Bipolar and related disorders

Revised

Characteristics

Definitions and types

The term '**affect**' relates to mood or feelings. A person with depression will have intense feelings of negativity or despair, while a person who is manic will have intense feelings of happiness and 'over-activity'. A person can have **depression (unipolar)** or they can be **bipolar** which is the alternative name for manic depression, where a person has swings of mood from one extreme to the other.

Abnormal affect concerns disorders of mood and emotion, most typically depression and mania or manic depression (bipolar disorder).

Features of **depressive episodes** include:

- physically lethargic; a loss of energy
- loss of interest; feelings of unhappiness, inadequacy, worthlessness; possibly thoughts of suicide
- continual urges to cry
- difficulty in concentrating and an inability to think positively, often with hopeless feelings of guilt
- difficulty in sleeping; possible loss of appetite and weight; avoiding other people.

Common misconception

Many students think 'abnormal affect' is a generalised term that concerns all 'abnormal' disorders. It does not. It concerns disorders of mood or feelings.

Features of **manic episodes** include:

- feeling very excited; having lots of energy and enthusiasm
- quickly moving from one thing to another; spontaneous and full of good ideas
- outbursts of exuberance, heightened good humour; often entertaining those present
- talking quickly; feeling less inhibited; making spur-of-the-moment decisions.

Measuring depression

The **Beck depression inventory** (BDI) is a 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression. Originally devised in 1961, the latest version is BDI-II (1996). It is scored on a 4-point scale from 0 (symptom is absent) to 3 (symptom is severe). Scores can range from 0 to 63 with a score over 40 indicating extreme depression. Typical questions are:

0 – *I do not feel sad*
1 – *I feel sad*
2 – *I am sad all the time and I can't snap out of it*
3 – *I am so sad and unhappy that I can't stand it*

0 – *I am not particularly discouraged about the future*
1 – *I feel discouraged about the future*
2 – *I feel I have nothing to look forward to*
3 – *I feel the future is hopeless and that things cannot improve*

Evaluation

- There is **cultural bias** because definitions of depression are based on the *DSM* and the cultural norms of the USA (*weakness*). The BDI is also based on US culture (*weakness*).
- The BDI is a **psychometric test**. It is **reliable** and **valid.** It gathers **quantitative data** only. (*Strengths and weaknesses for all.*)

Cross check

Cultural bias, page 88
Psychometric tests, page 89
Reliability, page 66
Validity, page 67
Quantitative data, page 60

Explanations of depression

Biological (genetic and neurochemical) explanations: depression may be genetic. The closer the genetic relationship, the more likely people are to be diagnosed with depression. First-degree relatives (close family members) share

50% of their genes and according to **Oruc et al.** (1998), first-degree relatives of people diagnosed with depression are significantly more likely to be diagnosed with depression than non-first-degree relatives.

Depression may be caused by **neurochemicals**. Schildkraut (1965) suggested that too much noradrenaline causes mania and too little causes depression. However, serotonin was found to exist in low levels for both depression and mania. What is known is that both serotonin and noradrenaline imbalances are involved in affective disorders.

Cognitive explanation: Beck (1979) proposes a cognitive theory, believing that people react differently to aversive stimuli because of the thought patterns that they have built up throughout their lives. Schemas (core beliefs) are formed in early life, for example a self-blame schema makes the person feel responsible for everything that goes wrong, while an ineptness schema causes them to expect failure every time. These predispose the person to have negative automatic thoughts (NATs), but they will only surface if an event triggers them. When that happens, cognitive errors maintain the negative beliefs. Depression results from the negative cognitive triad, comprising unrealistically negative views about the self, the world and the future.

Learned helplessness/attributional style: Seligman et al. (1988) extended the original theory of learned helplessness, suggesting that a person's attributional style determined why people responded differently to adverse *situational* events. If a person makes an internal attribution (they are the cause), and if they believe that this is stable and global (the cause is consistent and this applies everywhere), then they may feel helpless and may experience depression. However, if they make other attributions (e.g. that the cause is external or situational; or unstable and specific), then helplessness and depression are unlikely. Attributional style is assessed using the **attributional style questionnaire** (ASQ). Seligman and others have found depression to be associated with an internal/global/stable pattern. After therapy, depression is again assessed and the attributional style is indeed less internal/global/stable.

Expert tip

Many students write 'X is reductionist' without further elaboration or explanation. Doing this will score no marks. An explanation is needed of why 'X' is reductionist along with a strength or weakness of reductionism.

