

Mood Disorders: Assessment and Treatment

By Lance J Parks, LCSW

Study helps: When you scroll over the yellow sticky notes you will receive study helps.

Some of the information found in this program is used by permission from the Centre for Clinical Interventions (CCI, 2019). CCI provides extensive research and resources for clinicians and patients; however, they do provide the disclaimer that the information provided is for informational purposes only.

<https://www.cci.health.wa.gov.au/>

Chapter I: What is a Mood Disorder?

This chapter clarifies some common misconceptions about mood disorders and examines the background for the history of the topic along with a discussion on the two distinguished types of mood disorders.

Topics Covered

- a. The simple definitions
- b. A historical background to mood disorders
- c. The branches of depression and bipolar disorders

d. The Causes and Treatments for Mood Disorders

Mood Disorders: Definition and Histories

In common terms, a person's mood is defined as the emotional state and the visible characteristics exhibited by a person in a particular mood. (NIMH, 2019)

In everyday language, the usage of terms like good or bad mood is an effective description of a person's feelings and current state of mind. It is likely that someone would say that "she is in a good mood" or that "she is in a bad mood," and the people around that person would understand the emotional state of the speaker.

The clinical meaning of the term mood is not much different as per the definition which considers mood to be an observable state of a person. In medical terms, moods can be influenced by several different things and it is considered normal behavior to be in a good or bad mood. When the elevated or depressed moods interfere with everyday functioning and relationships, then he/she may be suffering from a mood disorder (NIMH, 2019).

A mood disorder can also be understood as a mental illness which causes the emotions of a person to be out of sync with the situation he/she is placed in.

Mood disorders have two major branches which are commonly observed in clinics and social support situations. The first is depression, and the second is bipolar disorder. Both of these have several subtypes and associated qualifiers

which help medical practitioners in understanding the exact nature of the ailment and to prescribe the proper treatment (NIMH, 2019). As shown by history, a full understanding of these ailments came only after extensive trial and error.

The history of treatment for those suffering from a mental illness, or a mood disorder, is quite often a history of horror and misery. It must be remembered that this judgment comes from the science which we have access to today. Historically, treatments were being conducted by the brightest and most scientific minds. The public accepted the conduct of the doctors as useful for the patients. One treatment which stands out is the use of the medical procedure called Leukotomy, which is popularly known as a “lobotomy.”

Demonic possession and witchcraft were often blamed for the symptoms of depression, bipolar disorder, schizophrenic disorders and several other mental problems which plagued individuals. As late as the eighteenth century, mental disorders were considered to be the result of unnatural acts performed with the help of the devil. The inquisition and other courts often burned mentally ill people at the stake so as to save their souls by killing their mortal bodies. Such treatment was considered merciful and was carried out throughout the western world. (Garcia, 1975). It was in 1938 that Egas Moniz, a Portuguese physician, developed the operation known as a Leukotomy to deal with mood disorders (Garcia, 1975).

This surgical procedure caused the nerves to the frontal lobes of the brain to be cut off. It met with resounding success since it often made aggressive mental patients extremely docile and helped calm several individuals who suffered from regular bouts of anxiety. When this process was examined in light of modern discoveries, it was found that there could be no lasting benefits and the side effects were a destroyed mind and some patients left in a vegetative state. It is interesting to note that Egas Moniz was awarded the Nobel Prize in medicine for his discovery (The Nobel Foundation, 2005).

In the present day, the American Psychiatric Association publishes a Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) which recognizes four mood disorders listed as:

- Major Depressive Disorder
- Bipolar Disorder I and II
- Cyclothymic Disorder
- Dysthymic Disorder

Cyclothymic and Dysthymic Disorders are more chronic types of disorders whose symptoms are less acute than those of Bipolar or Major Depressive Disorders.

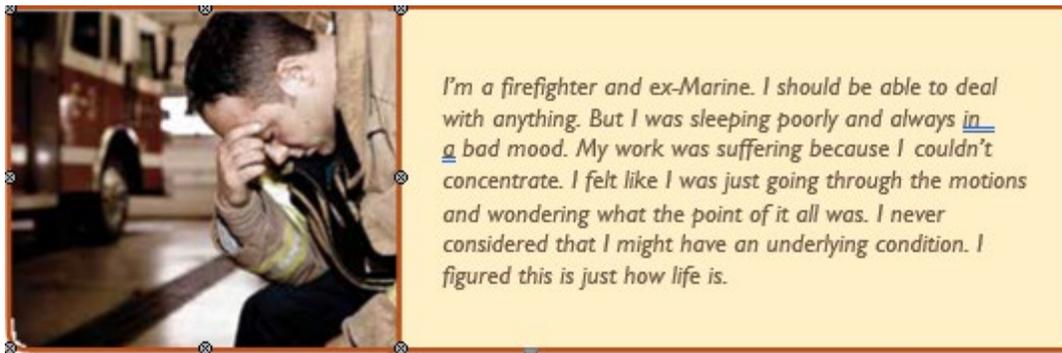
(APA, 2019) Because the symptoms are less acute it is sometimes difficult to determine whether a person is suffering from a cyclothymic or dysthymic disorder. Often, it requires a highly trained expert in the field of mood disorders to diagnose the exact type of disorder; therefore, differential diagnosis is usually based on whether a person has a Bipolar Disorder or Depressive Disorder.

Chapter 2: Depression and Depressive Disorders

Depression: What You Need to Know

The following is from the following source.

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015). Depression (NIH Publication No. 15-3561). Bethesda, MD: U.S. Government Printing Office.



National Institute of Mental Health

1. Depression is a real illness.

Sadness is something we all experience. It is a normal reaction to difficult times in life and usually passes with a little time.

When a person has depression, it interferes with daily life and normal functioning. It can cause pain for both the person with depression and those who care about him or her. Doctors call this condition “depressive disorder,” or

“clinical depression.” It is a real illness. It is not a sign of a person’s weakness or a character flaw. You can’t “snap out of” clinical depression. Most people who experience depression need treatment to get better.

Signs and Symptoms

Sadness is only a small part of depression. Some people with depression may not feel sadness at all. Depression has many other symptoms, including physical ones. If you have been experiencing any of the following signs and symptoms for at least 2 weeks, you may be suffering from depression:

- **Persistent sad, anxious, or “empty” mood**
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy, fatigue, being “slowed down”
- Difficulty concentrating, remembering, making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms

Factors That Play a Role in Depression



Many factors may play a role in depression, including genetics, brain biology and chemistry, and life events such as trauma, loss of a loved one, a difficult relationship, an early childhood experience, or any stressful situation.

Depression can happen at any age, but often begins in the teens or early 20s or 30s.

Most chronic mood and anxiety disorders in adults begin as high levels of anxiety in children. In fact, high levels of anxiety as a child could mean a higher risk of depression as an adult.

Depression can co-occur with other serious medical illnesses such as diabetes, cancer, heart disease, and Parkinson's disease. Depression can make these conditions worse and vice versa. Sometimes medications taken for these illnesses may cause side effects that contribute to depression. A doctor experienced in treating these complicated illnesses can help work out the best treatment strategy.

Research on depression is ongoing, and one day these discoveries may lead to better diagnosis and treatment. To learn more about current research, visit the NIMH website at www.nimh.nih.gov.

Types of Depression

There are several types of depressive disorders.

Major depression: Severe symptoms that interfere with the ability to work, sleep, study, eat, and enjoy life. An episode can occur only once in a person's lifetime, but more often, a person has several episodes.

Persistent depressive disorder: A depressed mood that lasts for at least 2 years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for 2 years.

Some forms of depression are slightly different, or they may develop under unique circumstances. They include:

Psychotic depression, which occurs when a person has severe depression plus some form of psychosis, such as having disturbing false beliefs or a break with reality (delusions), or hearing or seeing upsetting things that others cannot hear or see (hallucinations).

Postpartum depression, which is much more serious than the "baby blues" that many women experience after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.

Seasonal affective disorder (SAD), which is characterized by the onset of depression during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively

treated with light therapy, but nearly half of those with SAD do not get better with light therapy alone.

Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.

Bipolar disorder is different from depression. The reason it is included in this list is because someone with bipolar disorder experiences episodes of extreme low moods (depression). But a person with bipolar disorder also experiences extreme high moods (called “mania”).

You can learn more about many of these disorders on the NIMH website at www.nimh.nih.gov.

2. Depression affects people in different ways.

Not everyone who is depressed experiences every symptom. Some people experience only a few symptoms. Some people have many. The severity and frequency of symptoms, and how long they last, will vary depending on the individual and his or her particular illness. Symptoms may also vary depending on the stage of the illness.



My friends keep asking what's wrong with me. I have a great job and a wonderful family. But nothing seems fun anymore. I'm tired all the time. I'm trying to force myself to be interested in my kid's activities, but I'm just not anymore. I feel lonely, sad, and don't have the energy to get things done. I feel like I'm being a bad mom.

Women

Women with depression do not all experience the same symptoms. However, women with depression typically have symptoms of sadness, worthlessness, and guilt.

Depression is more common among women than among men. Biological, lifecycle, hormonal, and psychosocial factors that are unique to women may be linked to their higher depression rate.

For example, women are especially vulnerable to developing postpartum depression after giving birth, when hormonal and physical changes and the new responsibility of caring for a newborn can be overwhelming.

Men

Men often experience depression differently than women. While women with depression are more likely to have feelings of sadness, worthlessness, and excessive guilt, men are more likely to be very tired, irritable, lose interest in once-pleasurable activities, and have difficulty sleeping.



I'd drink and I'd drink just to get numb. I'd get numb to try to numb my head. You're talking many, many beers to get to that state when you can shut your head off. But then you wake up the next day, and it's still there. You have to deal with it. It doesn't just go away.

Men may turn to alcohol or drugs when they are depressed. They also may become frustrated, discouraged, irritable, angry, and sometimes abusive. Some men may throw themselves into their work to avoid talking about their depression with family or friends, or behave recklessly. And although more women attempt suicide, many more men die by suicide in the United States.

Children

Before puberty, girls and boys are equally likely to develop depression. A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Because normal behaviors vary from one childhood stage



My son Timothy used to be an outgoing 9-year-old who loved school. Now he frequently complains of stomachaches and refuses to go to school. He yells at his younger sister a lot. He quit the soccer team and instead has stayed in his room playing video games.

to another, it can be difficult to tell whether a child is just going through a temporary “phase” or is suffering from depression. Sometimes the parents become worried about how the child’s behavior has changed, or a teacher mentions that “your child doesn’t seem to be himself.” In such a case, if a visit to the child’s pediatrician rules out physical symptoms, the doctor will probably suggest that

the child be evaluated, preferably by a mental health professional who specializes in the treatment of children. Most chronic mood disorders, such as depression, begin as high levels of anxiety in children.

Teens

The teen years can be tough. Teens are forming an identity apart from their parents, grappling with gender issues and emerging sexuality, and making independent decisions for the first time in their lives. Occasional bad moods are to be expected, but depression is different.



I was constantly bullied, my heart was in the midst of being broken, and my grades were falling. The pain I suffered day after day, night after night was unbearable. I felt as if I was drowning. I hated myself. My mom was worried and took me to the doctor. My doctor diagnosed me with depression at the end of my junior year in high school. I needed help.

Older children and teens with depression may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. If you're unsure if an adolescent in your life is depressed or just "being a teenager," consider how long the symptoms have been present, how severe they are, and how different the teen is acting from his or her usual self. Teens with depression may also have other disorders such as anxiety, eating disorders, or substance abuse. They may also be at higher risk for suicide.

Children and teenagers usually rely on parents, teachers, or other caregivers to recognize their suffering and get them the treatment they need. Many teens don't know where to go for mental health treatment or believe that treatment won't help. Others don't get help because they think depression symptoms may be just part of the typical stress of school or being a teen. Some teens worry what other people will think if they seek mental health care.

QUICK TIPS FOR TALKING TO YOUR DEPRESSED CHILD OR TEEN:

- **Offer emotional support**, understanding, patience, and encouragement.
- **Talk to your child**, not necessarily about depression, and listen carefully.
- **Never discount the feelings your child expresses, but** point out realities and offer hope.
- **Never ignore comments about suicide.**
- **Remind your child that with time and treatment**, the depression will lift.

Depression often persists, recurs, and continues into adulthood, especially if left untreated. If you suspect a child or teenager in your life is suffering from depression, speak up right away.



My mother is 68 years old, and I've noticed some changes. She isn't interested in her favorite foods anymore. She has trouble sleeping at night and snaps at the grandchildren more than usual. She used to be pretty outgoing, but now she keeps to herself a lot.

Older People

Having depression for a long period of time is not a normal part of growing older. Most older adults feel satisfied with their lives, despite having more illnesses or physical problems. But depression in older adults may be difficult to recognize because they may show different, less obvious symptoms.

Sometimes older people who are depressed appear to feel tired, have trouble sleeping, or seem grumpy and irritable. Confusion or attention problems caused

by depression can sometimes look like Alzheimer's disease or other brain disorders. Older adults also may have more medical conditions such as heart disease, stroke, or cancer, which may cause depressive symptoms. Or they may be taking medications with side effects that contribute to depression.

Some older adults may experience what doctors call vascular depression, also called arteriosclerotic depression or subcortical ischemic depression. Vascular depression may result when blood vessels become less flexible and harden over time, becoming constricted. The hardening of vessels prevents normal blood flow to the body's organs, including the brain. Those with vascular depression may have or be at risk for heart disease or stroke.

