Unit 9: Mood Disorders

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MOOD DISORDERS

DEFINITION

a. Mood Disorders

- John Hopkins Medicine (n.d.) defines Mood Disorders as a mental health class “to broadly describe all types of depression and bipolar disorders.” This is further defined by the American Psychiatric Association (2013), which defines each type of depressive and bipolar disorder, as stated below:

b. Bipolar and Related Disorders

- Generalized Definition of Bipolar Disorder: The Substance Abuse and Mental Health Services Administration (2024) states that it is “a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or “manic” episodes) to lows (depression or “depressive” episode).” Classifications of Bipolar Disorders and their specific definitions include:

- Bipolar I Disorder
  - Type of bipolar disorder that represents the “modern understanding of classic manic-depressive disorder”, although neither psychosis nor the lifetime experience of a major depressive episode is a requirement.
- Bipolar II Disorder
  - Bipolar disorder that requires lifetime experience of at least one episode of major depression and at least one hypomanic episode
- Cyclothymic Disorder
  - Adults who experience at least 2 years of both hypomanic and depressive periods without fulfilling the criteria for an episode of mania, hypomania, or major depression
- Substance/Medication-Induced Bipolar and Related Disorder
  - Manic, bipolar-like symptoms associated with the intake of certain medications and abuse of substances

- Bipolar and Related Disorder due to Another Medical Condition
    - Manic, bipolar-like symptoms associated with a secondary medical condition (i.e., Cushing's disease, multiple sclerosis, stroke, TBI, etc.)
- Other Specified Bipolar and Related Disorder
    - Individuals who have symptoms characteristic of a bipolar and related disorder, but do not meet the full criteria for them
    - Used in situations where the clinician **chooses to communicate** the specific reason that the presentation does not meet the criteria for previous types.
- Unspecified Bipolar and Related Disorder
    - Individuals who have symptoms characteristic of a bipolar and related disorder, but do not meet the full criteria for them
    - Used in situations where the clinician **chooses NOT to communicate** the specific reason that the presentation does not meet the criteria for previous types

c. Depressive Disorder and Related Disorders

- Generalized Definition of Depressive Disorder: A disorder characterized by the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function. This is further defined into classifications, which include:
- Disruptive Mood Dysregulation Disorder
    - Presentation of children up to the age of 12 years old with persistent irritability and frequent episodes of extreme behavioral dyscontrol
- Major Depressive Disorder
    - Classic condition of depression, characterized by discrete episodes of at least 2 weeks duration involving clear-cut changes in affect, cognition, and neurovegetative functions and interepisode remissions
- Persistent Depressive Disorder
    - A more chronic form of depression, characterized by mood disturbance that continues for at least 2 years in adults, and 1 year in children
- Premenstrual Dysphoric Disorder
    - A specific and treatment-responsive disorder that begins sometime following ovulation and remits within a few days of menses, with a marked impact on functioning
- Substance/Medication-Induced Depressive Disorder
    - A form of depressive disorder associated with substances of abuse and some prescribed medications
- Depressive Disorder Due to Another Medical Condition

    - A form of depressive disorder associated with a secondary condition (i.e., Huntington's Disease, multiple sclerosis)
- Other Specified Depressive Disorder
    - Presentation of depressive disorder symptoms but does not meet the full criteria of any of the disorders in the depressive disorders diagnostic class
    - Used in situations where the clinician **chooses to communicate** the specific reason that the presentation does not meet the criteria for previous types.
- Unspecified Depressive Disorder
    - Presentation of depressive disorder symptoms but does not meet the full criteria of any of the disorders in the depressive disorders diagnostic class
    - Used in situations where the clinician **chooses NOT to communicate** the specific reason that the presentation does not meet the criteria for previous types.

ETIOLOGY

a. According to Mood Disorders | Mercy (2022) and John Hopkins Medicine (n.d.) no single cause is known, but are likely caused by factors such as imbalance of chemicals in the brain, difficult life events and trauma, or passed down through genetics.

b. Biological Factors (Sekhon & Gupta, 2023b)

i. In episodes of depression, there is a decrease of the two neurotransmitters, namely: Serotonin and Norepinephrine.

ii. Medical conditions that will lead to mood disorders include:

1. Brain tumors
2. CNS syphilis
3. Delirium
4. Encephalitis
5. Influenza
6. Metabolic changes associated with hemodialysis
7. Multiple sclerosis
8. Q fever (a disease caused by the bacteria Coxiella burnetii.)
9. Cancer

10. AIDS
11. Hypothyroidism

c. Genetic Factors
   i. Parental mood disorder

d. Hormonal Factors
   i. Increased HPA activity is linked to stress and depression.
   ii. Increased TSH has been linked to depression.

e. Psychosocial Factors
   i. Stressful life events
   ii. Childhood abuse
   iii. Personality traits or disorders
   iv. Attachment issues

PREVALENCE & INCIDENCE

a. What is the number of cases of a disease in a specific population at a particular time point or over a specified time? Provide data locally and internationally, if applicable.

