
UNIT 3 OTHER MOOD DISORDERS: MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

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3.0 INTRODUCTION

The depressive disorders are grouped under a category in the DSM-IV-TR called Mood Disorders. Included in this category are major depressive disorder, dysthymic disorder, bipolar disorder, cyclothymic disorder, mood disorder due a general medical condition and substance induced mood disorder. Two subtypes of mood disorders include seasonal affective disorder and postpartum depression, while premenstrual dysphoric disorder has been proposed as a diagnosis for further study. For each of these mood disorders there are specific criteria that a person's symptoms must meet in order to receive a diagnosis. Major depressive disorder, dysthymic disorder, bipolar disorder and cyclothymic disorder have been discussed in previous units. These disorders reflect a disturbance in mood or emotional reaction that is not due to any other physical or mental disorder. In the present unit we will discuss mood disorders that occur due to general medical condition such as cancer, diabetes, or a recent heart attack.

3.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain the nature of mood disorder due to general medical condition;
- Describe the diagnostic criteria for mood disorder due to a general medical condition;

- Analyse the differences between mood disorder due to general medical condition and major depressive disorder; and
- Explain the some of the major medical conditions that induce mood disorder.

3.2 MOOD DISORDER DUE TO GENERAL MEDICAL CONDITION

It has been estimated that approximately one of every ten major depressive episodes is caused by medical illness, substance abuse, or medication used to treat another disorder (Clinton, 1993). Almost one of every four hospitalised medical patients has depressive symptoms (Moldin, et. al. 1993). Approximately 27–57% of patients with certain neurologic conditions (e.g., Parkinson’s disease, multiple sclerosis, Huntington’s disease, and epilepsy) develop symptoms of severe depression at some point during their illness. For medical conditions that do not directly affect the brain, prevalence rates appear to be more variable, ranging from less than 8% (for chronic renal disease), to 19% (for coronary artery disease, to 40% (for primary hypothyroidism).

The diagnostic criteria for mood disorder due to a general medical condition are less vigorous than those for the primarily psychiatric mood disorders and require only the presence of depressed mood/diminished enjoyment or elevated, expansive, or irritable mood (manic symptoms). Regarding the medical illness, the required signs, symptoms, and laboratory findings are simply those that, in conjunction with the clinical history, yield the medical diagnosis.

According to Diagnostic of Statistical Manual of Mental Disorders- Fourth Edition-Text Revised the diagnosis of mood disorder due to general medical condition is done when:

- a) the person has significant disturbance in mood that includes either (or both) of depressed mood or significantly reduced level of interest or pleasure in most or all activities, mood that is euphoric, heightened, or irritable,
- b) the person’s symptoms are directly related to the presence of a medical condition,
- c) another disorder does not better explain the mood disturbance,
- d) the mood condition is not present only when a person is delirious
- e) the symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) further specifies that the psychiatric presentation of a medical illness is classified as “the presence of mental symptoms that are judged to be the direct physiological consequences of a general medical condition.”

Therefore, understanding common psychiatric symptoms and the medical diseases that may cause or mimic them is of utmost importance. Failure to identify these underlying causal medical conditions can be potentially dangerous because serious and frequently reversible conditions can be overlooked. Major Depressive, Manic, Mixed, and Hypomanic Episodes in Bipolar I Disorder must be distinguished from episodes of a Mood Disorder Due to a General Medical Condition.

The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are judged to be the direct physiological consequence of a specific general

medical condition (e.g., multiple sclerosis, stroke, hypothyroidism). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is diagnosed.

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve

- depressed mood
- markedly diminished interest or pleasure
- elevated, expansive, or irritable mood.

Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met.

The predominant symptom type may be indicated by using one of the following subtypes:

- With Depressive Features,
- With Major Depressive–Like Episode,
- With Manic Features, or
- With Mixed Features.

There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition. The mood disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder with Depressed Mood that occurs in response to the psychosocial stress of having the general medical condition).

The diagnosis is also not made if the mood disturbance occurs only during the course of a delirium. The mood disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. In some cases, the individual may still be able to function, but only with markedly increased effort. In determining whether the mood disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition.