Sometimes it can be difficult to distinguish grief from major depression. Grief after loss of a loved one is a normal reaction and generally does not require professional mental health treatment. However, grief that is complicated and lasts for a very long time following a loss may require treatment.

Older adults who had depression when they were younger are more at risk for developing depression in late life than those who did not have the illness earlier in life.

3. Depression is treatable.

Depression, even the most severe cases, can be treated. The earlier treatment begins, the more effective it is. Most adults see an improvement in their

symptoms when treated with antidepressant drugs, talk therapy (psychotherapy), or a combination of both.



If you think you may have depression, start by making an appointment to see your doctor or health care provider. This could be your primary doctor or a health provider who specializes in diagnosing and treating mental health conditions (psychologist or psychiatrist). Certain medications, and some medical conditions, such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities by doing a physical exam, interview, and lab tests. If the doctor can find no medical condition that may be causing the depression, the next step is a psychological evaluation.

Talking to Your Doctor

How well you and your doctor talk to each other is one of the most important parts of getting good health care. But talking to your doctor isn't always easy. It takes time and effort on your part as well as your doctor's.

To prepare for your appointment, make a list of:

- Any symptoms you've had, including any that may seem unrelated to the reason for your appointment
 - ▶ When did your symptoms start?
 - ▶ How severe are your symptoms?

- ▶ Have the symptoms occurred before?
- ▶ If the symptoms have occurred before, how were they treated?
- Key personal information, including any major stresses or recent life changes
- All medications, vitamins, or other supplements that you're taking, including how much and how often
- Questions to ask your health provider

If you don't have a primary doctor or are not at ease with the one you currently see, now may be the time to find a new doctor. Whether you just moved to a new city, changed insurance providers, or had a bad experience with your doctor or medical staff, it is worthwhile to spend time finding a doctor you can trust.

Tests and Diagnosis

Your doctor or health care provider will examine you and talk to you at the



appointment. Your doctor may do a physical exam and ask questions about your health and symptoms.

There are no lab tests that can specifically diagnose depression, but your doctor may also order some lab tests to rule out other conditions.

Ask questions if the doctor's explanations or instructions are unclear, bring up problems even if the doctor doesn't ask, and let the doctor know if you have concerns about a particular treatment or change in your daily life.

Your doctor may refer you to a mental health professional, such as a psychiatrist, psychologist, social worker, or mental health counselor, who should discuss with you any family history of depression or other mental disorder, and get a complete history of your symptoms. The mental health professional may also ask if you are using alcohol or drugs, and if you are thinking about death or suicide. If your doctor does not refer you to a mental health professional or you feel your concerns were not adequately addressed, call or visit the website for your health insurance provider, Medicare (www.medicare.gov/), or Medicaid (<http://medicaid.gov/>). You can also try searching in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Behavioral Health Treatment Services Locator (<https://findtreatment.samhsa.gov/>) or one of the other resources listed at the end of this booklet to find one.

NEED HELP NOW?

Call the 24-hour, toll-free confidential National Suicide Prevention Lifeline at **1-800-273-TALK (8255)** or go to www.suicidepreventionlifeline.org.

Treatment

Depression is treated with medicines, talk therapy (where a person talks with a trained professional about his or her thoughts and feelings; sometimes called "psychotherapy"), or a combination of the two. Remember: No

two people are affected the same way by depression. There is no “one-size-fits-all” for treatment. It may take some trial and error to find the treatment that works best for you.



Medications

QUICK TIP: MEDICATIONS

Because information about medications is always changing, the following section may not list all the types of medications available to treat depression. Check the Food and Drug Administration (FDA) website (www.fda.gov) for the latest news and information on warnings, patient medication guides, or newly approved medications.

Antidepressants are medicines that treat depression. They may help improve the way your brain uses certain chemicals that control mood or stress.

There are several types of antidepressants:

- Selective serotonin reuptake inhibitors (SSRI)
- Serotonin and norepinephrine reuptake inhibitors (SNRI)
- Tricyclic antidepressants (TCA)
- Monoamine oxidase inhibitors (MAOI)

There are other antidepressants that don't fall into any of these categories and are considered unique, such as Mirtazapine and Bupropion.

Although all antidepressants can cause side effects, some are more likely to cause certain side effects than others. You may need to try several different antidepressant medicines before finding the one that improves your symptoms and has side effects that you can manage.

Most antidepressants are generally safe, but the U.S. Food and Drug Administration (FDA) requires that all antidepressants carry black box warnings, the strictest warnings for prescriptions. In some cases, children, teenagers, and young adults under age 25 may experience an increase in suicidal thoughts or behavior when taking antidepressants, especially in the first few weeks after starting or when the dose is changed. The warning also says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment.

Common side effects listed by the FDA for antidepressants are:

- Nausea and vomiting
- Weight gain
- Diarrhea
- Sleepiness
- Sexual problems

Other more serious but much less common side effects listed by the FDA for antidepressant medicines can include seizures, heart problems, and an imbalance of salt in your blood, liver damage, suicidal thoughts, or serotonin

syndrome (a life-threatening reaction where your body makes too much serotonin). Serotonin syndrome can cause shivering, diarrhea, fever, seizures, and stiff or rigid muscles.



Your doctor may have you see a talk therapist in addition to taking medicine. Ask your doctor about the benefits and risks of adding talk therapy to your treatment. Sometimes talk therapy alone may be the best treatment for you.

How Should Antidepressants Be Taken?

People taking antidepressants need to follow their doctor's directions. The medication should be taken in the right dose for the right amount of time. It can take 3 or 4 weeks until the medicine takes effect. Some people take the medications for a short time, and some people take them for much longer periods. People with long-term or severe depression may need to take medication for a long time.

Once a person is taking antidepressants, it is important not to stop taking them without the help of a doctor. Sometimes people taking antidepressants feel better and stop taking the medication too soon, and the depression may return. When it is time to stop the medication, the doctor will help the person slowly and safely decrease the dose. It's important to give the body time to adjust to the change. People don't get addicted, or "hooked," on the medications, but stopping them abruptly can cause withdrawal symptoms. If a medication does not work, it may be helpful to be open to trying another one.

FDA WARNING ON ANTIDEPRESSANTS

Antidepressants are generally considered safe, but some studies have suggested that they may have unintentional effects, especially in young people. The FDA adopted a "black box" warning label—the most serious type of warning—on all antidepressant medications. The warning says there is an increased risk of suicidal thinking or suicide attempts in children, adolescents, and young adults up through age 24.

The warning also says that patients of all ages taking antidepressants should be watched closely, especially during the first few weeks of treatment. Possible side effects to look for are depression that gets worse, suicidal thinking or behavior, or any unusual changes in behavior such as trouble sleeping, agitation, or withdrawal from normal social situations. Families and caregivers should report any changes to the doctor.

Finally, the FDA has warned that combining the newer SSRI or SNRI antidepressants with one of the commonly used “triptan” medications used to treat migraine headaches could cause a life-threatening illness called “serotonin syndrome.” A person with serotonin syndrome may be agitated, have hallucinations (see or hear things that are not real), have a high temperature, or have unusual blood pressure changes.

Serotonin syndrome is usually associated with the older antidepressants called MAOIs, but it can happen with the newer antidepressants as well, if they are mixed with the wrong medications.

The benefits of antidepressant medications may outweigh their risks to children and adolescents with depression. To find the latest information, talk to your doctor and visit www.fda.gov.



Are Herbal Medicines Used to Treat Depression?

You may have heard about an herbal medicine called St. John's wort. St. John's wort is an herb. Its flowers and leaves are used to make medicine. It is one of the top-selling botanical products in the United States. But St. John's wort is not a proven therapy for depression. The FDA has not approved its use as an over-the-counter or prescription medicine for depression, and there are serious concerns about its safety and effectiveness.

Taking St. John's wort can weaken many prescription medicines, such as:

- Antidepressants
- Birth control pills
- Cyclosporine, which prevents the body from rejecting transplanted organs
- Digoxin, a heart medication
- Some HIV drugs

- Some cancer medications
- Medications used to thin the blood

QUICK TIP: IF YOU ARE CONSIDERING ST. JOHN'S WORT FOR DEPRESSION

- Do not use St. John's wort to replace conventional care or to postpone seeing a health care provider. If not adequately treated, depression can become severe.
- Keep in mind that dietary supplements can cause medical problems if not used correctly or if used in large amounts, and some may interact with medications you take. Your health care provider can advise you.
- Many dietary supplements have not been tested in pregnant women, nursing mothers, or children. Little safety information on St. John's wort for pregnant women or children is available, so it is especially important to talk with health experts if you are pregnant or nursing or are considering giving a dietary supplement to a child.
- Tell all your health care providers about any complementary health approaches you use. Give them a full picture of what you do to manage your health.

For more information, please visit the website for the National Center for Complementary and Integrative Health at <https://nccih.nih.gov/>.

For more information on medications for depression, please visit the FDA website at www.fda.gov. You can also find information on drugs, supplements, and herbal information on the National Library of Medicine's Medline Plus website (www.nlm.nih.gov/medlineplus/druginformation.html).



Talk Therapy (“Psychotherapy”)

Several types of psychotherapy—or “talk therapy”—can help people with depression.

There are several types of psychotherapies that may be effective in treating depression. Examples include cognitive-behavioral therapy, interpersonal therapy, and problem-solving therapy.

COGNITIVE-BEHAVIORAL THERAPY (CBT)

CBT can help an individual with depression change negative thinking. It can help you interpret your environment and interactions in a positive, realistic way. It may also help you recognize things that may be contributing to the depression and help you change behaviors that may be making the depression worse.

INTERPERSONAL THERAPY (IPT)

IPT is designed to help an individual understand and work through troubled relationships that may cause the depression or make it worse. When a behavior is causing problems, IPT may help you change the behavior. In IPT, you explore major issues that may add to your depression, such as grief, or times of upheaval or transition.

PROBLEM-SOLVING THERAPY (PST)

PST can improve an individual's ability to cope with stressful life experiences. It is an effective treatment option, particularly for older adults with depression. Using a step-by-step process, you identify problems and come up with realistic solutions. It is a short-term therapy and may be conducted in an individual or group format.

For mild to moderate depression, psychotherapy may be the best option. However, for severe depression or for certain people, psychotherapy may not be enough. For teens, a combination of medication and psychotherapy may be the most effective approach to treating major depression and reducing the chances of it coming back. Another study looking at depression treatment among older adults found that people who responded to initial treatment of medication and IPT were less likely to have recurring depression if they continued their combination treatment for at least 2 years.

More information on psychotherapy is available on the NIMH website at www.nimh.nih.gov/health/topics/psychotherapies/index.shtml.

Computer and/or Internet-Based Therapies



Your therapist could be only a mouse click or email away. There are many therapy programs available online or on the computer (e.g., DVDs, CDs), and some research shows that Internet-based therapies may be just as helpful as face-to-face. But results can vary from program to program and each program is different.

Many of these therapies are based on the two main types of psychotherapies—CBT and IPT. But they may be in different formats.

For example, you might learn from materials online and get support from your therapist by email. It could be a video conferencing session that progresses much like a face-to-face session. Or you may use a computer program with video, quizzes, and other features with very little contact with a therapist.

Sometimes these therapies are used along with face-to-face sessions.

Sometimes they are not.

There are pros to receiving therapy on the Internet or on the computer. These options could provide more access to care if you live in a rural area where providers aren't available or if you have trouble fitting sessions into your

schedule. Also, tech-savvy teens who feel uncomfortable with office visits may be more open to talking to a therapist through a computer screen.

There are also cons. For example, your health insurance may only cover therapy that is face-to-face. And although these various formats may work for a range of patients, they also may not be right for certain patients depending on a variety of factors.

If you are interested in exploring Internet or computer-based therapy, talk to your doctor or mental health provider. You may also be able to find an online mental health care provider on your own. But remember that there are many online “therapists” who may lack the proper training or who may try to take advantage of you. Speak with your provider first to see if he or she can provide a recommendation or trusted source for more information. You can also check the online provider’s credentials and ask about his or her treatment approach.

Sometimes you may need to have a conversation with more than one provider to find the right one for you. If cost is an issue, be sure to also contact your health insurance provider to see what’s covered and what’s not.



Depression: Is There an APP for That?

If you have a smartphone, tablet, or “phablet” (phone tablets), you may have noticed that there are many mobile applications, or apps, marketed as support for people with depression. Some of these apps aim to provide treatment and education. Other apps offer tools to help you assess yourself, manage your symptoms, and explore resources.

With a few taps on the screen, you could have information and tools to help your depression in the palm of your hand. **But, just like with online health information, it is important to find an app that you can trust.**

Here are a few things that are important to remember about mobile apps for depression:

- Some apps provide reliable, science-based health information and tools.
Some do not.

- Some app developers consult doctors, researchers, and other experts to develop their app. Others do not.
- A mobile app should not replace seeing your doctor or other health care provider.
- Talk to your doctor before making any changes recommended by any online or mobile source.

QUICK TIP: QUESTIONS TO ASK BEFORE USING A MOBILE HEALTH APP:

- Who developed the app? Is that information easy to find?
- Who wrote and/or reviews the information?
- Is your privacy protected? Does the app clearly state a privacy policy?
- Does the website offer quick and easy solutions to your health problems? Are miracle cures promised?