Depressive Disorder	
Locally	*Internationally*
● The prevalence of depression was reported to be 3.34% in the Philippines in 2015. ● As per the World Health Organization (WHO) report, it is estimated that 154 million people are affected by depression in the Philippines. Depression can strike anyone at any time in their life, and it is estimated that women are 1.5 times more likely to experience it than men. ● Close to 1 in 10 young adults (8.9%) in the Philippines experience moderate to severe depressive symptoms	● **In General:** ○ An estimated 3.8% of the population experience depression, including 5% of adults (4% among men and 6% among women), and 5.7% of adults older than 60 years. Approximately 280 million people in the world have depression (1). Depression is about 50% more common among women than among men. Worldwide, more than 10% of pregnant women and women who have just given birth experience depression (2). More than 700 000 people die due to suicide every year. Suicide

● The prevalence of moderate to severe depression in Filipino young adults is higher among females than males.	is the fourth leading cause of death in 15–29-year-olds. ● **Disruptive Mood Dysregulation Disorder:** ○ The 6-month to 1-year prevalence is estimated to be 2-5%, with higher rates in males and school-age children. ● **Major Depressive Disorder:** ○ 12-month prevalence is 7% in the US, 3 times higher in 18-29 year olds vs 60+ year olds. Females have 1.5-3 times higher rates than males. ● **Persistent Depressive Disorder:** ○ 12-month prevalence is 0.5% for persistent depressive disorder and 1.5% for chronic major depressive disorder in the US. ● **Premenstrual Dysphoric Disorder:** ○ 12-month prevalence is 1.8-5.8% of menstruating women, with lower estimates from prospective daily ratings.The most rigorous estimate of premenstrual dysphoric disorder is 1.8% for women whose symptoms meet the full criteria without functional impairment and 1.3% for women whose symptoms meet the current criteria with functional impairment and without co-oc curring symptoms from another mental disorder. ● **Substance/Medication-Induced Depressive Disorder:**

	○ Lifetime prevalence is 0.26% in the US adult population.

Bipolar Disorder	
Locally	*Internationally*
● According to the World Health Organization (2020), 520,614 Filipinos are diagnosed with Bipolar Disorder.	● **Bipolar I:** ○ 12-month prevalence is 0.6% in the US, ranging from 0-0.6% internationally. Lifetime male-female ratio is 1.1:1. ● **Bipolar II:** ○ 12-month prevalence is 0.8% in the US, 0.3% internationally. Pediatric prevalence is difficult to establish. ● **Cyclothymic Disorder:** ○ Lifetime prevalence is 0.4-1%, up to 3-5% in mood disorder clinics. In the general population, cyclothymic disorder is apparently equally common in males and females. ● **Substance/Medication-Induced Bipolar and Related Disorder:** ○ There are no epidemiological studies of substance/medication-induced mania or bipolar disorder.

b. What is the rate of new cases of a disease occurring in a specific population over a particular time? Provide data locally and internationally, if applicable

Locally	*Internationally*
● According to the World Health Organization (2020), 1,145,871 Filipinos suffer from Major Depressive Disorder, while 520,614 are diagnosed with Bipolar Disorder.	● Waraich et al. (2004) state in their systematic review that "significant variation was observed among 1-year incidence rates of Major Depressive Disorder, with a corresponding pooled rate of 2.9 per 100." ● Rowland and Marwaha (2018) state that "the mean age of onset for bipolar appears to be in the early twenties, although findings vary between 20-30 years." They also state that "first-episode bipolar mania has an annual incidence of around 5 per 100,000 of population, and peak incidence occurs between 21–25 years."