Further, the clinician must establish that the mood disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the mood disturbance and the general medical condition is etiological, several considerations provide some guidance in this area.

One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the mood disturbance.

A second consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at onset or course or absence of family history).

Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of mood symptoms can provide a useful context in the assessment of a particular situation.

In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Mood Disorder, a Substance-Induced Mood Disorder, or other primary mental disorders (e.g., Adjustment Disorder).

The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions...sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide.

The manic symptoms experienced during mood disorder due to a general medical condition are the same as those experienced during other manic episodes...elation, confidence, delusional thinking, high level of energy, increased activity, productivity, loud and rapid speech, racing thoughts, risky behaviour, impulsive behaviour, increased sexual behaviour, over spending, fast reckless driving, wild business schemes, overeating, drinking too much, irritability, anger, and agitation.

There are a large number of medical conditions which can cause mood disorder due to a general medical condition. Some of the major medical conditions which can cause a mood disorder due to a general medical condition are discussed below:

3.2.1 Parkinson's Disease

Parkinson's disease (PD) is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra. It is estimated that Parkinson disease affects approximately 1% of the population older than 50 years and up to 2.5% of the population older than 70 years (National Institute of Neurological Disorders and Stroke, 2001). The hallmark clinical signs of the motor triad include (1) tremor (2) rigidity, and (3) bradykinesia/akinesia.

The classic motor signs may not be obvious early in the disease, and patients may initially present with only clinical signs of depression. Thus, PD may be misdiagnosed as a primary depressive illness, and concomitant depression may remain undiagnosed in a patient with PD. Similarities in the symptoms common to major depression and PD include impaired memory/concentration, slowed psychomotor activity, restricted affect, and fatigue or decreased energy.

The true prevalence of depression among people with Parkinson's disease is difficult to determine because there are no standardised assessment tools designed to evaluate depressive symptoms in the context of this illness. However, it is estimated to be quite common as many as half of people with Parkinson's may suffer from depression (Working Group Meeting of National Institute of Neurological Disorders and Stroke, National Institute on Aging, and National Institute of Mental Health 2001).

Most treatments are aimed at patients' specific symptoms. PD must be considered in the differential diagnosis of an elderly person presenting with first-time depression/anxiety symptoms, especially when the patient appears depressed but denies experiencing a depressed mood. In addition, treatment of symptoms can be complicated in patients with PD because antiparkinsonian drugs may exacerbate psychiatric symptoms and vice versa. Consultation with both neurologists and psychiatrists can be helpful when treating these patients.

3.2.2 Multiple Sclerosis

Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system. Prevalence is estimated to be approximately 50 cases per 100,000 people. It is more common in women than in men and usually manifests in persons aged 20-40 years. This disorder is a highly variable illness, with differences among patients and changes within a patient over time.

Behavioural symptoms in multiple sclerosis include personality changes and feelings of euphoria and/or depression. Approximately 25% of patients experience euphoria that is different from hypomania and is characterised by an unusually cheerful mood. One study showed a 2-fold increase in the lifetime risk of bipolar disease in MS patients. Major depression is very common in individuals with MS; indeed, 25-50% of patients experience major depression after the onset of multiple sclerosis. Suicide attempts are common in patients with multiple sclerosis who are depressed. For treating the depression a combination of psychotherapy and medication is found to be useful.

3.2.3 Seizure Disorder

Epilepsy is one of the most common chronic neurologic diseases, affecting approximately 1% of the US population. Approximately 30-50% of patients with a seizure disorder have psychiatric symptoms sometime during the course of their illness. Psychiatric symptoms can be viewed in the context of their time relationship with the seizures as preictal, ictal, postictal, and interictal. Two major categories of seizures are partial and generalised. Increased psychopathology has been associated with different features (eg, seizure phenomenology, brain pathology, antiepileptic drug use, psychosocial factors). Generalised seizures simultaneously involve both cerebral hemispheres, with classic symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours. Partial seizures have focal signs and symptoms resulting from electrical discharge in a limited site in one brain hemisphere. Simple partial seizures occur without any impairment of consciousness and usually stem from primary motor, sensory, or visual cortical regions. Complex partial seizures are associated with impairment of consciousness and usually originate from a focus in the temporal lobe. In such seizures, psychiatric signs abound, with memory dysfunction, affective auras, perceptual changes (eg, hallucinations), and depersonalisation.

