. It does this by including 'specifiers'. A **specifier** is an extension to the diagnosis that further clarifies the course, severity or special features of the disorder. In the case of major depressive disorder, there are several specifiers that distinguish major depressive disorders in terms of their severity (mild, moderate or severe), the number of episodes (single or recurrent), the degree of recovery between depressive episodes (in partial remission or in full remission) and whether there are accompanying psychotic features. This last specifer is major depressive disorder 'with psychotic features', which refers to an episode of depression as described above in which person experiences delusions and/or hallucinations. In addition, the *DSM-5* allows specification of particular features of the sufferer's depression. These include:

- major depressive disorder with melancholic features, which is characterised by a profound, nearly complete inability to experience pleasure. Mood is usually worse in the mornings and the sufferer may experience early morning awakening, marked psychomotor retardation or agitation, significant **anorexia** (i.e., loss of appetite) or weight loss and excessive guilt
- major depressive disorder with catatonic features, which is characterised by movement disturbance symptoms, such as immobility at one extreme or excessive, purposeless activity at the other extreme
- major depressive disorder with peripartum onset, which refers to episodes that occur during pregnancy or within four weeks after childbirth. While brief episodes of depressed mood (often referred to as 'the baby blues') can occur in up to 70 per cent of women within one to 10 days after childbirth, depression with peripartum onset is a more serious disorder (Cooper & Murray, 1998). The risk of suffering from this form of depression is thought to be greater among those women experiencing psychosocial stressors such as a perceived lack of support from their partner, family and friends, feeding and physical difficulties with the infant, stressful life events, a previous history of depression and complications during pregnancy
- major depressive disorder with seasonal pattern, which is diagnosed when there is a regular relationship between the onset of the sufferer's **major depressive episodes** and a particular time of the year (most often with onset in the autumn or winter months)
- major depressive disorder of mixed features when some symptoms of elevated mood are present alongside depression

DAL

Depressive disorders are characterised by feeling sad, depressed, empty or hopeless and/or a loss of interest in activities.

- major depressive disorder with anxious distress which identifies depression accompanied by significant anxiety such as irrational worry, inability to relax or a sense of impending threat. This specifier recognises the strong comorbidity between depression and anxiety, with about 50 per cent of people with major depressive disorder reporting significant anxiety symptoms (Kessler, Chiu, Demler, & Walters, 2005) as well as accumulating evidence that anxiety and depression are the expression of common biological and psychological dispositions including shared genetic factors (Hettema, Neale, Myers, Prescott, & Kendler, 2006). The presence of anxiety in depression also has important clinical implications as anxiety being comorbid with depression increases the risk of suicide (Boden, Fergusson, & Horwood, 2007) and predicts a longer length of the depressive episode (Parker et al., 1999). These considerations suggest that major depressive disorder often has its roots in difficulties in the expression and regulation of anxiety. The anxiety specifier for depressive disorders will hopefully enable clinicians to identify and treat people before they develop an enduring major depressive disorder or a significant anxiety disorder such as **generalised anxiety disorder (GAD)**.

generalised anxiety disorder (GAD) Anxiety disorder characterised by chronic worry in daily life accompanied by physical symptoms of tension.

The *DSM-5* diagnostic criteria for major depressive disorder no longer exclude those cases when the symptoms are better accounted for by bereavement as in the *DSM-IV-TR* (APA, 2000). In other words, bereaved individuals can now be diagnosed with major depression if they meet the necessary criteria. This change has caused considerable controversy, with some clinicians concerned that it will lead to the inappropriate diagnosis and treatment of bereaved individuals who are distressed yet undergoing an adaptive adjustment process. The *DSM-5* has attempted to minimise the chances of inappropriately diagnosing bereaved individuals with a mental disorder by listing some distinctions between non-pathological grief and major depression (e.g., a preoccupation with thoughts about the deceased in the former versus self-critical thoughts in the latter).