DOES THE FDA REGULATE MOBILE APPS?

Many mobile apps for depression provide information or general patient educational tools. Because these are not considered medical devices, the FDA does not regulate them.

Some mobile apps carry minimal risks to consumers or patients, but others can carry significant risks if they do not operate correctly. The FDA is focusing its oversight on mobile medical apps that:

- Are intended to be used as an accessory to a regulated medical device—for example, an app that allows a health care professional to make a specific diagnosis by viewing a medical image from a picture archiving and communication system on a smartphone or a mobile tablet.
- Transform a mobile platform into a regulated medical device—for example, an app that turns a smartphone into an electrocardiograph (ECG) machine to detect abnormal heart rhythms or determine if a patient is experiencing a heart attack.

DOES NIMH HAVE AN APP FOR DEPRESSION?

NIMH does not currently offer any mobile apps, but NIMH's website, www.nimh.nih.gov, is mobile-friendly. This means you can access the NIMH website anywhere, anytime, and on any device—from desktop computers to tablets and mobile phones.

If you see an app that claims to be created or reviewed by NIMH, please call the NIMH Information Resource Center to verify that it was developed or reviewed by us.

NIMH INFORMATION RESOURCE CENTER

Telephone:

- 1-866-615-6464 (toll-free)
- 1-301-443-8431 (TTY)
- 1-866-415-8051 (TTY toll-free)

Available in English and Spanish

Monday through Friday

8:30 a.m. to 5:00 p.m. Eastern Time

Electroconvulsive Therapy and Other Brain Stimulation Therapies

If medications do not reduce the symptoms of depression, electroconvulsive therapy (ECT) may be an option to explore. There are a lot of outdated beliefs about ECT, but here are the facts:

- **ECT can provide relief for people with severe depression who have not been able to feel better with other treatments.**
- ECT can be an effective treatment for depression.
- ECT may cause some side effects, including confusion, disorientation, and memory loss. Usually these side effects are short term, but sometimes they can

linger. Talk to your doctor and make sure you understand the potential benefits and risks of the treatment.

Some people believe that ECT is painful or that you can feel the electrical impulses. This is not true. Before ECT begins, a patient is put under brief anesthesia and given a muscle relaxant. He or she sleeps through the treatment and does not consciously feel the electrical impulses.

Within 1 hour after the treatment session, which takes only a few minutes, the patient is awake and alert.

Other more recently introduced types of brain stimulation therapies used to treat severe depression include repetitive transcranial magnetic stimulation (rTMS) and vagus nerve stimulation (VNS). In 2008, the FDA approved rTMS as a treatment for major depression for patients who have not responded to at least one antidepressant medication. In 2005, the FDA approved VNS for use in treating depression in certain circumstances—if the illness has lasted 2 years or more, if it is severe or recurrent, and if the depression has not eased after trying at least four other treatments. VNS is less commonly used, and more research is needed to test its effectiveness.

Beyond Treatment: Things You Can Do

If you have depression, you may feel exhausted, helpless, and hopeless. It may be extremely difficult to take any action to help yourself. But as you begin to

recognize your depression and begin treatment, you will start to feel better. Here are other tips that may help you or a loved one during treatment:

- Try to be active and exercise. Go to a movie, a ballgame, or another event or activity that you once enjoyed.
- Set realistic goals for yourself.
- Break up large tasks into small ones, set some priorities, and do what you can as you can.
- Try to spend time with other people and confide in a trusted friend or relative. Try not to isolate yourself and let others help you.
- Expect your mood to improve gradually, not immediately. Do not expect to suddenly “snap out of” your depression. Often during treatment for depression, sleep and appetite will begin to improve before your depressed mood lifts.
- Postpone important decisions, such as getting married or divorced or changing jobs, until you feel better. Discuss decisions with others who know you well and have a more objective view of your situation.
- Remember that positive thinking will replace negative thoughts as your depression responds to treatment.
- Continue to educate yourself about depression.



4. You are not alone.

Major depressive disorder is one of the most common mental disorders in the United States. You are not alone.

Sometimes living with depression can seem overwhelming, so build a support system for yourself. Your family and friends are a great place to start. Talk to trusted family members or friends to help them understand how you are feeling

and that you are following your doctor's recommendations to treat your depression.

In addition to your treatment, you could also join a support group. These are not psychotherapy groups, but some may find the added support helpful. At the meetings, people share experiences, feelings, information, and coping strategies for living with depression.

Remember: Always check with your doctor before taking any medical advice that you hear in your group.

You can find a support group through many professional, consumer, advocacy, and service-related organizations. On the NIMH website (www.nimh.nih.gov/outreach/partnership-program/index.shtml), there is a list of NIMH Outreach Partners. Some of these partners sponsor support groups for different mental disorders including depression. You can also find online support groups, but you need to be careful about which groups you join. Check and make sure the group is affiliated with a reputable health organization, moderated professionally, and maintains your anonymity.

If unsure where to start, talk to someone you trust who has experience in mental health—for example, a doctor, nurse, social worker, or religious counselor. Some health insurance providers may also have listings of hospitals offering support groups for depression. Remember: Joining a support group does not replace your doctor or your treatment prescribed by your doctor. If a support group member makes a suggestion that you are interested in trying, talk to your doctor first. Do not assume what worked for the other person will work for you.



If You Think a Loved One May Have Depression

If you know someone who is depressed, it affects you too. The most important thing you can do is to help your friend or relative get a diagnosis and treatment. You may need to make an appointment and go with him or her to see the doctor. Encourage your loved one to stay in treatment or to seek different treatment options if no improvement occurs after 6 to 8 weeks.

To help your friend or relative:

- Offer emotional support, understanding, patience, and encouragement.
- Talk to him or her, and listen carefully.
- Never dismiss feelings, but point out realities and offer hope.

- Never ignore comments about suicide and report them to your loved one's therapist or doctor.
- Invite your loved one out for walks, outings, and other activities. Keep trying if he or she declines, but don't push him or her to take on too much too soon.
- Provide assistance in getting to doctors' appointments.
- Remind your loved one that with time and treatment, the depression will lift.

Caring for someone with depression is not easy. Someone with depression may need constant support for a long period of time. Make sure you leave time for yourself and your own needs. If you feel you need additional support, there are support groups for caregivers too.

4. Helpful resources

NIMH has a variety of publications on depression available at www.nimh.nih.gov/health/publications/depression-listing.shtml. If you need additional information and support, you may find the following resources to be helpful.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

CMS is the Federal agency responsible for administering the Medicare, Medicaid, State Children's Health Insurance (SCHIP), and several other

programs that help people pay for health care. Visit www.cms.gov/ for more information.

CLINICAL TRIALS AND YOU

Clinical trials are part of clinical research and at the heart of all medical advances. Clinical trials look at new ways to prevent, detect, or treat disease. Treatments might be new drugs or new combinations of drugs, new surgical procedures or devices, or new ways to use existing treatments. To learn more about participating in a clinical trial, please visit www.nih.gov/health/clinicaltrials/index.htm.

DEPRESSION (PDQ®)

PDQ® (Physician Data Query) is the National Cancer Institute's comprehensive cancer database. The PDQ cancer information summaries are peer-reviewed, evidence-based summaries on topics including adult and pediatric cancer treatment, supportive and palliative care, screening, prevention, genetics, and complementary and alternative medicine. Visit www.cancer.gov (Search: Depression).

LOCATE AFFORDABLE HEALTH CARE IN YOUR AREA

Within the Federal Government, a bureau of the Health Resources and Services Administration provides a Health Center Database for a nationwide directory of clinics to obtain low or no-cost health care.

Start your search at http://findahealthcenter.hrsa.gov/Search_HCC.aspx.

MENTAL HEALTH TREATMENT PROGRAM LOCATOR

The Substance Abuse and Mental Health Services Administration is pleased to provide this online resource for locating mental health treatment facilities and programs. The Mental Health Treatment Locator section of the Behavioral Health Treatment Services Locator lists facilities providing mental health services to persons with mental illness. Find a facility in your state at <https://findtreatment.samhsa.gov/>.

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

NAMI is the Nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

There are nearly 1,000 NAMI state organizations and NAMI affiliates across the country. Many NAMI affiliates offer an array of free support and education programs. Find your local NAMI at www.nami.org/Find-Your-Local-NAMI.

NIDA FOR TEENS: DEPRESSION

NIDA for Teens website is a project of the National Institute on Drug Abuse (NIDA), National Institutes of Health. Created for middle and high school students and their teachers, this website provides accurate and timely information for use in and out of the classroom. Find information and discussions on depression at <http://teens.drugabuse.gov/> (Search: Depression).

NIHSENIORHEALTH: DEPRESSION

NIHSeniorHealth (www.NIHSeniorHealth.gov) has added depression to its list of health topics of interest to older adults. This senior-friendly medical website is a joint effort of the National Institute on Aging and the National Library of Medicine,

which are part of the National Institutes of Health (NIH). It is available at <http://nihseniorhealth.gov/depression/>.

ST. JOHN'S WORT AND DEPRESSION

This fact sheet has information about St. John's wort, a popular herb being used by the public today to treat mild depression. This publication includes information on the FDA's role to monitor the use of this herb, how St. John's wort works, how it is used to treat depression, and a drug interaction advisory. Read it at <https://nccih.nih.gov/health/stjohnswort/sjw-and-depression.htm>.

QUESTIONS TO ASK YOUR DOCTOR

Asking questions and providing information to your doctor and other care providers can improve your care. Talking with your doctor builds trust and leads to better results, quality, safety, and satisfaction. Visit the Agency for Healthcare Research and Quality website for tips at www.ahrq.gov/patients-consumers/index.html.

This publication is in the public domain and may be reproduced or copied without permission from NIMH. We encourage you to reproduce it and use it in your efforts to improve public health. Citation of NIMH as a source is appreciated. However, using government materials inappropriately can raise legal or ethical concerns, so we ask you to use these guidelines:

- NIMH does not endorse or recommend any commercial products, processes, or services, and our publications may not be used for advertising or endorsement purposes.

- NIMH does not provide specific medical advice or treatment recommendations or referrals; our materials may not be used in a manner that has the appearance of such information.
- NIMH requests that non-Federal organizations not alter our publications in ways that will jeopardize the integrity and “brand” when using the publication.
- Addition of non-Federal Government logos and website links may not have the appearance of NIMH endorsement of any specific commercial products or services, or medical treatments or services.
- Images used in publications are of models and are used for illustrative purposes only. Use of some images is restricted.

If you have questions regarding these guidelines and use of NIMH publications, please contact the NIMH Information Resource Center at 1-866-615-6464 or e-mail at nimhinfo@nih.gov.

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015). Depression (NIH Publication No. 15-3561). Bethesda, MD: U.S. Government Printing Office.

Some studies suggest that almost a 25% of all people experience depressed mood at some time in their life. It is also estimated that nearly a third of patients

seeking care are suffering from some sort of a depressive disorder, and many cases of these disorders go unreported within the general population. It is important to understand the effects and causes of the disorder along with the relevant symptoms that can be recognized. There is a common misconception that depression is a feeling of sadness for no apparent reason, and every person who might be feeling blue is said to be depressed. This is not entirely true because clinical depression, is more complex than that.

What is Depression? (CCI, 2019)

It is important to understand that depression is not caused by one thing, but probably by a combination of factors interacting with one another. These factors can be grouped into two broad categories - biology and psychology. Many biological and psychological factors interact in depression, although precisely which specific factors interact may differ from person to person.

Biological Factors

The biological factors that might have some effect on depression include: genes, hormones, and brain chemicals.

Genetic Factors

Depression often runs in families, which suggests that individuals may inherit genes that make them vulnerable to developing depression. However, one may inherit an increased vulnerability to the illness, but not necessarily the illness itself. Although many people may inherit the vulnerability, a great many of them may never suffer a depressive illness.

Hormones

Research has found that there are some hormonal changes that occur in depression. The brain goes through some changes before and during a depressive episode, and certain parts of the brain are affected. This might result in an over- or under-production of some hormones, which may account for some of the symptoms of depression. Medication treatment can be effective in treating these conditions.

Brain Chemicals (Neurotransmitters)

Nerve cells in the brain communicate to each other by specific chemical substances called neurotransmitters. It is believed that during depression, there is reduced activity of one or more of these neurotransmitter systems, and this disturbs certain areas of the brain that regulate functions such as sleep, appetite, sexual drive, and perhaps mood. The reduced level of neurotransmitters results in reduced communication between the nerve cells and accounts for the typical symptoms of depression. Many antidepressant drugs increase the neurotransmitters in the brain.

Psychological Factors (Thinking)

Many thinking patterns are associated with depression. These thinking patterns include:

- overstressing the negative
- taking the responsibility for bad events but not for good events
- having inflexible rules about how one should behave
- thinking that you know what others are thinking and that they are thinking badly of you

Loss

Sometimes people experience events where loss occurs, and this can bring on depression. The experience of loss may include the loss of a loved one through bereavement or separation, loss of a job, loss of a friendship, loss of a promotion, loss of face, loss of support, etc.

Sense of Failure

Some people may stake their happiness on achieving particular goals, such as getting A's on their exams, getting a particular job, earning a certain amount of profit from a business venture, or finding a life partner. If for some reason they are not able to achieve those goals, they might believe that they have failed somehow, and it is this sense of failure that can sometimes bring on, or increase, depression.