An estimated average, 10% of patients with complex partial epilepsy have psychotic symptoms such as paranoid ideation, thought disorder, and hallucinations. Mood disorder symptoms occur most often with foci in the temporal lobe. Statistically, 30% of patients with epilepsy have a history of suicide attempts, which attests to the importance of diagnosing depression in these patients. Fear and anxiety are the most common ictal affective states. As far as treatment of depression of patients suffering from seizure disorder is concerned psychotherapy such as cognitive behavioural therapy is generally recommended.

3.2.4 Diabetes

Diabetes is a disorder that impairs the way the body uses digested food for growth and energy. Most of the food we eat is broken down into glucose, a form of sugar that provides the main source of fuel for the body. After digestion, glucose passes into the bloodstream. Insulin helps glucose get into cells and converts glucose to

energy. Without insulin, glucose builds up in the blood, and the body loses its main source of fuel.

In **type 1 diabetes**, the immune system destroys the insulin-producing beta cells of the pancreas. This form of diabetes usually strikes children and young adults, who require daily or more frequent insulin injections or using an insulin pump for the rest of their lives.

Type 2 diabetes, which accounts for about 90 percent of diabetes cases in the United States, is most common in adults over age 40. Affecting about 6 percent of the U.S. population, this form of diabetes is strongly linked with obesity (more than 80 percent of people with type 2 diabetes are overweight), inactivity, and a family history of diabetes. People with type 2 diabetes first develop insulin resistance, a disorder in which muscle, fat, and liver cells do not use insulin properly. At first, the pancreas produces more insulin, but gradually its capacity to secrete insulin falters, and the timing of insulin secretion becomes abnormal. After diabetes develops, insulin production continues to decline.

Studies suggest that individuals with depression may be at greater risk for developing diabetes. Treatment for depression helps people manage symptoms of both diseases, thus improving the quality of their lives. Studies further suggest that diabetes doubles the risk of depression compared to those without the disorder (Anderson, Lustman, & Clouse, 2000). The chances of becoming depressed increase as diabetes complications worsen. Research shows that depression leads to poorer physical and mental functioning, so a person is less likely to follow a required diet or medication plan. Treating depression with psychotherapy, medication, or a combination of these treatments can improve a patient's well-being and ability to manage diabetes.

3.2.5 Parathyroid Disorder

Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia. Hyperparathyroidism is more common in women than in men. Annual incidence is in the 0.1% range and affects up to 0.2% of the population older than 60 years.

Hyperparathyroidism is frequently associated with significant psychiatric symptoms, which are caused by the resultant hypercalcemia and can precede other somatic manifestations of the illness. Patients can experience delirium, sudden dementia, depression, anxiety, psychosis, apathy, stupor, and coma.

Hypomagnesemia also occurs in association with hyperparathyroidism, usually after surgical removal of a parathyroid adenoma.

In hypoparathyroidism, expect to find low serum levels of calcium and magnesium. Patients most commonly experience delirium but may also experience psychosis, depression, or anxiety

3.2.6 Thyroid Disorders

Hyperthyroidism is a common clinical condition caused by excess thyroid hormone. Because this disorder is so common, a high index of clinical awareness for thyroid disease and its complications is needed in any patient who presents with psychiatric symptoms. Always include evaluations of thyroid-stimulating hormone (TSH [thyrotropin]) and free thyroxine (T4) levels in the medical workup of patients presenting with psychiatric symptoms for the first time. Graves disease is the most common

cause in the population. Some evidence indicates that stress can precipitate Graves disease and aggravate treated disease. Toxic nodular goiter is most prevalent in the elderly population.

