

**Affective Disorders:  
Examining Assessment, Treatments, and Therapies in Clinical and Health Science**

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## **Affective Disorders:**

### **Examining Assessment, Treatments, and Therapies in Clinical and Health Science**

People with affective disorders experience a wide array of symptoms that sometimes defy rational thought and disrupt daily life. Bipolar spectrum disorders, depressive disorders, and anxiety disorders constitute the three most predominant categories of affective disorders, which share common forms of treatment due to their overlapping symptoms. If not treated properly, each can have adverse effects on one's mental and physical well-being. Affective disorders may be assessed through self-report questionnaires, clinician interviews, and other diagnostic procedures to determine the nature of the illness and the appropriate treatment.

#### **Bipolar Spectrum Disorders**

Bipolar disorder (BD) is a complicated illness due to its variability and cyclic nature. Lifetime prevalence of bipolar spectrum disorders (BD I, BD II, and BD not-otherwise specified) is reported to range from 3%-5%, with a commensurate prevalence between males and females (see Dell'Aglio, Basso, Argimon, & Arteché, 2013). Assessment of BD can be done with self-report measures (Hirschfeld, 2014) and clinical interviews for the DSM-V (SCID; American Psychiatric Association [APA], 2013). Among the self-report measurements most commonly used are the Mood Disorder Questionnaire (MDQ; Hirschfeld et al., 2000), which concerns individuals' past experiences with hypomania and mania, and the General Behavior Inventory (Depue, Krauss, Spont, & Arbisi, 1989).

Bipolar disorder is characterized by a cycling through depressive and hypomanic/manic episodes (Altshuler et al., 2010; APA, 2013). During hypomanic episodes, patients may experience elevated moods, a decreased need for sleep, and increased activity. These symptoms intensify in mania. The final diagnosis is determined by whether an individual has previously experienced mania, or hypomania, in addition to experiencing at least one major depressive episode (APA, 2013; Phillips & Kupfer, 2013). Bipolar I describes a more severe subtype of BD wherein individuals have experienced at least one manic episode, while Bipolar II denotes those who have experienced hypomania, but never mania. Depressive episodes can last days to months and can affect a person's physical well-being through significant decreases in activity, over- or under-eating, and onset of insomnia or hypersomnolence (Gurpegui et al., 2012).

The physical consequences of BD can foster the development of metabolic syndrome (Fiedorowicz, Palagummi, Forman-Hoffman, Miller, & Haynes, 2008), which entails the combined presence of at least three of five metabolic factors (e.g., obesity, hypertension, dyslipidemia), and can significantly increase the risk of cardiovascular disease (CVD; Swartz & Fagiolini, 2012). Research has shown that CVD manifests approximately 10 years earlier in people with BD than in controls and is associated with many premature deaths (Goldstein, Fagiolini, Houck, & Kupfer, 2009). Treating BD with atypical antipsychotics may promote the development of metabolic syndrome and therefore elevate the already high risk for weight gain and CVD (Fiedorowicz et al. 2008).

The course of treating BD is phasic, as manic or mixed features are treated before depressive episodes with mood-stabilizers and/or atypical antipsychotics (Goodwin et al., 2016). Mood-stabilizers such as lithium and valproate are the most commonly

recommended forms of treatment for BD, and may be combined with SSRI antidepressants when depressive symptoms are present (Goodwin et al., 2016). Treatment may also combine pharmacological treatment methods with cognitive behavioral therapy (CBT; Peters et al., 2014), lifestyle interventions (Sylvia, Nierenberg, Stange, Peckham, & Deckersbach, 2011), and in some severe cases, electroshock therapy (ECT; Goodwin et al., 2016).

### **Depressive Disorders**

Depressive disorders are characterized by the duration and timing of pervasive symptoms as well as by the disorders' diverse etiologies. Persistent depressive disorder (dysthymia) for instance represents the consolidation of what was formerly chronic major depressive disorder (MDD) and dysthymic disorder (Rhebergen, 2012). Currently, the diagnostic criteria for persistent depressive disorder include a quotidian presence of a depressed mood, among other depressive symptoms, for at least two years with a reprieve of no more than two months. General depressive symptoms entail increased or decreased sleep and eating, a loss of energy and focus, low self-esteem, and feelings of hopelessness (APA, 2013). Compared to bipolar disorder, unipolar MDD has a lifetime prevalence almost four times that of BD at 16.2% (Kessler et al., 2003, in Hirschfeld 2014). Other unspecified depressive disorders are defined in relation to their seasonality or whether symptoms have appeared as a result of substance use or another medical condition (APA, 2013).