Stress

An accumulation of stressful life events may also bring on depression. Stressful events include situations such as unemployment, financial worries, serious difficulties with spouses, parents or children, physical illness, and major changes in life circumstances.

While we cannot do much about the genes we have inherited, there are a number of things we can do to overcome depression, or to prevent us from becoming depressed. Your doctor may have suggested medication, especially in a severe depression. While taking medication can be of assistance in overcoming depression, psychological treatments are also available. Ask your doctor or mental health practitioner for more details.

Grief and Bereavement (Loss) (CCI, 2019)

As mentioned above, the loss of a loved one can cause different levels which are often similar to depressive symptoms. This section addresses the feelings which may come with grief.

Uncomplicated Grief

Grief and loss are part of life and is experienced by most of us at some point in life. People deal with grief in many different ways, and not necessarily going through a predictable group of 'stages,' although some do.

How people grieve can depend on the circumstances of the loss (e.g., sudden death, long illness, death of a young person) as well as past experiences of loss. There is no time limit on grief - some people get back to their usual routine fairly quickly, others take longer. Some people prefer time alone to grieve, others crave the support and company of others.

Below are just some of the range of experiences which can be part of uncomplicated grief:

- Symptoms of depression or anxiety, such as poor sleep, lowered appetite, low mood, feeling of anxiety - for some people the anxiety will be more obvious, for others the depression.
- A sense of the loss not quite being 'real' at first, or refusal to believe it has occurred
- Feeling disconnected from others, sense of numbness
- Guilt about not initially feeling pain about the loss
- Worries about not grieving 'normally' or 'correctly'
- Mood swings and tearfulness
- Guilt about interactions with the person who has died (e.g. I should have spent more time with her or/ wish we didn't have that argument)
- Waves of sadness or anger which can be overwhelming and sometimes suddenly triggered by reminders
- Seeking reminders of the person who has died, e.g. being in their home or with their belongings, or perhaps at times even feeling you see or hear the deceased person
- Guilt about gradually getting back to 'normal' life and at times not 'remembering' to feel sad

Coping with Uncomplicated Grief

Most people going through the pain described above will eventually adjust to the loss and return to normal life, although of course carrying some sadness about the loss. Most people do not require medication or counselling to manage

uncomplicated grief, and should simply be supported to go through their individual grief process. It is important to maintain a healthy diet and some physical activity during this time. Some people may find it helpful to engage in counselling or to attend groups with others who have suffered a recent loss.

Complicated Grief

Complicated grief is a general term for describing when people adjust poorly to a loss. This is very difficult to define, as there is no standard which limits what is normal or healthy grief.

Below are some warning signs which may suggest that a person is not coping well with grief and may be at a greater risk of the grieving process taking longer to resolve or being more difficult:

- Pushing away painful feelings or avoiding the grieving process entirely
- Excessive avoidance of talking about or reminders of the person who has died
- Refusal to attend the funeral
- Using distracting tasks to avoid experiencing grief, including tasks associated with planning the funeral
- Abuse of alcohol or other drugs (including prescription)
- Increased physical complaints or illness
- Intense mood swings or isolation which do not resolve within 1-2 months of the loss
- Ongoing neglect of self-care and responsibilities

Again, it is important to emphasize that there are no 'rules for grieving' and that many of the items above may occur as part of uncomplicated grief. However, people who are coping very poorly one month after a loss may continue to cope

poorly 1-2 years later, so if these warning signs are present then it is often worthwhile seeking some help early on, to increase the chances of adjusting in the long term.

Coping with Complicated Grief

Psychological therapy can support people to safely explore feelings of grief and connect with painful feelings and memories, paving the way for resolution.

Therapy may also support people to use strategies such as relaxation, engaging in positive activities, and challenging negative thoughts, in order to combat the associated symptoms of anxiety and depression.

Antidepressant medication may also be used to alleviate depression associated with grief, and this can be useful in conjunction with psychological strategies.

Tranquilizing medications can interfere with the natural grieving process.

Although early help is recommended, health professionals are able to support people to work through complicated grief even years after the loss.

Major Depression Disorder (MDD)

Major Depression Disorder creates a highly intense state of sadness, combined with despair, that causes a disturbance in the social functioning of the individual. This illness affects the body and the mind, as well as the thought patterns of the individual, in very significant ways. It often changes a person's self perception, as well as the perception of his/her situation, hopes, and dreams. The friends and family of the individual may think that he/she can pull him or herself out of the downward spiral if they tried. This could be likened to the belief that a person with a broken bone can simply ignore the pain he/she is feeling and use the strength of will to get back to full strength.

This misconception comes from some basic misunderstandings about the causes of mental disorders and mental illnesses. Additionally, the media influences the public's ideas about individuals who suffer from mood disorders or other mental illness. Without getting effective treatment, a person can continue to suffer the symptoms and effects of the disorder for an extended period of time. For example, Major Depression can last for years when it is not treated by medicine, psychotherapy or psychosocial therapy. It greatly reduces any chance a person has of enjoying life, or being able to contribute at work or in family life.

Like other physical ailments which have stages and recurrences, Major Depression is classified in technical terms. The following are provided levels of depression:

- Mild
- Moderate
- Severe but without psychotic elements
- Severe and with psychotic elements
- In Partial Remission
- In Full Remission
- Unspecified

DSM 5 Diagnostic Criteria for Major Depressive Disorder includes:

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, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly 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).
 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
(Note: In children, consider failure to make expected weight gain.)
 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).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as 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 or to another medical condition.
- D.  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.
- E. There has never been a manic episode or a 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.

(APA 5, 2013)

Symptoms of Depressive Disorder

Amongst the general psychiatric disorders, mood disorders are most common since a fourth of all patients in public mental health facilities have such disorders. Additionally, 65% of all psychiatric outpatients, as well as 10% of all patients seen in other clinical settings, have one or more mood disorders. Even amongst the generally healthy population, more than 20% of women and 10% of men are expected to experience a mood disorder over the course of their life. Some symptoms of mood disorders are relatively common and difficult to detect, but it is possible to assess a person for Depressive or Bipolar Disorder if a professional knows what symptoms to look for.

Therefore, it becomes critical for social workers, nurses and other professionals to understand what symptoms define these disorders and how to differentiate these symptoms from normal behavior. A final decision regarding the diagnosis of the disorder, the viability of the suggested treatment, as well the prescription of medicine needed for the cure, depend on the analysis made by a licensed doctor or qualified expert. It is important to know what to look for so that proper referrals and recommendations can be made when required.

With regard to the symptoms of Clinical Depression, it must be clarified that not every individual will experience all of the symptoms, and the intensity of the symptom may vary during the day, or over a period of time. Additionally, the elderly, children, men and women may exhibit different symptoms; therefore, an awareness of the person's demographics and social background is also important.

There is a common misconception that elder people are supposed to feel depressed and it is normal for them to be depressed because of their age. However, many older people continue to live normal and happy lives despite their age. The symptoms described above can affect anyone at any age; therefore, these symptoms should not be ignored when examining or meeting older individuals. An older person may not be able to engage in activities he once enjoyed, and may even show some signs of depression due to medication or feeling weak, but such signs could also be indicative of MDD, especially if there is no medication involved.

Additionally, other sources for the symptoms described should be eliminated while making an assessment. For example, a person undergoing the physiological effects of substance abuse could experience the same symptoms on a daily basis. Similarly, a person who is experiencing the side effects of certain medication could also report the same effects. Even certain medical conditions e.g. hypothyroidism, could manifest themselves with similar

symptoms. Social factors like losing one's job or the loss of a loved one can also be used to account for the conditions mentioned above rather than clinical depression. Lastly, the symptoms described by the subject should not exhibit any elements from the manic episode of Bipolar Disorder.

Persistent Depressive Disorder (Dysthymia)

In comparison to Major Depression Disorder, this ailment is less severe. **Dysthymia does not cause the same level of mental and/or physical disability.** A person suffering from Dysthymia can take part in day-to-day activities and even get some gratification out of those activities, but the feelings of sadness and a lack of self-worth are persistent. A person with Dysthymia can also lapse into a full case of Major Depressive Disorder since the effects of Dysthymia are chronic and it is usually a long-term condition which may require extensive therapy, as well as medication, in order to manage its symptoms.

DSM 5 Diagnostic Criteria of Persistent Depressive Disorder

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

- A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account 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 overeating.
 - 2. Insomnia or hypersomnia.
 - 3. Low energy or fatigue.
 - 4. Low self-esteem.
 - 5. Poor concentration or difficulty making decisions.
 - 6. Feelings of hopelessness.
- C. During the 2-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.
- 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. (APA, 2013)

Chapter 3: Bipolar Disorders

What is Bipolar Disorder?

Bipolar Disorder or Manic Depression is a mood disorder, and is the name given to the experience of abnormal moods or exaggerated mood swings. This illness is characterized by the experience of extremely “high” moods where one becomes extremely euphoric or elated, and the experience of extremely “low” moods where one becomes extremely sad and finds it difficult to experience pleasure. The high moods are called **manic episodes** and the low moods are called **depressive episodes**. These episodes can range from mild to severe and affect how a person thinks, feels and acts. In some individuals the mood changes occur quickly, and there may be multiple cycles per day. For others suffering from this disorder, moods may last for a period of weeks. There may also be periods of normal mood in between the stages of mania and depression.

<https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Bipolar-Disorder>

Features of Bipolar Disorders

Manic Episodes:

Mania is an extreme mood state of this disorder. It describes an abnormally elevated euphoric, driven and or irritable mood state. **Hypomania** is the

term given to the more moderate form of elevated mood. Symptoms of mania may include:

Irritability or quick to anger, touchy. This is expressed as a result of the person with an elevated mood having a rapid flow of ideas and thoughts. The manic person gets angry when the other person does not comprehend or connect the ideas they have, or lack enthusiasm for some new plans.

Decreased need for sleep: Those experiencing mania often have excessive energy and a lack of need for sleep.

Rapid flow of ideas: As mentioned under irritability, the manic individual will have a rapid flow of ideas and be very excited about them. They want others to be excited about it also. These ideas will change quickly from one idea to another. This can become incoherent to the person listening so they are unable to understand.

Grandiose ideas: People who are manic will often have huge ideas and believe themselves to be smarter, more talented or generally better than other people. This will often be delusions of grandeur.

Uncharacteristically poor judgement: A person's ability to make rational decisions can be impaired when they are manic and not able to concentrate or focus on reality. These decisions will often be out of character for the individual.

Increased sexual drive: Because of the increased drive, they will often make poor decisions regarding sexual encounters and partners.
(CCI, 2019)

Cognitive Changes in Mania

(CCI, 2019)

The onset of mania or hypomania can often be a pleasant experience for people with bipolar disorder. Positive changes in mood can be quite dramatic,

and people often feel energized, excited, and optimistic. On the other hand, people sometimes find that mania and hypomania begin with irritability and agitation, or that they experience both feelings of dysphoria and euphoria at the beginning of a manic episode. For those who experience mixed episodes, quick changes can occur between being in a good mood and extreme irritability.

The cognitive changes associated with mania or hypomania include changes in the way people or situations are viewed, and changes in the amount and quality of new ideas. These changes can act as a signal that a manic episode is developing, and that action needs to be taken to prevent the symptoms from getting worse.

Increased Optimism and Grandiosity

When people are manic or hypomanic, the most common symptom is the development of an unusually positive view of self, the future, and the world at large. When people are becoming manic, they often find themselves feeling particularly self-confident and experiencing a general sense of well-being. This is often accompanied by beliefs that include overestimating their abilities, an optimism that causes them to view the world as particularly helpful, or an underestimation of the negative consequences of their behavior. Sometimes this self-confidence can progress to the point where the person's thinking is grandiose and delusional.

When people are becoming manic or hypomanic they may develop a wealth of new ideas and plans that often have the potential to be successful. Unfortunately,

when people are manic, it can be difficult to distinguish between good ideas and grandiose delusions. The other thing that often happens during a manic episode is that a person's ability to concentrate and follow through with plans is impaired (particularly when they are overactive or not sleeping much). All of these factors, together with little or no planning, can cause even the best ideas to fail.

During a manic or hypomanic episode, people may forget to consider the potential negative consequences of their behavior. There is a tendency to rush into an activity or make a decision without carefully considering the pros and cons associated with each choice. They may also be feeling so optimistic that they dismiss the potential negative consequences anyway.

Some people may think they have special powers, particularly in the areas of creativity and personal interactions. These beliefs are maintained when people focus only on events that appear to confirm the belief, while ignoring evidence to the contrary.

Paranoia

Early in the development of mania or hypomania, paranoid thinking is often evident, and may manifest as suspiciousness of others. This suspiciousness is often based on very real events and a history of bad feelings between the person experiencing mania, and the target of his or her paranoia. The paranoia is often maintained by focusing on evidence that confirms the paranoid thoughts. Interactions with the target person are likely to be tense because of the suspicion involved, and the target person is likely to react in some way to the tension and

hostility. This reaction can then be read by the person as confirming their paranoia.

Increased Fluency of Ideas

During mania and hypomania, there is often a flood of new ideas and interests. People with hypomanic symptoms frequently overestimate how much can be accomplished in a given day and underestimate the time it takes to complete tasks. The increase in mental activity that accompanies mania acts to distract people from these tasks they have started doing, making it even more difficult to complete activities.