Similar to patients with hyperthyroidism, those with hypothyroidism often develop symptoms of depression and anxiety. The usual clinical features include apathy, psychomotor retardation, depression, and poor memory. However, when hypothyroidism develops rapidly, the psychiatric features are usually delirium and psychosis, which has also been termed myxedema madness. Subclinical hypothyroidism can have either mild or no symptoms of thyroid hormone deficiency. It is fairly common and affects 5-10% of the population, mainly women, and occurs in 15-20% of women older than 45 years.

3.2.7 Heart Disease

Heart disease includes two conditions called angina pectoris and acute myocardial infarction (“heart attack”). Like any muscle, the heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease. If not enough oxygen-carrying blood reaches the heart, the heart may respond with pain called angina. When the blood supply is cut off completely, the result is a heart attack. The part of the heart that does not receive oxygen begins to die, and some of the heart muscle may be permanently damaged.

Research over the past two decades has shown that people with heart disease are more likely to suffer from depression than otherwise healthy people, and conversely, that people with depression are at greater risk for developing heart disease. (Nemeroff, Musselman, & Evans, 1998). Furthermore, people with heart disease who are depressed have an increased risk of death after a heart attack compared to those who are not depressed (Frasure-Smith, Lesperance, & Talajic, 1995). Depression may make it harder to take the medications needed and to carry out the treatment for heart disease. Treatment for depression helps people manage both diseases, thus enhancing survival and quality of life.

Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and alter blood clotting. They can also lead to elevated insulin and cholesterol levels. These risk factors, with obesity, form a group of signs and symptoms that often serve as both a predictor of and a response to heart disease. Furthermore, depression or anxiety may result in chronically elevated levels of stress hormones, such as cortisol and adrenaline. As high levels of stress hormones are signaling a “fight or flight” reaction, the body’s metabolism is diverted away from the type of tissue repair needed in heart disease.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. Persons with heart disease, their families and friends, and even their physicians and cardiologists (physicians specialising in heart disease treatment) may misinterpret depression’s warning signs, mistaking them for inevitable accompaniments to heart disease. Symptoms of depression may overlap with those of heart disease and other physical illnesses.

Effective treatment for depression is extremely important, as the combination of depression and heart disease is associated with increased sickness and death. Specific types of psychotherapy can relieve depression. Exercise is another potential pathway to reducing both depression and risk of heart disease.

Treatment for depression in the context of heart disease should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the heart disease treatment. Medications for depression can take several weeks to work and may need to be combined with ongoing psychotherapy.

3.2.8 HIV/AIDS

AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. HIV is spread most commonly by having sex with an infected partner. HIV also is spread through contact with infected blood, which frequently occurs among injection drug users who share needles or syringes contaminated with blood from someone infected with the virus. Women with HIV can transmit the virus to their babies during pregnancy. Many people do not develop any symptoms when they first become infected with HIV. As the immune system deteriorates, a variety of complications start to take over. For many people, their first sign of infection is large lymph nodes or "swollen glands" that may be enlarged for more than three months.

Although as many as one in three persons with HIV may suffer from depression (Bing, Burnam, & Longshore, 2010) the warning signs of depression are often misinterpreted. People with HIV, their families and friends, and even their physicians may assume that depressive symptoms are an inevitable reaction to being diagnosed with HIV. But depression is a separate illness that can and should be treated, even when a person is undergoing treatment for HIV or AIDS. Some of the symptoms of depression could be related to HIV, specific HIV-related disorders, or medication side effects. However, a skilled health professional will recognise the symptoms of depression and inquire about their duration and severity, diagnose the disorder, and suggest appropriate treatment.

3.2.9 Cancer

Development of different varieties of cancer is subject of psychological influences. This has resulted in the development of a new field called psychoncology (Anderson, 1992; Antoni and Goodkin, 1991). Oncology means study of cancer. Cancer can develop in any organ or tissue of the body. Normally, cells grow and divide to produce more cells only when the body needs them. But sometimes cells keep dividing when new cells are not needed. These extra cells may form a mass of tissue, called a tumor. Tumors can be either benign (not cancerous) or malignant (cancerous).

Cells in malignant tumors are abnormal and divide without control or order, resulting in damage to the organs or tissues they invade. Cancer cells can break away from a malignant tumor and enter the bloodstream or the lymphatic system. This is how cancer spreads, or "metastasizes," from the original cancer site to form new tumors in other organs. The original tumor, called the primary cancer or primary tumor, is usually named for the part of the body in which it begins. Research has enabled many men, women, and young people with cancer to survive.