Cross check

Nature–nurture debate, page 75
Determinism, page 90
Reductionism, page 89
Individual–situational debate, page 74

Evaluation

- The **nature–nurture** debate is applicable here (*strengths and weaknesses*) because the extremes of genetics (nature) and nurture (learning) are shown by Oruc et al. and Seligman.
- Each explanation is **reductionist**, focusing on one aspect only (*strengths and weaknesses*).
- **Determinism** also applies (*strengths and weaknesses*), because any genetic explanation is 'biological determinism'.
- The **individual–situational** debate applies (*strengths and weaknesses*) because genetic and cognitive explanations focus on the individual whereas for Seligman situational factors play a role.

Expert tip

Many students refer to 'anti-depressants' to cover a wide range of drug treatments (including those for schizophrenia). It is far more accurate to refer to the drug type (e.g. SSRIs) and then apply it to treating depression, obsessive–compulsive disorder, etc.

Treatment and management of depression

Biochemicals: there are three main types of drug that relieve the symptoms of depression:

- **MAOIs** (monoamine oxidase inhibitors, e.g. Marplan, Nardil, Parnate, Emsam)
- **SSRIs** (selective serotonin reuptake inhibitors, e.g. Citalopram, Escitalopram)
- **SNRIs** (serotonin and noradrenaline reuptake inhibitors, e.g. Venlafaxine, Duloxetine)

Anti-depressants affect neurotransmitters. Those relevant to depression are serotonin and noradrenaline. SRRIs inhibit serotonin and SNRIs inhibit both serotonin and noradrenaline. MAOIs inhibit a wider range of neurotransmitters such as adrenaline and melatonin in addition to serotonin and noradrenaline. Anti-depressants do not remove the *cause* of depression but instead relieve the symptoms.

Now test yourself

10 Outline the drug treatments used for depression.

Answer on p. 197

Tested

Cross check

'Strengths and weakness' of changes, page 96

Electro-convulsive therapy (ECT) was originally developed as a treatment for schizophrenia in 1938 by Cerletti. In its early days it was given bilaterally, where electrodes were placed on each side of the patient's head. ECT is now used to treat severe depression when other treatments are ineffective. A patient is given a general anaesthetic (unlike in the early days) and an electrical pulse is given to the head. Bilateral ECT (both sides of the head) is more common as this is more effective than unilateral ECT. Some patients are confused afterwards and some suffer memory problems.

Strengths of using ECT

- It has a higher success rate for depression than any other treatment.
- ECT is immediate, quicker than taking anti-depressants or any other form of treatment.
- It can be applied to anyone without restriction (some people cannot take anti-depressants because of side-effects).

Weaknesses of using ECT

- ECT is not a permanent solution; people often relapse so either follow-up ECT is needed or it is used alongside other treatments (such as anti-depressants).
- ECT has short-term side-effects: confusion and memory loss.
- ECT has long-term side-effects, sometimes severe, such as permanent memory loss, loss of skills or a change in personality.

Cognitive restructuring: Beck et al. (1979) believe in cognitive restructuring. This is done in a six-stage process, starting with an explanation of the therapy. Next the person is taught to identify unpleasant emotions, the situations in which these occur and associated negative automatic thoughts. Then the person is taught to challenge the negative thoughts and replace them with positive thoughts. Finally, the person can begin to challenge the underlying dysfunctional beliefs before the therapy ends. Dobson (1989) compared restructuring scores on the **Beck depression inventory** (BDI) with other treatments: 98% were better than controls; 70% better than those in anti-depressant drug treatments; and 70% better than those in some other form of psychotherapy.

Rational emotive therapy: Ellis (1962) outlined rational emotive therapy, which developed into **rational emotive behaviour therapy** (REBT). Ellis focused on how illogical beliefs are maintained through:

A: an **a**ctivating event, perhaps the behaviour or attitude of another person
B: the **b**elief held about A
C: the **c**onsequences – thoughts, feelings or behaviours – resulting from A.

Ellis described the illogical or irrational beliefs using the terms **musterbating** (I *must* be perfect at all times) and **I-can't-stand-it-itis** (the belief that when something goes wrong it is a major disaster). In order to change to rational beliefs, Ellis expands the ABC model to include:

D: **d**isputing the irrational beliefs
E: the **e**ffects of successful disruption of the irrational beliefs.

Evaluation

- **Biomedical:** drug treatments and electro-convulsive therapy both have strengths and weaknesses.
- Different treatments reflect different **approaches** to mental illnesses (*strengths and weaknesses*).
- The issues of **nature–nurture**, **determinism**, **reductionism** and the **individual–situational** debate applying to the treatment and management of schizophrenia also apply here (see page 95).

Cross check

Treatment and management of schizophrenia: electro-convulsive therapy, page 96

Now test yourself

11 Outline the rational emotive behaviour therapy proposed by Ellis.

Answer on p. 197

Tested

Cross check

Strengths and weaknesses of drugs, page 96
Approaches to mental illness, page 92
Nature–nurture debate, page 75
Determinism, page 90
Reductionism, page 89
Individual–situational debate, page 74