Thinking Errors in Mania

Social judgement can be impaired in hypomania and is usually quite impaired during manic episodes. People with bipolar disorder often experience a decreased sense of self-awareness during their interactions with others. They may say or do unusual things, or fail to notice the impact that their words or actions have on other people.

Recognizing Symptoms

The symptoms of mania, hypomania, or mixed episodes usually emerge over a period of days to weeks. Often people become aware of a pattern in the development of their symptoms, for example, hypomania or mania may begin with one symptom such as insomnia, and then progress to other symptoms (e.g.,

increased sexual interest, feelings of euphoria). Changes in the nature of people's thoughts, or preoccupation with certain ideas can also be part of this progression. Some people learn to recognize these changes in their thinking and can say, "It's happening again. I always start thinking that way when I'm getting high." This recognition can be a critical step for intervening early to prevent a full-blown manic episode.

DSM 5 Criteria for Manic Episodes

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).

- A. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four 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.
 5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
 7. Excessive involvement in 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.
- 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.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive 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 diagnosis.

The essential feature of a manic episode is a distinct period during which there is an abnormally, persistently elevated, expansive, or irritable mood and persistently increased activity or energy that is present for most of the day, nearly every day, for a period of at least 1 week (or any duration if hospitalization is necessary), accompanied by at least three additional symptoms from Criterion B. If the mood is irritable rather than elevated or expansive, at least four Criterion B symptoms must be present. (APA, 2013)

The mood in a manic episode can be described or observed as excessively cheerful and euphoric. It may manifest itself in hap-hazard enthusiasm for interpersonal and sexual interactions. As mentioned before, many times the predominant mood can be irritability, especially when their wishes have been denied.

In children, if the normal happiness and silliness are normal in context at special occasions, they would not be seen as a symptom of a manic episode; however, if

these moods are recurrent and inappropriate within the context of the situation or environment, these may be symptom of a manic episode. These would need to be accompanied by persistently increased activity or energy levels that are obvious to those who know the child. (APA, 2013)

Hypomania

Hypomania is a more moderate elevated mood. Differentiated from mania because those experiencing hypomania would not need to be hospitalized and are more in touch with reality. They are not given to the extreme destructive behaviors of those experiencing a manic episode. It is important to note hypomania can rapidly move into a mania.

DSM 5 -- Hypomanic Episodes

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

- B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
 - 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.

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
 7. Excessive involvement in 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 individual when not symptomatic.
 - D. The disturbance in mood and the change in functioning are observable by others.
 - E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
 - F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive 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 of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A-F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Depressive Episodes

Depression is characterized by a significantly lowered or decreased mood. Its severity, duration and persistence, and the presence of characteristic symptoms can distinguish a major depressive episode from a milder episode of depression. The most common symptoms of depression include:

Persistent sad, anxious or empty mood: People often describe depression as an overwhelming feeling of sadness and hopelessness. They may experience a loss of enjoyment in the activities of everyday life that they used to take a lot of pleasure in.

Poor or disrupted sleep: A person when they are depressed often experience sleep disturbances, and this can be due to increased anxiety. They then find it difficult to fall asleep, or wake up frequently during the night worrying about day-to-day events or wake up early in the morning and are unable to get back to sleep.

Feelings of worthlessness or hopelessness: sometimes people become overwhelmed with a sense of their own ability to be of use to anyone, and can become convinced they are useless and worthless. Thoughts may revolve around the hopelessness of the situation and the future.

Decreased interest in sex: As the person becomes depressed, they gradually become less interested in social activities and sex.

Poor concentration: Thinking can become slowed and the person can have difficulty in making decisions. They find it difficult to concentrate on reading a book, or on the day to day tasks, such as shopping. This can often create anxiety or agitations in a person.

Thoughts of suicide, or suicide attempts: When a person becomes overwhelmed by their feelings of hopelessness and despair, they may have thoughts of ending their lived or make plans to commit suicide. (CCI, 2019)

DSM 5 - Major Depressive Episode

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. Markedly 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).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
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).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as 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.

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

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. (APA 5, 2013)

Based on the nature of the changes of mood, the subtypes of Bipolar Disorder can be classified as Type I or Type II.

Psychosis

Patients suffering from Bipolar Disorder or Clinical Depression can both **experience certain elements of psychosis** of which the primary symptoms are hallucinations and delusions. In terms of hallucinations, a person can hear or see things which are not present in the room. The delusions, on the other hand, are internalized with manic episodes, creating images of grandeur and strength, such as believing oneself to be particularly powerful or wealthy. The delusions of a depressive episode come with an idea that the patient is guilty of something terrible or has no social standing whatsoever. Interestingly, these are also the

symptoms of schizophrenia, which can complicate the diagnostic or assessment process for both Bipolar Disorder and Clinical Depression (APA, 2013).

Bipolar I Disorder

“The bipolar I disorder criteria represent the modern understanding of the classic manic-depressive disorder or affective psychosis described in the nineteenth century, differing from that classic description only to the extent that neither psychosis nor the lifetime experience of a major depressive episode is a requirement. However, the vast majority of individuals whose symptoms meet the criteria for a fully syndromal manic episode also experience major depressive episodes during the course of their lives.” (APA, 2013)

A person with Bipolar I Disorder experiences the state of mania at least once; however, the state of elation in mood, and the reversal of symptoms, are usually short lived and the emotional situation can quickly return to a depressive state. The effect of such a manic state can be quite devastating as the person may make irrational decisions concerning their personal life, financial situation, or their relationships without fully understanding the consequences. They may also engage

in reckless behavior, illicit drug use or go on a drinking/eating binge. Additionally, the high may go to such an extreme level that a person suffering from Type I Bipolar Disorder may have to be confined in order to prevent harm to themselves or to others. While coming down from the elevated mood there is a chance that the person could go into a further state of depression than before. (APA, 2013)

This is the most common and prevalent of the different bipolar mood disorders. It is characterized by the experiences of full-blown manic episodes and severe depressive episodes. These patterns of abnormal mood states individual may experience are very varied and different. Since the symptoms often come and go, Bipolar I is often referred to as a relapsing and remitting illness, continued treatment is important to prevent a relapse, even when symptom are not longer present. (CCI, 2019)

DSM 5 Bipolar I Disorder Diagnostic Criteria

- A. Criteria have been met for at least one manic episode (Criteria A-D under “Manic Episode” above).
- 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 II Disorder

Bipolar II Disorder is characterized by the experience of full-blown episodes of depression and episodes of hypomania that almost never develop into full-fledged mania. (CCI, 2019)

Bipolar II disorder is characterized by a clinical course of recurring mood episodes consisting of one or more major depressive episodes and at least one hypomanic episode. The major depressive episode must last at least 2 weeks, and the hypomanic episode must last at least 4 days, to meet the diagnostic criteria. During the mood episode(s), the requisite number of symptoms must be present most of the day, nearly every day, and represent a noticeable change from usual behavior and functioning. (APA, 2013)

With more than one or many changes of mood between manic states and depressive states, a person can be diagnosed as having Bipolar II Disorder. This type is different from Type I because the highs experienced are not at dangerously high levels. Even though there are shared symptoms of the high state with Bipolar I, the person can still function without severe disturbance, and interact reasonably well socially.

DSM 5 Bipolar II Diagnostic Criteria

- A. Criteria have been met for at least one hypomanic episode (Criteria A-F under "Hypomanic Episode" above) and at least one major depressive episode (Criteria A-C under "Major Depressive Episode" above).
- B. There has never been a manic episode.
- C. The occurrence of the hypomanic episode(s) 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. (APA, 2013)

For both Bipolar I and Bipolar II Disorders, researchers have shown that there is a significant biological component and certain individuals could have a predisposition towards this disorder. As in the case of all other mental and mood disorders, the environmental factors play a large part in making the situation better or worse.

Cyclothymic Disorder

DSM 5 Diagnostic Criteria (APA, 2013)

- 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 major depressive, manic, or hypomanic episode have never been met.
- 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 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., hyperthyroidism).
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The essential feature of cyclothymic disorder is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and periods of depressive symptoms that are distinct from each other (Criterion A). The hypomanic symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a hypomanic episode, and the depressive symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a major depressive episode.

Bipolar I disorder, with rapid cycling, and bipolar II disorder, with rapid cycling.

Both disorders may resemble cyclothymic disorder by virtue of the frequent marked shifts in mood. By definition, in cyclothymic disorder the criteria for a major depressive, manic, or hypomanic episode has never been met, whereas the bipolar I disorder and bipolar II disorder specifier "with rapid cycling" requires that full mood episodes be present. (APA, 2013)

The Causes of Bipolar Disorder

(CCI, 2019)

No one factor has been identified to cause bipolar disorder, that is, it is not caused by a person, event or experience. There are a number of factors that interact with each other that may contribute to the development of this disorder in some people.

First, we begin by looking at three key factors in this model, namely: genetic vulnerability, biological vulnerability and life stress.

Genetic Vulnerability

Bipolar disorder tends to run in families. First degree relatives of people with bipolar disorder have an increased risk of developing bipolar disorder. Children of bipolar patients face an 8% risk of getting the illness versus 1% in the population. Children of bipolar patients also face an increased risk (12%) of getting unipolar depression (i.e., depression only, without mania). Identical

twins are also more likely to both develop this disorder than fraternal twins. While these results indicate to some extent that this disorder is genetically inherited, they also suggest that there are other factors that may contribute to its development.

Biological Vulnerability

This refers to possible biochemical imbalances in the brain that makes a person vulnerable to experiencing mood episodes. An imbalance of brain chemicals or an inability for them to function properly may lead to episodes of "high" or "low" moods.

Life Stress



Stressful events or circumstances in a person's life, such as, family conflicts, employment difficulties, bereavement, or even positive events, such as getting married, having children, moving house, etc, can place extra demands on the person, leading to them feeling stressed, frustrated, anxious, sad, etc.

The occurrence of bipolar disorder can thus be explained as an interaction of the 3 above factors. A person who is genetically and/or biologically vulnerable may not necessarily develop bipolar disorder. These vulnerabilities are affected by how they cope with stressors in their life. For example, a person who has a family history of diabetes may not develop diabetes if they are careful with what they eat and have enough exercise. This brings us to a discussion on protective and risk factors.

Protective & Risk Factors

A risk factor is something that will increase the chances of a person who is already vulnerable becoming ill. Examples of risk factors are: poor or maladaptive coping strategies, alcohol or drug use, irregular daily routines,

interpersonal conflicts, stressful events, etc. Protective factors, on the other hand, are those that can help to prevent a vulnerable person from becoming ill. Protective factors include good coping strategies, good social support networks, effective communication and problem solving skills, etc. It is when the risk factors outweigh the protective factors, that the chances of developing the disorder are high. This principle applies when considering the risk of recurrence as well.

Course of Illness

While some patients may experience long periods of normal moods, most individuals with bipolar disorder will experience repeated manic and/or depressive episodes throughout their lifetime. The ratio of manic episodes to depressive episodes will vary from one individual to the next, as will the frequency of episodes. Some individuals may experience only two or three episodes in their lifetime while others may experience a rapid cycling pattern of four or more episodes of illness per year. Whatever the pattern, it is important that bipolar patients learn effective ways of managing their illness and preventing the recurrence of further episodes. (CCI, 2019)

The Bipolar Disorder

The development of Bipolar Disorder causes a shifting mood that swings like a pendulum between two extreme sets of symptoms. They are quite different from the normal changes in energy or mood levels which a person may go through during the day since the symptoms are usually quite severe. The person who is afflicted with Bipolar Disorder can have considerable difficulties in successfully maintaining social/intimate relationships, a sustained performance level at school

or work, and may even commit suicide during a state of an extreme low. Commonly, the Bipolar Disorder develops in a person's early adult years, although in some cases even children or the elderly can exhibit the symptoms associated with the disorder.

As a mental disorder, it is notoriously difficult to diagnose because the patient moves between various moods with periods of normalcy in between. In relation to the Depression Disorder, the treatment period may be considerably longer, and the management of this disease is quite difficult without family or other forms of social support groups. The basic symptom of this disorder is mood swings where one state is *mania* and the other is *depression*. Along with the mood, the mental state, personal abilities and exhibited energy levels of the individual are also changed.

A case of Bipolar Disorder where the manic episode is mild (Hypomania) may feel quite good to the person experiencing it. In fact, a good mood may even cause a person to improve their work output and enhance their social functions beyond normal abilities. However, it must be recognized that it is a temporary state and without proper therapy and treatment the case of Hypomania may become a situation with severe mania or Clinical Depression coupled with Psychosis.

If an individual has mood shifts between the manic state and the depressive state more than four times in a given year the disorder is called **Rapid-Cycle Bipolar Disorder**. Some individuals may even experience four or more episodes within a seven-day period or even during the course of a single day. In rare cases, a person may enter into a Mixed Bipolar State where he experiences both the symptoms of a manic episode, as well as symptoms of a depressive episode. For instance, a patient may describe feeling extremely depressed and sad while having suicidal thoughts, yet feel energized and refuse to accept that anything is wrong with him.

Quick shifts in a person's mood also indicate that the disease has entered its later stages and the patient is in need of immediate medical assistance. With effective treatment, the disease can often be brought down to a manageable level, although a small percentage of individuals will continue to experience residual symptoms throughout their lives. While many people can live healthy and unaffected lives while having Bipolar Disorder, they often need to depend on drugs and other control methods to maintain a normal living standard.