About 9 million Americans of all ages are living with a current or past diagnosis of cancer. People who face a cancer diagnosis will experience many stresses and emotional upheavals. Fear of death, interruption of life plans, changes in body image and self-esteem. Still, not everyone with cancer becomes depressed. Depression can exist before the diagnosis of cancer or may develop after the cancer is identified. While there is no evidence to support a causal role for depression in cancer, depression may impact the course of the disease and a person's ability to participate in treatment.

Despite the enormous advances in brain research in the past 20 years, depression often goes undiagnosed and untreated. While studies generally indicate that about 25 percent of people with cancer have depression, only 2 percent of cancer patients in one study were receiving antidepressant medication (Regier, Narrow, & Rae, (1993).

Treatment for depression can help people feel better and cope better with the cancer treatment process. There is evidence that the lifting of a depressed mood can help enhance survival (McDaniel, Musselman, & Porter, 1995). Treatment for depression in the context of cancer should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the cancer treatment. This is especially important when antidepressant medication is needed or prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as cancer may be available.

3.2.10 Stroke

A stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells. Stroke can occur in all age groups and can happen even to fetuses still in the womb; but three-fourths of strokes occur in people 65 years of age and over, making stroke a leading cause of disability in older persons. Of the 600,000 American men and women who experience a first or recurrent stroke each year, an estimated 10 to 27 percent experience major depression. An additional 15 to 40 percent experience some symptoms of depression within two months following a stroke (Depression Guideline Panel, 1993).

The average duration of major depression in people who have suffered a stroke is just under a year. Among the factors that affect the likelihood and severity of depression following a stroke are the location of the brain lesion, previous or family history of depression, and pre-stroke social functioning. Stroke survivors who are also depressed, particularly those with major depressive disorder, may be less compliant with rehabilitation, more irritable, and may experience personality change.

Treatment for depression in stroke survivors should be managed by a mental health professional—for example, a psychiatrist, psychologist, or clinical social worker—who is in close communication with the physician providing the post-stroke rehabilitation and treatment. This is especially important when antidepressant medication is prescribed, so that potentially harmful drug interactions can be avoided. In some cases, a mental health professional that specialises in treating individuals with depression and co-occurring physical illnesses such as stroke may be available.

3.3 LET US SUM UP

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. This is diagnosed when: the patient is depressed or has lost interest in activities, there is significant impairment in important areas of functioning, the patient's mood is elevated, expansive or irritable, or a combination of these, there is medical evidence to support the diagnosis, the change in mood is not due to stress of the medical condition. the change in mood doesn't occur only in delirium.

Mood disorder due to a general medical condition is characterised by depressions or manic episodes which are caused by a medical condition. The symptoms of mood disorder due to a general medical condition are the same as during other types of depressions...sadness, emptiness, loss of interest and pleasure, irritability and anger, changes in appetite, sleep problems, restlessness, slow movement and thinking, fatigue, worthlessness and guilt, poor concentration, thoughts about death and suicide. The manic symptoms experienced during mood disorder due to a general medical condition are the same as those experienced during other manic episodes...elation, confidence, delusional thinking, high level of energy, increased activity, productivity, loud and rapid speech, racing thoughts, risky behaviour, impulsive behaviour, increased sexual behaviour, over spending, fast reckless driving, wild business schemes, overeating, drinking too much, irritability, anger, and agitation.

Depressive disorder due to a general medical condition affects a lot of people. There are many medical conditions which can cause mood disorder due to a general medical condition. These include:

- 1) Parkinson disease
- 2) Multiple sclerosis
- 3) Seizure disorder
- 4) Diabetes
- 5) Parathyroid disorder
- 6) Thyroid disorders
- 7) Heart disease
- 8) HIV/AIDS
- 9) Cancer
- 10) Stroke

Treatment for mood disorder due to a general medical condition must include treatment of the medical condition causing the depression or manic disorder. Psychiatric and psychological treatment of the mood disorder is also often needed. Psychiatric treatment will include medication to reduce the depressive or manic symptoms. Psychological treatment will provide the person with emotional support and help him develop coping skills.