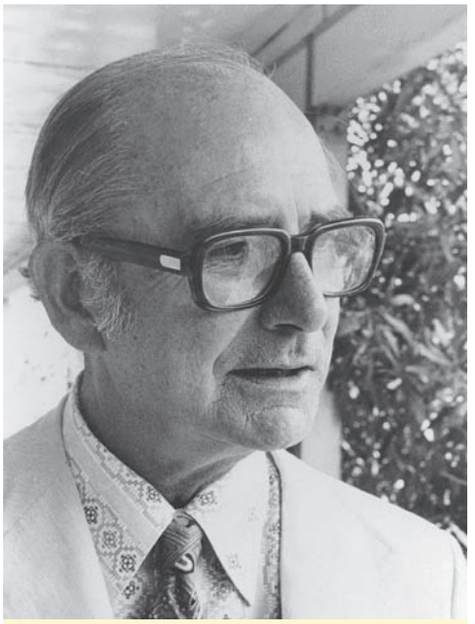
Two other important changes introduced with the *DSM-5* are noteworthy. First, **dysthymic disorder** has been renamed as 'persistent depressive disorder'. This change in terminology more clearly describes a depressive disorder where the mood disturbance and at least two other adjunct symptoms (e.g., insomnia, poor self-esteem and low energy) last for at least two years without a notable remission of symptoms. The second noteworthy change is the addition of a disorder of mood disturbance characterised by severe temper outbursts and persistent irritability and anger, that is, **disruptive mood dysregulation disorder**. This is predominantly a disorder observed in children with severe recurrent problems with anger, irritability and temper outbursts, which are severely out of proportion to the situation and developmentally inappropriate. This symptom profile is highly prevalent in the United States but has been generally viewed sceptically in Europe and Australasia. Another potential problem is that, given that there are a number of other diagnoses in the *DSM-5* where behavioural and emotional dysregulation are core features (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder with hyperactivity, impulse control disorders and even other mood disorders such as bipolar disorder), reliably distinguishing disruptive mood dysregulation disorder from these conditions could prove challenging.

dysthymia (dysthymic disorder) Depressive disorder that is less severe than major depression but more chronic.

disruptive mood dysregulation disorder A depressive disorder characterised by severe and persistent irritability as evident in temper outbursts that are extremely out of proportion to the situation.

Although the *DSM-5* tries to deal with the heterogeneity of major depressive disorders, the classification system can be critiqued for ignoring potential distinctions based on different causal factors potentially involved in different types of depression. An Australian research team has argued for an alternative subtyping model for the depressive disorders using possible aetiologies as well as symptom features (Parker, 2000; Parker et al., 2010; Parker & Hadzi-Pavlovic, 1996). This model suggests three broad classes of depressive disorders: psychotic, melancholic and non-melancholic. In terms of aetiology, both psychotic and melancholic depression are theorised to be primarily biologically based, while non-melancholic disorders are thought to be driven by life-event stressors and psychological factors. In terms of symptoms, melancholic depression is characterised by the presence of significant psychomotor disturbance, while psychotic depression is characterised by both psychomotor disturbance and psychotic features. In combining information about symptoms and causal factors in the subtyping of depression, the model aims to provide greater direction regarding the most

serendipitous yet remarkable discovery of lithium in an old wooden building on the grounds of the Repatriation Mental Hospital, Bundoora, Victoria (Mitchell & Hadzi-Pavlovic, 1999). He believed that urea (a protein breakdown product in urine) was a causal factor in what he referred to as 'manic depressive insanity'. While trying to overcome a technical difficulty in experiments on guinea pigs, he began using lithium urate (being the most soluble of the urates) to alter the toxicity of urea. Cade witnessed, unexpectedly, that the lithium itself was acting as a protective agent against the toxicity of urea. He deduced that lithium alone may have a therapeutic effect in mania, and further experiments found this to be true. Therein lies one of the most profound discoveries in modern medicine. After conducting the trials on guinea pigs and then on himself and finding no adverse effects, Cade administered the lithium (in an uncontrolled trial) to 10 patients with mania, six with schizophrenia and three with depression. In contrast to the minimal benefits experienced by the patients with the other conditions, the effect on the patients with mania was dramatic. A number of other Australian researchers extended Cade's research, leading to some pivotal clinical studies on bipolar disorder in the 1950s (Cade, 1979). In honouring the significant contribution made by Cade in the treatment of mania, some researchers have proposed that bipolar I disorder (defined below) be known as 'Cade's Disease' (Ghaemi, Ko, & Goodwin, 2002).



COURTESY THE FAMILY OF PROFESSOR JOHN CADE

John Cade, the Australian psychiatrist who discovered the beneficial effects of lithium, which was to transform the treatment of individuals with bipolar disorder.

The following four decades were marked by a growth in genetic studies that revealed the high heritability of bipolar disorder. In addition, new classes of mood stabiliser and antidepressant medications began to emerge. More recently, there has been exponential interest in studies exploring diagnostic models and the neurobiological and psychological factors underpinning the condition.