Depressive Disorder

Depression can strike anyone at any age and the causes of this disorder are many and complex. There have been moves to organize the causes according to

the groups which are affected by it since women exhibit different causes for depression than men. Similarly, the elderly have different causes for depression as compared to children. There is research which shows that there may be a connection between family history, a change in the brain structure/chemistry and depression. Generally speaking, individuals with low self-esteem, a negative outlook on the world and life, along with strains of pessimism, are more prone to Depressive Disorders than others.

Physical changes in the body such as major operations, neurosurgery, emergence of cancer, Parkinson's disease or changes in hormone levels may also contribute to a case of depression. These are particularly dangerous situations as patients need to have some strength and fortitude to defeat the disease, whereas a depressed patient may give up hope of recovery.

Environmental factors, such as going through a period of grief for the loss of a loved one, severe financial or situational difficulties, rapid stressful changes or even the move to a different location, can expose a latent Depressive Disorder. In addition, living through a natural disaster can bring out a case of Clinical Depression in some individuals.

As mentioned, gender plays a role in depression. Men are only half as likely to experience (or report experiencing) depression as compared to women. The hormonal changes in a woman's body throughout the periods of menstrual cycle alterations, pregnancy, postpartum, pre-menopause, menopause and even

puberty can trigger depression for a woman. It is important to note that social stratification and setups place women at additional risks, since being a single parent or living with aging parents can contribute to depression. Postpartum Depression is a special case of depression which affects women alone because the major hormonal changes in the female body after delivery and the emotional responsibility of caring for her child can be quite traumatic.

While men are less likely to be affected by a case of Depressive Disorder, quite a large number of men do suffer from it, but are less likely than women to report a case of depression. This is reflected in that for every woman who commits suicide in America, there are four men who commit suicide. Additionally, older men are more likely to kill themselves as there is a greater chance of suicide amongst men after they are seventy years old. Clinically Depressed men are more likely to die of heart disease and use alcohol or other drugs as compared to the general population.

A man may mask depression by working unusually long hours, which makes him a socially acceptable 'workaholic' instead of a socially reviled alcoholic.

Moreover, a man may also present the symptoms of depression differently than a woman, making the diagnosis more difficult. Finally, due to the social taboos and misconceptions associated with being mentally ill or having a mood disorder, men are less likely to ask for assistance; often medical and social professionals need to recognize the symptoms of depression on their own.

Bipolar Disorder

The causes for Bipolar Disorder are more difficult to pinpoint since there are both genetic elements as well as environmental factors which contribute to an onset of this disease. There is strong evidence to support the claim that Bipolar Disorder runs in a family, but the genes a person is born with do not present the whole picture. For example, a study on twins shows that, even though the genes of the twins are identical, they both may not develop Bipolar Disorder. However, the identical twin of an individual who has Bipolar Disorder is certainly at a greater risk to develop the disease.

Of course, with this information in hand, scientists are quite interested in the genetic makeup of individuals with Bipolar Disorder and believe that as discoveries are made in the field of genetics, better tools and medicines will be created to handle this disease. Medical science has also shown that the brain images of individuals who have Bipolar Disorder are different from healthy samples. A greater understanding of these differences will allow future medical professionals to better understand the disease and use effective therapies for curing the ailment.

Chapter 4: Assessment and Treatment

This chapter discusses and examines the large variety of symptoms and signs for mood disorders, and gives detailed information about the psychosocial assessment which can be made to see if an individual may have one or more mood disorders.

Psychosocial Assessment of Mood Disorders

An assessment regarding mood disorders can be made by a medical practitioner, family therapist, or a social worker. The purpose of the assessment is to understand the patients' current psychological behavior and to examine the sources of stress within the person's environment which could be leading to or contributing towards the mood disorder. Fundamentally, the assessment seeks to review the psychological as well as social development of the individual and understand how the patient's background could have an influence on their present state.

As noted earlier, a patient's family history and genetic make up connects directly with the incidence of Bipolar and Depression Disorders, therefore the psychosocial assessment has to look at the family background and incidence of mood disorders in the patient's family. The assessment made by the field professional becomes a very important document for the full and final diagnosis

which is made by other professionals and a well-assessed patient would have better chances of making a full recovery.

Nurses, as well as social service officers, should make sure that the psychosocial assessment is not delayed and an attempt should be made to complete the assessment as soon as first contact is made with the patient. Information can be added to the assessment over time but the sooner it is started and completed the better. There can be situations where it is impossible to interview a person since she may be comatose, mentally unable to comprehend or respond to the questions, or even refuse to talk to the service provider. In these cases it might be more prudent to complete as much of the assessment as is possible with the help of family members or friends and neighbors.

The assessment looks for many different social and psychological problems which a patient may have. These cover a wide range of findings of present problems including medical issues like diabetes, high blood pressure, and obesity. It also looks at psychological problems such as disorientation, hallucinations, lack of concentration, obsessive thoughts, sleep disturbances, sexual preoccupation and aggressiveness. The social situations are examined by looking at things such as legal issues, family conflicts, homelessness, language barriers, even attitude towards religion. Of course, there are legal implications concerning confidentiality and privacy while such an examination is being

conducted and those need to be clarified to the patient before an assessment is to be made.

An assessment of the social and psychological conditions of the case would be incomplete without noting the set of assets and liabilities which a patient has with her (Foster, 2005). For example, the assets with a patient which could help in the recovery and treatment of the mood disorder are as follows:

- Level of Education
- Employment Status
- Understanding of personal problems
- Motivation for treatment
- Family or other social support network

Even a person's sense of humor and willingness to cooperate with social workers and medical professionals is an asset for treatment. On the other hand, a patient can also have liabilities which hinder the treatment that must be noted in the assessment process. These liabilities are as follows:

- Lack of support from family or social groups
- Legal or financial issues towards getting help
- Recent loss of a job or healthcare coverage
- Present living conditions

A person may even have religious/cultural conflicts with the idea of getting treatment for a mood disorder which could act as a liability towards the help

offered to the patient. Again, these things need to be recorded in the assessment so a proper treatment plan can be formulated.

For minors, the required signatures and acceptance forms should be filled out by a parent or present guardian. Some of this would depend on what the prevailing statutes in the State you are practicing. In some States, minors have the right to receive services without parental consent or knowledge. The patient's family and loved ones can be interviewed in the process if the patient gives his/her consent for them to be questioned. The family members of the patient can be quite useful in giving information about mental illness in the family or other cases of mood disorders experienced by siblings of the patient. If cases of mental illness or mood disorders are present then it is important to know which treatments were given to the family members and which worked for them.

It must be remembered that the more detail which can be gathered about the patient the better the assessment would be. When looking at symptoms the aim should be to find out the complete history of symptoms. For example, when did the patient start experiencing them, the level of their severity and was there ever a time when the symptoms diminished? The assessment should also inquire about previous treatments given to the patient and get an understanding about the patient's drug and alcohol use. Quite often, even asking the patient directly if she feels depressed would help in judging the presence or absence of a mood disorder.

Throughout the process of obtaining information for a psychosocial assessment, the nurse or social worker should be on the lookout for the patient's descriptions of feelings and emotions or signs which suggest that the patient is suffering from one or more mood disorders. Finally, the process requires that a patient should be informed if others will be allowed to see the information to be involved in the treatment or review process. Once the assessment is complete, and a positive diagnosis has been made by a qualified physician, then the treatment of the patient can start in earnest.

[Psychosocial and Medical Treatments](#)

This chapter discusses the treatment of mood disorders through Medical psychosocial means and evaluates the success of the treatment methods. Additionally, it recommends ways and means by which the stigma associated with mood disorders can be eliminated.

[Depression and Psychosocial Treatments](#)

Psychosocial treatment is often effective in combating the symptoms of an episode if a person has Depressive Disorder. However, it must be understood that medication and the prescription of drugs might also be a requirement in certain situations. As a subset of psychosocial therapy, counseling and family therapy methods are also useful in recovery. Family therapy is particularly

important when it comes to the cases where children or adolescents have been affected with Depression.

Psychotherapy is a requirement in many cases because medical science has not yet advanced to a level where every mood disorder or mental ailment could be cured by a pill. Science has not fully identified the neurological or chemical basis of why certain individuals have feelings of love, courage, or compassion just as science has not identified why some people feel depressed, angry or lose control of their emotional state. However, therapy for patients suffering from a mood disorder is necessary and is often helpful in stopping the disease in its tracks and even eliminating it altogether.

The primary aim of psychosocial therapy is to provide assistance to the patient in understanding the disease, as well as to try and alter behavior patterns in combination with efforts from the patient. After undergoing successful psychosocial therapy, a patient is able to communicate more effectively with others and can continue to improve until the disease becomes completely manageable. A large portion of the therapy provided to the patient looks at ways in which the patient can improve their outlook of the world as well as their own person. Since such methods seek to renew the cognitive behavior of the individual they are considered to be a part of Cognitive Behavior Therapy (CBT).

The success of CBT for depressed patients who are undergoing psychosocial treatments is limited because there is a high rate of relapse into an episode of depression once the therapy is stopped. This clearly suggests that the patient should have a social support group or an understanding family which continues to assist and monitor the patient. Psychosocial therapy coming in the shape of interpersonal therapy centers can be quite helpful here because such centers help an individual cope with personal grief, drastic changes in life and other difficulties for patients with mood disorders.

Depending on the requirements of individual cases, psychosocial therapies for patients with Clinical Depression include elements from CBT, interpersonal supportive therapy, as well as social group/family support. The delivery of such therapies can be given in both inpatient and outpatient settings, depending on medical recommendations based on the psychosocial assessments of the patient. Modern research also suggests that patients with milder forms of depression can battle their mood disorder with self help sessions as well as therapy. A patient suffering from Clinical Depression may think that no one cares for them or that the individuals around him do not understand the state he is in. Psychosocial treatment in such cases is tremendously beneficial since it clearly shows that there are people who do care and are willing to sacrifice a lot to ensure that the patient gets better.

There might be a misconception about the depressed person that he is lazy and can easily snap out of his present state. Nurses and social workers have to do their part in psychosocial therapy to educate and inform the people around the patient that a mood disorder requires medical assistance as much as any other disease. Emotional support from the friends of the patient must continue to come with understanding, patience, love and supportive guidance. A depressed person needs to be listened to whenever he is willing to communicate and his feelings should not be belittled. For example, remarks about suicide or thoughts/plans about committing suicide are red flags for both nurses and the people around the individual which should be reported to the physician handling the case.

If possible, the depressed person should be taken for short walks in natural surroundings, taken to see a movie, or engaged in some activity which helps them take their mind off the disease. This must not be enforced on them, but rather they should be gently persuaded towards it (Ernst, 2006). Goals and milestones setup for a person with mood disorders can be monitored to see how much progress they have made and how they can help in improving their condition. However, a failure to meet goals can depress the person further, therefore, small goals should be set and met before larger ones can be given. Finally, engagement in social groups, religious activities, sports and hobbies can also help a person suffering from depression.

Psychotherapy for Depression (CCI, 2019)

Depression can be treated with medical treatments such as antidepressant medication or electroconvulsive therapy, and psychotherapy. Please see your medical doctor or psychiatrist for more information about medical treatments as this will not be discussed in this handout.

We're now going to talk briefly about two psychological therapies that have been proven to be effective most of the time. You might have come across words such as "best practice" "evidence-based practice," "evidence-based treatment" or "evidence-supported therapy." These words refer to a particular type of treatment or therapy that has been evaluated and has proven to be effective. **For the treatment of depression, the evidence-supported therapies include cognitive therapy and behavior therapy.**

Cognitive Therapy

The aim of cognitive therapy is to help individuals realize that they can influence their mood by identifying and changing their thoughts and beliefs. When people are depressed, they often think very negative thoughts about themselves, their lives, and their future. This further worsens their mood. Cognitive therapy focuses on discovering and challenging unhelpful assumptions and beliefs, and developing helpful and balanced thoughts. Cognitive therapy is also structured, time-limited, and focused on the 'here-and-now.' This form of treatment for

depression has been proven to be effective when individuals are able to acquire the skills that are being taught in therapy.

Behavior Therapy

Depressed people tend to feel lethargic and unmotivated. They often stay at home and avoid going out and interacting with people. As such, they may miss out on opportunities that help lift their mood. Behavior therapy aims to identify and change aspects of behavior that may perpetuate or worsen the depression. Some behavioral strategies include: goal setting, activity scheduling, social skills training, and structured problem solving.

Cognitive and Behavioral Therapy have been shown to be effective most of the time. Often, a combination of these therapies are offered for people who experience depression. This information package focuses on providing information on the cognitive and behavioral aspects of depression, which includes suggested strategies for how you could better manage your mood.

Thinking and Feeling

(CCI, 2019)

People often believe that the feelings and emotions they experience are determined by external events, situations, and the behavior of others. For example, we may hear ourselves say, "My boss made me so nervous," "My

partner made me so angry," "This trip down south made me feel so relaxed," or "I'm depressed because I didn't get the job I wanted." What is the assumption underlying these statements? That someone or something other than ourselves was directly determining the feelings we experienced. We come to these conclusions automatically without asking ourselves if this assumption is true. However, if we stop to analyze the process that links an external situation to our emotional responses, we will find that there is a step in between.