3.4 UNIT END QUESTIONS

- 1) Explain the nature of mood disorder due to general medical condition.
- 2) Discuss the diagnostic criteria for mood disorder due to a general medical condition.
- 3) Differentiate between mood disorder due to general medical condition and major depressive disorder.
- 4) Explain the etiology of bipolar disorder.
- 5) Discuss any three of the major medical conditions which may cause mood disorder.

3.5 GLOSSARY

- Antidepressant medication** : General term for a number of drugs used to relieve depression and to elevate mood.
- Bipolar disorder** : Mood disorder in which a person experiences both manic and depressive episodes.
- Cognitive Behaviour therapy** : Therapy based on altering cognitive dysfunctional thoughts and cognitive disorders.
- Cyclothymic disorder** : A long lasting disorder that includes both mania and depressive episodes, neither of which meet the criteria for major episodes. Lasts for at least two years.
- Depression** : Pervasive feeling of sadness that may begin after some loss or stressful event, but that continue long afterwards.
- Depressive disorder** : Depressive symptoms that meet diagnostic criteria for either single episode of major depression, or recurrent episodes.
- Diabetes** : Diabetes is a disorder that impairs the way the body uses digested food, especially glucose (a form of sugar), for growth and energy.
- Dizygotic twins** : Twins that develop from two separate eggs.
- Dysthymia** : A longstanding depressed mood accompanied by loss of interest and lack of pleasure in situations which most people would find enjoyable.
- Episodic (disorder)** : Term used to describe a disorder that tends to abate and to recur.
- HIV/AIDS** : AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers.
- Heart Disease** : Heart disease includes two conditions called angina pectoris and acute myocardial infarction ("heart attack"). Heart needs a constant supply of oxygen and nutrients that are carried to it by the blood in the coronary arteries. When the coronary arteries become narrowed or clogged and cannot supply enough blood to the heart, the result is coronary heart disease.
- Hypomania** : A disorder characterised by unusual elevation in mood that is not as extreme as that found in mania.
- Major depressive disorder** : A severe depression characterised by dysphoric mood as well as poor appetite, sleep problems, feelings of restlessness, loss of pleasure, loss of

energy, feeling of inability to concentrate, recurring thoughts of death or suicide attempts. Depressive episodes occur most of everyday for at least two weeks.

- Mania** : Euphoric, hyperactive state in which an individual's judgment is impaired.
- Monozygotic twins** : Identical twins developed from one fertilised egg.
- Mood disorder** : One of a group of disorders primarily affecting emotional tones. It can be depression, manic excitement, or both. It may be episodic or chronic.
- Multiple sclerosis** : Multiple Sclerosis is a disorder characterised by multiple episodes of symptoms of a neuropsychiatric nature related to multifocal lesions in the white matter of the central nervous system.
- Parathyroid disorder** : Dysfunction of the parathyroid glands results in abnormalities in the regulation of electrolytes, especially calcium. Excessive excretion of parathyroid hormone results in a state of hypercalcemia.
- Parkinson disease** : Parkinson disease is a disorder characterised by movement abnormalities caused by degeneration of the neurons in the substantia nigra.
- Psychotherapy** : Treatment of mental disorders by psychological methods.
- Seizure disorder** : A neurological disorder with symptoms of loss of consciousness, tonic-clonic movements or limbs, tongue biting, and incontinence. While the diagnosis is relatively straightforward, the postictal state is characterised by a gradual clearing of delirium lasting a few minutes to many hours.
- Stress** : Effects created within an organism by the application of a stressor.
- Stroke** : Stroke occurs when the blood supply to part of the brain is suddenly interrupted or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding brain cells.
- Thyroid disorders** : Hyperthyroidism is a clinical condition caused by excess thyroid hormone
- Unipolar disorder** : Mood disorder in which a person experiences only depressive episodes, as opposed to bipolar disorder, in which both manic and depressive episodes occur.

3.6 SUGGESTED READINGS

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