Methods of measuring depressive disorders vary in that many self-report and clinician scales cater to different aspects of the disorders. The widely-used Beck Depression

Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) assesses the most common symptoms of depression such as persistent sadness, diminished interest, undue guilt, irritability, and suicide ideation, whereas the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) measures the severity and duration of the symptoms listed above. The Hamilton Depression Rating Scale (HAM-D; Hamilton, 1960) determines the severity of depressive symptoms among previously diagnosed patients (Hirschfeld, 2014).

Depression, if left untreated, can have many negative health consequences. Several studies show that major depressive episodes are followed by an increased occurrence of heart disease, including coronary artery disease and cardiac arrest (Anderson, 2003). The development of these diseases may be connected to the effects of rumination, which has been shown to increase the risk of hypertension due to prolonged physiological reactivity after stress (Key, Campbell, Bacon, & Gerin, 2008). Pennix and colleagues (1998) even found that participants who were chronically depressed for at least six years were 88% more likely to develop cancer within the next four years after controlling for other risk factors.

Depression predicts suicide attempts in adolescents (Nanayakkara, Misch, Chang, & Henry, 2013), proving problematic to physical well-being as adolescents are nearly twice as likely to experience depression than adults (National Institute of Mental Health [NIMH], 2016a). Lithium may be effective in reducing the risk of suicide in depressed people and those with BD, as reductions in risk of over 60% have been found in past research (Cipriani, Hawton, Stockton, & Geddes, 2013). Studies have also demonstrated that CBT and antidepressants are both effective in treating depression (DeRubeis, Siegle, & Hollon,

2008), and are often used in tandem. Lastly, non-pharmacological approaches, such as social support from family and support groups, as well as regular exercise, can also help mitigate the symptoms of depression.

## **Anxiety Disorders**

While many people experience occasional anxiety, anxiety disorders are characterized by overwhelming worry that interferes with daily activities and relationships (NIMH, 2016*b*). Some of the risk factors include a family history of anxiety disorders, exposure to stressful life events, shyness in childhood, and being female (women are 60% more likely to be affected than men) (NIMH, 2016*c*). Anxiety disorders are the most common type of mental illness in the United States, affecting about 40 million adults, and are often comorbid with depression. Different types of anxiety disorders include generalized anxiety disorder (GAD), panic disorder, specific phobias, and social anxiety disorder (APA, 2013). In addition to professionals using the SCID to diagnose anxiety disorders, the 40-item State-Trait Anxiety Inventory (STAI; Spielberger, 1983) measures both state and trait feelings of anxiety, whereas the self-report Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) focuses solely on somatic symptoms.

Individuals with GAD experience uncontrollable worry uncharacterized by another anxiety disorder; diagnosis requires three or more symptoms like restlessness, fatigue, and irritability for at least six months on most days (APA, 2013). Panic disorder, on the contrary, is characterized by experiences of repeated unexpected anxiety attacks, accompanied by feelings of lack of control and worry about the onset of another attack, accelerated heart rate, trembling, and difficulty breathing (NIMH, 2016*b*). Such effects are

similarly noted in cases of specific phobia, which is an unreasonable and irrational fear of something particular (e.g., animal, situation) usually developed in childhood, and when triggered reflects certain emotional and physical aspects of a panic attack (APA, 2013). Social anxiety disorder may sometimes be referred to as social phobia and entails extreme discomfort in social and performance situations for fear of feeling embarrassed, judged, rejected, or offending others (NIMH, 2016b).

The experience of feeling anxiety appears to be most directly correlated with an increased risk for developing coronary heart disease, even when accounting for other factors (Kubzansky & Kawachi, 2000). Indeed, research shows that people with self-reported and diagnosed anxiety are at greater risk for hypertension (Wu, Chien, & Lin, 2014) and coronary artery disease (atherosclerosis; Paterniti, Zureik, Ducimetiere, Feve, & Alperovitch, 2001), though unhealthy behaviors such as smoking and frequent alcohol or drug use found among people with anxiety disorders are likely to mediate this association.

Anxiety disorders are often treated with a form of CBT called exposure therapy that gradually exposes patients to the thing they fear to become systematically desensitized and better able to control their fear. Medication typically prescribed for anxiety disorders include SSRI antidepressants, benzodiazepines, and beta-blockers (NIMH, 2016). The most effective treatment for anxiety ultimately depends on the specific disorder and any possibly comorbid disorder.

### **Conclusions and Future Directions**

Although affective disorders overlap in approaches to treatment, as is evident by the popular use of antidepressants in each, it is apparent by the frequent rate of comorbidity between anxiety and depressive disorders as well as between unipolar depression and

bipolar spectrum disorders, that methods of measurements should cater more to differential diagnoses. Refining and revising diagnostic measures may aid clinicians and patients in reaching a more complete understanding of the disorders' unique course within each individual affected. In this way, treatment, whether pharmacological or behavioral therapy, may become more effective for those experiencing a myriad of symptoms that cannot be easily defined as belonging to simply one disorder.

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