How Our Thoughts Influence Our Feelings

What really makes us feel and respond the way we do, is often not the situation or the words and actions of another person, but how we perceive that situation or that person's actions. It is how we see something or someone and what we think about it or them that really influences how we feel. It is our thoughts and beliefs about an event that significantly influences our emotions and actions.

Here's an example. Suppose you went to a party and your host introduces you to Mike. As you talk to him, you notice that he does not look directly at you but often looks around the room. How would you feel if you thought, "Boy, this guy is so rude! He won't even look at me while I'm talking with him! How nasty!" What if you thought, "Mike must think that I'm really unattractive and uninteresting. I must be a really boring person. Nobody wants to talk to me!" What about if you were to think, "Mike's probably waiting for a friend to come. Maybe he's getting a bit anxious." You probably realized that you felt three different emotions as a result of those three different thoughts. Often, we are not aware of our thoughts and

beliefs because they are so automatic and happen quickly. But they are there, and they affect the way we feel.

What am I Feeling?

It is often difficult to know exactly what we are feeling, and sometimes it can also be difficult to put it into words. The list below contains words that describe feelings, and this might be a useful starting point in you being able to understand the connection between your thinking and your feelings.

Words That Describe Feelings			
Tense	Enraged	Frightened	Cheerful
Annoyed	Happy	Panicky	Euphoric
Unhappy	Exhilarated	Frustrated	Mad
Exuberant	Keyed-up	Scared	Uneasy
Anxious	Irritated	Flat	Sad
Depressed	Joyful	Tired	Discouraged
Angry	Excited	Nervous	Jealous

This is only a limited list but it should give you an idea of the kinds of words we could use to describe our feelings.

Automatic Thoughts

Just as we are not always conscious of the way we walk or how we drive a car, we are often not aware of our thinking. Some of our thinking is so habitual that it is automatic, and just like driving, when things are automatic, we might not be conscious of them. All of the time, our brains are turning over thoughts and ideas.

However, we are not consciously aware of most of them because it happens relatively fast and we are not accustomed to slowing them down. Our automatic thoughts, however, play an important role in our emotional well-being.

There are three kinds of automatic thoughts:

Neutral thoughts, e.g. "I think I will buy some bread today."

Positive thoughts, e.g. "This is something I can do really well."

Negative thoughts, e.g. "I often find it hard to concentrate - I must be really stupid."

Automatic thoughts often reflect worries and concerns, however they can be about anything at all, anything we have ever seen, heard or learned. In addition, it can be anything we know about from any source at all. Obviously, though, negative automatic thoughts are the ones that can cause us emotional distress. People who are depressed tend to think negative thoughts about themselves, the world about them, and their future, and it is these thoughts that can be changed to lift your depression.

Feelings are not Thoughts

When we first try to distinguish thoughts from feelings, it can be easy to confuse them. We might be used to talking about thoughts and feelings as being part of the same experience, but it is more helpful to separate them and remember that feelings are not thoughts. For example, you might hear a person saying "I think

I'm anxious," but they're probably thinking "Everyone will laugh at me," and feel hurt. More commonly, you might hear someone saying something like "I feel that my partner doesn't appreciate the gift I bought for him," when they are actually thinking "My partner doesn't appreciate the gift I bought for him," and feel hurt.

Being aware of your feelings and your thoughts is the first step towards feeling better. If thinking influences feelings, then it makes sense that if you want to change the way you feel, you need to change the way you think. Look out for the information flyer entitled "Changing the Way You Think" for more details on how to do this.

Improving Feelings

(CCI, 2019)

People often believe that the feelings and emotions they experience are caused by external events, situations, and the behavior of others. For example, we might hear ourselves say, "My partner made me so angry," "My boss made me so nervous," "This trip down south made me feel so relaxed," or "I'm depressed because I didn't get the job I wanted." What is the assumption underlying these statements? That someone or something other than ourselves was directly determining the feelings we experienced. However, if we stop to analyze the process that links an external situation to our emotional responses, we will find that there is a step in between.

What Influences My Feelings

What really makes us feel and respond the way we do, is not the situation or the words and actions of another person, but how we perceive that situation or that person's actions. It is our thoughts and beliefs about an event that significantly influences our feelings and actions.

Here's an example. Suppose you went to a party and your host introduces you to Mike. As you talk to him, you notice that he does not look directly at you but often looks around the room. How would you feel if you thought, "Boy, this guy is so rude! He won't even look at me while I'm talking with him! How nasty!"

What if you thought, "Mike must think that I'm really unattractive and uninteresting. I must be a really boring person. Nobody wants to talk to me!"

What about if you were to think, "Mike's probably waiting for a friend to come. Maybe he's getting a bit anxious."

You probably realized that you felt three different emotions as a result of those three different thoughts. Often, we are not aware of our thoughts and beliefs because they are so automatic and happen quickly. But they are there, and they affect the way we feel.

Why do I feel Distressed?

We've talked about the way our thoughts affect how we feel. If we are feeling happy and excited, chances are we have been thinking positive thoughts and about positive things. On the other hand, if we are feeling anxious, depressed,

and upset, it is very likely that we have been thinking negative thoughts. We call these unhelpful thoughts (simply because they lead to unpleasant feelings or unhelpful actions!). All of us, at times, think things that make us feel sad or anxious, and that is a normal part of life. However, if you often feel distressed or upset, you might need to examine your thinking in order to improve how you feel.

Feelings are not Thoughts

When we first try to distinguish thoughts from feelings, it can be easy to confuse them. We might be used to talking about thoughts and feelings as being part of the same experience, but it is more helpful to separate them and remember that feelings are not thoughts. For example, you might hear a person saying "I think I'm anxious," but they're probably thinking "Everyone will laugh at me," and feel anxious. More commonly, you might hear someone saying something like "I feel that my boyfriend doesn't appreciate the gift I bought for him," when they are actually thinking "My boyfriend doesn't appreciate the gift I bought for him," and feel hurt.

Unhelpful Thinking Styles

What sorts of thoughts are unhelpful? Unhelpful thoughts are those that tend to focus on the negative aspects of a situation, or those that overestimate the chances of a negative event occurring, or those that place unrealistic demands on yourself or others. These are also often known as unhelpful thinking styles

because they are patterns of thinking that have become a habit and contribute to a person feeling unhelpful negative feelings.

What Can I Do?

Plenty! There are lots of things you can do to help yourself feel better, and this next suggestion has been proven to be pretty effective. If unhelpful thoughts lead to distressing emotions, then it might be quite reasonable to say that the most effective thing to do would be to change those unhelpful thoughts to helpful ones!

Yeah? Okay, so, how can you do that?

First, identify how or what you are feeling. Then, ask yourself "What am I thinking? What conclusions am I making?" to see how and why you are feeling distressed. Remember, unhelpful thoughts will lead to you feeling upsetting emotions.

The next step is to challenge your thinking by exploring other possible explanations and looking at a situation from different points of view. You might ask yourself, "What other ways are there of viewing this situation? How might someone else view this situation? What other explanations could there be?"

The final step is to ask yourself, "How can I revise my original thoughts to take into account these other possible viewpoints?" Then, think of an alternative explanation. This becomes your new, balanced, and helpful thought. A balanced and helpful thought or belief is one that takes into consideration alternative

viewpoints and helps you feel better. Replace your original, unhelpful thought with this new, balanced, and helpful belief. Once you have done this, you will probably find that you feel better and your mood will be improved.

Behavioral Activation: Fun and Achievement

(CCI, 2019)

The symptoms of depression such as tiredness, lethargy, loss of interest, loss of motivation, loss of pleasure, and indecisiveness can lead to inactivity, and this often keeps the depression going or even make it worse.

Also, because of the lack of motivation, a depressed person might begin to neglect everyday tasks and responsibilities at work or at home, and the list begins to pile up. As such, when a depressed person thinks about the things they have to do, they might feel overwhelmed by the pile of things they have put off doing. This might result in them feeling guilty or thinking that they are ineffective or even, a failure. This will also worsen the depression.

Increasing Your Activity Level

One of the ways of overcoming depression is to increase your level of activity. There is a lot of evidence that shows that the more people do, and the more pleasant activities they get involved in, the better they feel. Becoming more active has a number of advantages:

Activity help you to feel better At the very least, when you start engaging in some kind of activity, it gives your mind something else to think about—a different focus. Doing things, even a little at a time, can help give you a sense that you are moving forward, taking control of your life again, and achieving something- experiencing a sense of MASTERY. You may even find PLEASURE and enjoyment in the activities you do.

Activity helps you to feel less tired. Usually, when you are physically tired, you need rest. However, when you are depressed, the opposite is true. Sleeping more and sitting around doing nothing will only cause you to feel more lethargic and tired. Also, doing nothing leaves room for your mind to ruminate on depressive thoughts, which will make your feel even more depressed.

Activity can help you think more clearly. Once you get started, you may find that you take a different perspective on particular problems in your life. Also, because your mind takes a different focus as a result of the activity, your thoughts may become clearer.

Fun and Achievement

It makes good sense to do fun and pleasurable things to make yourself feel better, but these are not the only sorts of activities that will help generate positive feelings. Being depressed isn't just about feeling sad - there are a lot of other feelings involved as well, such as hopelessness, guilt, and despair. So, it also

makes sense to do things that result in other positive feelings, such as achievement and a sense of purpose. When you are planning things to do for yourself, it is important to remember to include a mixture of activities, adding those that have the potential to give you other positive feelings. An example of this is paying off money on your credit card, or doing the ironing. Doing these things can help you feel more in control of your life (e.g., paying off your debts) and give you satisfaction that you have started doing something (e.g., catching up on household chores). Doing tasks that give you a sense of achievement or mastery will help you feel like you are starting to get back on top of things again. Some activities may combine the two. For example, making your bed may give you a sense of pleasure at having a neat, tidy bed, but it may also give you a sense of achievement at having done something to improve your home environment. This sense of achievement is just as important as getting pleasure out of something and may indeed prompt you to do more.

Start Simple

ven though there are a number of advantages in increasing your activity level, it may not be easy to get started. Often, this is because when you are depressed, you think negative thoughts such as "I won't enjoy doing this," or "It's too hard," or "I'll probably fail at this too." These thoughts may stop you from getting started. Often the big mistake people make is trying to do too much too soon. When you are depressed, things that you usually don't even have to think about doing (when you are not depressed) can seem to require a huge amount of

effort. The idea is to start with small easy steps and begin with things you can do. Think of it in terms of training for a sports event.

If you hadn't been doing any running for 6 months, would you try and run a marathon without doing any training? Of course not! You would go on a training programme that slowly builds up your fitness and endurance. Similarly, when you are depressed, it is unreasonable to expect yourself to be able to jump out of bed and clean the house before going out to meet a friend for a late lunch. If you set your goals too high, you might end up not doing them, become disappointed in yourself, and feel worse than ever. Instead, plan to do things that are achievable at your current level of functioning. Start with small steps and slowly build yourself up to the large tasks that seem unmanageable right now. For example, aim to get out of bed for 10 minutes, then slowly build up the amount of time you are out of bed for. Don't try to clean the whole kitchen - just aim to do the dishes. If this is too much, just stack all the dirty dishes in a pile. Aim to get one bench top clean, or just wash 5 plates. Any task can be broken down into smaller and smaller steps until you find something achievable.

Sometimes it is easier to aim to do a task for a set period of time rather than trying to achieve a set amount. Read a book for 5 minutes rather than reading a whole chapter. Say you will spend 10 minutes weeding the garden rather than aiming to weed a certain area. In this way, it will be easier for you to achieve your goal. In the beginning, the important thing is not what you do or how much you do, but simply the fact that you are DOING. Remember that action is the first step, not motivation, and you'll soon find yourself feeling better!

Bipolar Disorder Treatment

The following is used by permission from the Centre for Clinical Interventions (CCI, 2019). CCI provides extensive research and resources for clinicians and patients; however, they do provide the disclaimer that the information provided is for informational purposes only.

<https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Bipolar-Disorder>

Medical Treatments

Social Workers and other Therapists may refer those receiving treatment to a Medical Doctor so it may be determined if a medical intervention may be helpful. Actually prescribing medications, or telling a patient they need medication, is out of the scope of practice for social workers and therapists without a medical degree which legally permits them to prescribe and provide such care. Although not allowed to prescribe, since some or many people receiving therapeutic services may be receiving medication to augment their treatment, it is important for helping professional have an awareness of the medications and have some level of understand of how they work and potential side effects.

The recognized standard treatment for bipolar disorder is medication, which focuses on controlling or eliminating the symptoms and then maintaining the

symptom-free state by preventing relapse. The effective use of medication requires that the patient work closely with their medical practitioner. Some patients may respond well and experience few side effects with one type of medication, while others may do better with another. Thus, when taking medication, it is important that the patient/client monitor its effects and consult with a doctor.

Principles of Medication Management

1. For medication to be of benefit, they should carefully follow the prescribed treatment and take note of your symptoms and side effects.
2. If side effects develop, these should be reported to your doctor as soon as possible to avoid prolonged discomfort. It is strongly advised that you do not stop medication abruptly before first consulting with your doctor. This could bring on a return of a manic or depressive episode.
3. Alcohol, illicit medications, and other prescribed medicines may cause your medication for bipolar disorder to be ineffective and may increase side effects. You should report all other medications and substances you are taking to your doctor to ensure that none adversely interact with the medication prescribed for bipolar disorder.
4. Effective medical management of bipolar disorder requires you to monitor your symptoms and side effects, and work with your doctor to adjust dosages or types of medications.

