Chapter 7
Affective disorders

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lectures and discussions, students should have an understanding of:

1. The common biological bases of major depressive disorder.
2. The nature, aetiology, and treatment of suicide.
3. The nature, aetiology, and treatment of seasonal affective disorder.
4. The nature, aetiology, and treatment of bipolar disorder.

CHAPTER OUTLINE

7.1 Major depressive disorder
- Aetiology of major depressive disorder
- Socio-economic status
  - Biological mechanisms
  - Socio-cultural factors
  - Psychodynamic explanations
  - Behavioural explanations
  - From behavioural to cognitive understandings
- Treatment of major depression
  - Biological interventions
    - Electrical stimulation
  - Psychological interventions

7.2 Suicide
- Aetiology of suicide
  - Socio-cultural factors
  - Psychoanalytic explanations
  - Cognitive explanations
- Treatment of attempted suicide

7.4 Seasonal affective disorder (major depressive disorder - seasonal pattern)

Aetiology of MDD-SP
Circadian hypothesis
Serotonin hypothesis
A psycho-biological model
Treatment of generalized anxiety disorder
Biological interventions
Psychological interventions

7.5 Bipolar disorder
Aetiology of bipolar disorder
Biological mechanisms
Psychoanalytic explanations
Cognitive models
Treatment of bipolar disorder
Lithium therapy
Cognitive behavioural approaches

QUESTIONS FOR DISCUSSION

These may helpful to include at the beginning of the teaching session to get a sense of where people lie on these issues, to spark some interest in them, and as a link to refer to as the lecture progresses.

1. Which of the following cognitive factors provides a long-term risk for depression?
    a. Inappropriate cognitive schema
    b. Inappropriate negative automatic thoughts
    c. Inappropriate contextual attributions

2. According to UK government guidelines, which of the following is now no longer considered to be an inappropriate treatment for severe depression?
    a. Psychotherapy
    b. SSRIs
    c. Electroconvulsive Therapy
    d. They are all acceptable treatments for severe depression

3. Which of the following statements is NOT true…

    a. Rates of suicide vary considerably across cultures and countries
    b. Rates of suicide are particularly high among young women

c. Rates of suicide are relatively high among people with gender or sexual issues
d. Rates of suicide are relatively high among people diagnoses with schizophrenia

4. Which of the following statements is NOT true?

a. Bipolar disorder has similar biological mechanisms to depression
b. Psychosocial factors are not important in bipolar disorder as its aetiology is primarily biological
c. The optimal treatment for the manic phase of bipolar disorder is similar to that of Attention Deficit/Hyperactivity Disorder
d. None of the above are true

LECTURE SUGGESTIONS

The lecture/chapter deals with depression. So, you may think that each of the conditions within the chapter have a similar aetiology and treatment. However, this is far from the case. Major depression is associated with serotonergic dysregulation, long term cognitive factors, and present contextual challenges. Suicide, while located in the chapter, is also strongly associated with conditions such as eating disorders, gender dysphoria, and schizophrenia. Seasonal Affective Disorder, while considered by DSM as a specific manifestation of major depression, actually seems to have a markedly different cause: dysregulation of circadian rhythms and hormones. Treatment involves the use of strong light to trigger appropriate rhythms.
Finally, bipolar disorder appears to be as much or more related to neuronal dysfunction as serotoninergic dysfunction. Treatment is largely a drug (lithium) aimed at remedying this dysregulation. So, each problem and its solutions are actually quite different, and while it is convenient to 'lump' them together into one lecture, we really are considering very different conditions in reality.

The final two conditions are particularly interesting in that they represent conditions whose primary aetiology appears to be biological, but to which cognitive or contextual factors have been 'bolted on'. For bipolar disorder, the psychological models appear to be alternative models to the biological: or as noted in chapter 1, provide an explanation at a different level. For SAD, the cognitive behavioural processes have been integrated within a larger biopsychosocial model to provide a truly integrative model.

CLASSROOM ACTIVITIES

Homework: we all have low moods at times, which, while not clinical depression, can reduce our engagement in activities ("couldn't be bothered"), meaning we don't enjoy things as much as we could and so on. It may be interesting to reflect on a time when people felt this way and consider why this happened and what they could have done to improve their mood or reduce its impact. Interestingly, the simplest way may well have been behavioural: engaging in activities

that are enjoyable, or which at least distract from negative thoughts. The ‘naïve’ strategy is less likely to be cognitive. So, what does this say about the treatment of depression for people who have more severe emotional problems?

Case discussion in pairs: Jon has phoned the Samaritans and is actively suicidal. He says he can see no way out of his problems - suicide may be his only solution. Clearly, by phoning the Samaritans, he is not fully committed to this action, but the nature of the phone call may determine his future actions. If you were on the phone, how would you manage this situation? How would you engage with him? What questions would you ask? Would you offer solutions, try to get him to see solutions, or just be empathetic? What issues may need to be explored and addressed in the longer term if he were to engage with some form of psychological counselling/therapy?

Small group discussion: if you were severely depressed, which option would you take: psychotherapy versus pharmacotherapy? Two sides – argue the case for each decision.