THE DIAGNOSIS OF BIPOLAR DISORDERS

The *DSM-5* (APA, 2013) includes a chapter entitled 'Bipolar and Related Disorders' in recognition of the fact that the term 'bipolar disorder' actually embraces a spectrum of disorders, primarily consisting of bipolar I disorder, bipolar II disorder and cyclothymic disorder. What unites these conditions is the fact that affected individuals experience symptoms of pathologically elevated mood termed 'mania' or 'hypomania'.

MANIC, HYPOMANIC AND MIXED EPISODES

A **manic episode** as defined by the DSM-5 requires that a person show an elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy (this latter criterion being an addition to the criteria listed in the *DSM-IV-TR*) (APA, 2000; 2013). The individual must experience these abnormalities in mood and goal-directed activity for at least one week, plus at least three of the following symptoms:

- inflated self-esteem
- **grandiosity**—that is, a sense that anything is possible e.g. a belief that one can fly or that one can read the thoughts of other people
- sleep disturbance—that is, a decreased need for sleep accompanied by a belief that there is too much to achieve to spend time sleeping

manic episode
State of persistently elevated or irritable mood and abnormally increased goal-directed activity accompanied by symptoms such as inflated self-esteem, decreased need for sleep, racing thoughts, pressured speech and impulsive, self-destructive behaviours.

grandiosity
Inflated belief about one's worth, power, knowledge, ability or identity; when extreme, may constitute a grandiose delusion.

- pressure of speech, in which the individual is more talkative than usual or experiences a sense of pressure to keep talking
- flight of ideas, in which the individual's thoughts race from one idea to another
- distractibility—that is, difficulty focusing on one thing and ignoring irrelevant stimuli
- heightened activity, in which the individual is restless and overly zealous in pursuing goals
- risk taking, whereby the individual becomes excessively involved in potentially dangerous activities (such as embarking on unsound business ventures, driving dangerously or engaging in risky sexual practices).

These behaviours, thoughts and emotions are only regarded as symptoms of mania if they are out of character for the individual.

Hypomania basically has the same symptom profile as mania with the key distinction being that in hypomania the symptoms are not severe enough to markedly interfere with daily functioning, do not necessitate hospitalisation, and do not involve hallucinations or delusions. Also, the disturbance is of shorter duration, with the *DSM-5* criteria for hypomania specifying a period of persistently elevated, expansive or irritable mood that is clearly different from the individual's usual non-depressed mood, lasting for at least four days.

THE BIPOLAR DISORDERS

As shown in Table 3.2, the various bipolar disorders are characterised in terms of the distinct patterning of manic, hypomanic and major depressive episodes that the individual experiences. According to the *DSM-5*, **bipolar I disorder** is defined by the presence of one or more manic episodes. The individual has also usually experienced major depressive episodes but they are not necessary for the diagnosis. In contrast, the individual must have experienced at least one episode of major depression to be diagnosed with **bipolar II disorder** as well as at least one period of hypomania. Also in contrast to bipolar I disorder, manic episodes are not a feature of bipolar II disorder. Dunner and Fieve (1974) were the first to distinguish between bipolar I and II disorders, although there is ongoing debate as to whether these represent distinctive forms of the condition or simply differences in severity.

bipolar I disorder Form of bipolar disorder characterised by manic episodes; major depressive episodes often occur but are not necessary for the diagnosis.

bipolar II disorder Form of bipolar disorder characterised by hypomanic and major depressive episodes.

TABLE 3.2 The *DSM-5* (APA, 2013) diagnoses of bipolar I and bipolar II disorders according to the constellation of major depressive, manic and hypomanic episodes

MOOD EPISODE	BIPOLAR I	BIPOLAR II
Major depressive episode	Can be present but not necessary for a diagnosis	Present
Manic episode	Present	Not present
Hypomanic episode	Can be present but not necessary for a diagnosis	Present

About 90 per cent of individuals with bipolar disorder experience multiple episodes of mood disturbance during their lifetime (Mitchell, Hadzi-Pavlovic, & Loo, 2011). The period of mood disturbance is variable for the individual but generally occurs over weeks or months rather than a matter of days. Over time, the episodes may become more frequent and closer together. The subtype of **rapid cycling bipolar disorder** is diagnosed in those individuals who experience four or more bipolar episodes (mania or depression) within a year. This definition includes those who recover between episodes and those who switch continually from one polarity to the other.

rapid cycling bipolar disorder Diagnosis given when an individual has four or more bipolar episodes (mania or depression) within a single year.