Phases of Treatment

There are usually three phases to medical treatment for bipolar disorder. The most important aim, if they are experiencing an episode of mania, hypomania, or major depression, is to control or eliminate the symptoms so they can return to a normal level of day-to-day functioning. The duration of this acute phase of treatment may last from 6 weeks to 6 months. Sometimes, longer periods are necessary in order to find the most effective medications with minimal side effects.

In continuation treatment, the main aim is to maintain the symptom-free state by preventing relapse, which is the return of the most recent mood episode.

The third phase, the maintenance phase, is critical and essential for all patients with bipolar disorder. The goal for maintenance treatment is to prevent recurrence, that is, to prevent new episodes of mania, hypomania, or depression from occurring. For bipolar patients, as with other medical conditions such as diabetes or hypertension, maintenance treatment may last 5 years, 10 years, or a lifetime. But remember, prolonged symptom control will help them to function better in their daily lives.

For all phases of treatment and all medications, patients must take the prescribed medications on a daily basis. Unlike medications like paracetamol or antibiotics that are taken only when a person actually experiences a headache or

has the 'flu, medications for bipolar disorder must be taken regularly - on both good days and bad days - at the same dosage.

Types of Medication for Bipolar Disorder

Mood Stabilizers

A mood stabilizer is a medication that is used to decrease the chance of having further episodes of mania or depression. They are the first line agents for bipolar disorder. Depending on the associated symptoms with this disorder, anti-depressants or antipsychotics may also be used.

A mood stabilizer is given to a person as a maintenance medication because it regulates mood swings, but doesn't take away the cause. Feeling well does not mean a person can stop taking mood stabilizers, it means the medication is keeping them stable.

The most common mood stabilizers are Lithium Carbonate Carbamazepine, and Sodium Valproate. Sometimes these medications are used on their own or in combination with other medications.

Antidepressants

Antidepressants can also be used with mood stabilizers in the acute, continuation, and/or maintenance phases of medical treatment. There is no one particular antidepressant that is more effective than the others in bipolar disorder. In fact, there is a significant risk for antidepressants to induce or cause a "switch"

to manic or hypomanic episodes, especially if a patient on antidepressants is not taking a mood stabilizer.

Common antidepressants include:

- Selective serotonin reuptake inhibitors (SSRIs) - fluoxetine, paroxetine, sertraline
- Tricyclics - imipramine, amitriptyline, desipramine, dothiepin
- Monoamine reuptake inhibitors (MAOIs) - phenelzine and tranylcypromine

Antipsychotic Medication

Antipsychotics may also be used both in the acute phase of the disorder and sometimes as a longer term treatment.

Common antipsychotic agents include haloperidol, chlorpromazine, thioridazine, risperidone, and olanzapine. These medications are often combined with mood stabilizers to assist in controlling hallucinations, or delusions, to induce sleep, to reduce inappropriate grandiosity, or decrease irritability or impulsive behaviors.

These medications are usually not used for treating hypomania. Although antipsychotics are most often used in treatment of the acute phase of mania, some patients may continue on smaller dosages to ensure that they do not experience a relapse of psychotic or manic symptoms.

Another often used medication is clonazepam, which is classed under the benzodiazepines. This is used as an adjunct with other medications (mood stabilizers and antipsychotics) to aid in inducing sleep, reducing psychomotor agitation, and slowing racing thoughts and pressured speech.

very important with Remember your that it is very important patients/clients talk openly with their prescribing doctor or psychiatrist, and not to stop their medication without first discussing it with them. (CCI, 2019)

Psychosocial Treatments

Although effective medications have been found for bipolar disorder, many patients still experience episode recurrences and relapse. Some experience between-episode symptoms that may not be serious enough to be considered a full-blown episode, but could still cause some discomfort and interference with day-to-day activities. A high rate of relapse and episode recurrences could be because of medication non-compliance, alcohol and drug use, high stress levels, many between-episode symptoms, and poor daily functioning. These issues have alerted mental health professionals to try psychotherapy and psychosocial interventions, in addition to medication, to improve illness outcome and quality of life for bipolar patients.

Cognitive Behavioral Therapy

A treatment approach that has been well researched for a wide range of adult psychiatric disorders is cognitive behavioral therapy (CBT), which has recently been adapted to bipolar disorder. Although CBT for bipolar disorder is relatively new, it has been used in the treatment of a range of psychiatric disorders including unipolar depression, generalized anxiety disorder, panic disorder, social

phobia, and eating disorders. It has also been applied as an adjunctive treatment for disorders such as obsessive-compulsive disorder, personality disorder, and schizophrenia.

CBT is a structured and time-limited intervention. It is a comprehensive psychological therapy in which there is an emphasis on collaboration between therapist and patient, and on active participation by the patient in achieving therapeutic goals. CBT is also focused on problem solving. The central aim of CBT is to teach patients how their thoughts and beliefs play an important role in the way they respond to situations and people. The CBT approach also teaches patients the tools that could help them to make their response more helpful.

CBT can play a role in teaching bipolar patients about their disorder and helping them deal with adjustment difficulties. CBT can also help patients cope with everyday stressors through active problem-solving, and teach patients to monitor and regulate their own thoughts, moods, and activities, and thus be prepared to manage between-episode symptoms.

Research at the Centre for Clinical Interventions

CBT for bipolar disorder has been evaluated in a controlled trial here at the Centre for Clinical Interventions. The results of our study showed that CBT for bipolar disorder was effective in helping patients feel less depressed and more confident about managing their illness. While this type of psychosocial treatment is still being evaluated worldwide, preliminary results from a number of studies have been positive. (CCI, 2019)

As per the case of Depressive Disorder, treatment with medicine alone is not always an effective method to control Bipolar Disorder. In fact, patients may have a recurrence of the illness even when they maintain a dosage of common drugs for Bipolar Disorder like Lithium. There are several different types of evidence which show that some form of psychosocial therapy and intervention is required to enhance the effects of the medicine and to make the treatment last longer. Commonly accepted psychosocial therapies like interpersonal therapy, family oriented therapy and cognitive behavior therapy are therefore necessary for the treatment of Bipolar Disorder.

It was previously thought that patients with Bipolar Disorder could not benefit as much as patients with Depression since bouts of mania would greatly interfere with the therapy process. The latest research on the subject considers other factors like family support, CBT and monitoring of the patient as elements of psychosocial therapy which can act as effective counters to the impulsive behavior or uncooperative mood of a person suffering from BD. Additionally, it was found that patients (especially children) could continue learning, engage in active discussion, and make self-assessments if provided sufficient guidance from family members.

With Bipolar Disorder, family therapy becomes particularly important because, along with the individual, the whole family may suffer the effects of the disease since the social relationships of the patients are affected quite negatively. The role of the social worker or the nurse in such situations is to provide assistance, education and guidance as much as possible. Nurses and social workers are often recruited by doctors to provide certain assistance in the course of such psychotherapies for monitoring the progresses the inpatient in outpatient or inpatient settings. The cognitive therapy for Bipolar Disorder teaches the patient to recognize when they are going through one of their depressive or manic phases and how they can control their thoughts to control their behavior.

The process of education about the disease for the patient, as well as the family of the patient, helps them recognize patterns of behavior which can be adjusted over time. Additionally, the family members need to be watchful of any signs of relapse or fresh symptoms which show that the help being given is not sufficient. In such situations, additional therapy could be recommended, or a change in medication might be ordered by the doctors to ensure that the fresh symptoms do not evolve into a full episode. Moreover, psychosocial therapy is often more cost effective than medical or surgical procedures for combating mood disorders. Some are convinced that psychosocial therapy saves lives for patients suffering from mood disorders since they give a patient hope and understanding. The suicide rate for patients with mood disorders is quite high and if the mood disorder is detected and cured, the therapist gets the credit for saving a valuable

life as much as any doctor or nurse who saves a life in the emergency room or on an operating table. Additionally, psychotherapy for the treatment of Bipolar Disorder allows family members of the patient to play a part in the recovery process which reduces their feeling of helplessness and prevents the creation of guilt. Both Clinical Depression and the Bipolar Disorder can be helped with psychosocial treatments which include the following:

- Helping the patient as well as the family of the patient understand the disorder, its causes and symptoms.
- Monitoring the changes in the mood of the patient, the feelings of the patient and sleep patterns.
- Teaching the patient and concerned parties how to cope with the stress of the disease and reduce the effect of other stressors which can make the condition worse.
- Helping the patient manage his/her relationships to avoid/reduce the difficulties associated with decisions made or actions taken during a depressive or manic episode.
- Allowing patients to share experiences and offer helping hands in situations where group therapy is prescribed
- Offering an alternative to the patients for whom the side effects of pharmacological treatments are difficult to manage or for those who can not have pharmacological treatment at all.

Summary

Because bipolar patients experience episode recurrences and some difficulty in everyday living, some form of psychosocial treatment is recommended as an addition to medication. Recent research has found that cognitive behavioral therapy for bipolar disorder appears to be beneficial for patients. However, bipolar patients are reminded that this is an adjunctive treatment and must not be considered as a substitute for medication. (CCI, 2019)

Chapter 5: Conclusion--Reducing the Stigma

An important role played by nurses and social workers in psychosocial therapy, as well as the treatment of other mental illnesses, is trying to reduce the social stigma associated with mood disorders. **One of the main methods with which the stigma can be reduced is through the creation of a therapeutic alliance.**

The concept of this sort of alliance between nurse and the patient is greatly appreciated by Safran and Segal (1990), and they recommend an educational/support system to be created between the patient and the other professionals involved in the care.

The concept of social support against the negative influences of mood disorders is certainly not a new thought since Cole (2006) reports that as early as 1912 Sigmund Freud considered a healthy relationship between the analyst and client to be positive. Freud called it a working alliance for mental health. The humanist therapist, Carl Rodgers took the concept to a higher level when he called it

necessary as a support tool and *essential* for the growth and improvement of the client's condition. The development of ethical principles for the bond between the caregiver and receiver were defined by the Association for the Advancement of Behaviour Therapy (AABT) and these rules safeguard the interests of both the client and the nurses involved in the treatment (Cole, 2006).

Therapeutic Alliances

The role of the nurse in removing the stigmatisation and exclusion of the patient is not a static function since it changes dynamically based on the situation the nursing staff find themselves to be in. For example, a nurse may have to gently ask a patient to come back to her room while the patient wishes to be outside. A social worker may have to explain to the children of the patient why their father or mother is behaving in a way which is clearly strange and hard for them to understand. Since it is not possible for a professional to be present and to handle the same patient round the clock, the relationship builds with time and it can also fall. A person working with the patient might have limited time in which to make a connection, therefore the time spent with the patient should be utilised to learn from the patient and to understand how the patient deals with their situation, as well as what health care providers can do to help with the recovery process.

Mainstreaming

While the idea of creating separate hospitals for the patients who have psychological or mental disorders is losing its appeal, mainstreaming is still not the singular system under which all mood disorders can be treated. Happell (2005) makes the recommendation that the same standards of treatment should be maintained for those individuals who seek mental care as the standards for those people who are physically ill. The idea of universal health care at the highest level as a fundamental human right is not merely an idyllic dream; it is a philosophy which everyone connected with social services should strive for.

While it is comparatively easy to change the policies involved in the delivery of health services, it is rather more difficult to change the attitudes and the beliefs of people about individuals who need assistance with mental health problems. Even close family members can react negatively to a patient having a relapse with statements that reflect their annoyance. Going with the descriptions of mental health patients as presented in the general media, these attitudes might be even harder to change than previously thought.

Educating Everyone

The only way to overcome the fear, loathing and discrimination against people with mood disorders is to use the tool of education. Professionals must undertake the process of educating the patient's relatives, hospital staff and even the general population about the problems and issues faced by those suffering from

mood disorders and bring them out of the stigma given to them by society. In absolute terms, these individuals are no different from those who have a physical disability or a medical condition such as diabetes, but while there are support networks and special interest groups looking out for the benefit of those who are physically ill, very few patients with mental disorders or disabilities can find support around them.

Nurses and others are in a special position to educate others as much as they can with regard to the care and treatment of patients with mood disorders. This might mean taking additional courses, attending seminars or even interacting with the patients when they are placed on rotation. Working directly with such patients is a continual learning experience as well as a very rewarding experience that can only lead to the personal development and improvement of the individual nurse. Similarly, social workers can also help the cause for all patients with mood disorders if they can bring an understanding of the disease for themselves as well as others.

Bibliography

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing
- Centre for Clinical Interventions, (2019) Bipolar Disorder. Retrieved from the CCI website: <https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Bipolar-Disorder>
- U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015). Depression (NIH Publication No. 15-3561). Bethesda, MD: U.S. Government Printing Office.
- Bland, R. (1997). Epidemiology of Affective Disorders: A Review. *Canadian Journal of Psychiatry*, 42(1), 367–377.
- Cole, M. (2006). Power over therapy? *Mental Health Practice*, 9(9), 28-32.
- The Nobel Foundation. (2005). *Egas Moniz*. Retrieved October 13, 2006 from NobelPrize.org website: <http://nobelprize.org/medicine/laureates/1949/moniz-bio.html>