SIGNS, SYMPTOMS, PATHOMECHANICS (A. Bipolar Disorder)

Manifestations that the **Physician/Allied Health Professional** Perceive	**Bipolar and Related Disorder** ◆ **Bipolar I Disorder** ● One or more manic or mixed episodes, often accompanied by major depressive episodes ● Symptoms of mania such as abnormally elevated mood, decreased need for sleep, pressured speech, flight of ideas, distractibility, increased goal-directed activities ◆ **Bipolar II Disorder** ● One or more major depressive episodes accompanied by at least one hypomanic episode.

	● Hypomanic episodes involve elevated mood and increased energy/activity but are less severe than mania. ◆ **Cyclothymic Disorder** ● Numerous periods of hypomanic and depressive symptoms that do not meet criteria for a full hypomanic, manic or major depressive episode. ● Symptoms persist for at least two years. ◆ **Substance/Medication-Induced Bipolar and Related Disorder** ● A prominent mood disturbance meeting manic, hypomanic or depressive criteria that is judged to be due to effects of substance use, medication or other treatment. ● Onset is usually within a month of substance use. ◆ **Bipolar and Related Disorder Due to Another Medical Condition** ● A prominent mood disturbance meeting manic, hypomanic or depression criteria that is judged to be etiologically related to the physiological effects of another medical condition. ● Onset is usually within a month of the medical condition. ◆ **Other Specified Bipolar and Related Disorder** ● Symptoms meeting some but not all criteria for a bipolar subtype, or criteria of insufficient duration. ◆ **Unspecified Bipolar and Related Disorder** ● Symptoms meeting criteria for a bipolar disorder but lack adequate information to specify type or make a more specific diagnosis.
Manifestations that the **Parents/Significant Others** Perceive	➔ **Bipolar and related disorders** ◆ Mood swings or unusual shifts in behavior ◆ Behavioral changes ◆ Changes in functioning ➔ **During a manic episode, a loved one may notice them:** ◆ Feeling overly happy or “high” for prolonged periods ◆ Feeling “jumpy” and easily distracted

	◆ Having a reduced need for sleep and food ◆ Having racing thoughts and rapid talking ◆ Being extremely restless, impulsive, and engaging in risky behaviors ◆ Having feelings of grandiosity (feeling overly self-important) and invincibility ➔ **During a depressive episode, a loved one may notice them:** ◆ Feeling sad, hopeless and withdrawn for long periods ◆ Losing interest in previously enjoyed activities ◆ Showing significant changes in appetite and sleep schedule ◆ Feeling slow and unable to carry out simple tasks ◆ Having problems in memory, concentration, and decision making
Manifestations that the **Patient** Experiences	➔ **Manic episodes:** ◆ Feeling keyed up or tense ◆ Feeling unusually restless ◆ Difficulty concentrating due to worry ◆ Fear that something awful may happen ◆ Feeling of losing control ➔ **Depressive episodes:** ◆ Prominent dysphoria or depressed mood ◆ Diminished interest or pleasure in activities ◆ Psychomotor retardation ◆ Fatigue or loss of energy ◆ Feelings of worthlessness or inappropriate guilt ◆ Recurrent thoughts of death or suicidal ideation ➔ **Mixed features:** ◆ Presence of both manic and depressive symptoms during the same episode ➔ **Rapid cycling:** ◆ At least 4 mood episodes (manic, hypomanic, or major depressive) in the previous 12 months

	➔ **Melancholic features:** ◆ Loss of pleasure, lack of reactivity to pleasurable stimuli ◆ Distinct quality of depressed mood ◆ Diurnal variation (worse in the morning) ◆ Early-morning awakening ◆ Psychomotor changes ◆ Significant anorexia or weight loss ◆ Excessive or inappropriate guilt ➔ **Atypical features:** ◆ Mood reactivity ◆ Significant weight gain or increased appetite ◆ Hypersomnia ◆ Leaden paralysis ◆ A pattern of interpersonal rejection sensitivity ➔ **Psychotic features:** ◆ Presence of delusions or hallucinations during mood episodes ➔ **Peripartum onset:** ◆ The onset of mood symptoms during pregnancy or within 4 weeks after delivery ➔ **Seasonal pattern:** ◆ Regular temporal relationship between mood episodes and a particular time of the year
Structural & Anatomical Changes	• Blond (2012) states that “neuroimaging studies support a central role for an amygdala–anterior paralimbic neural system in bipolar disorder”, with a notable abnormality in the development of this system associated with the disorder.
Pathomechanics	• The pathomechanics involve neuroanatomical changes, particularly thinning of the cortical gray matter in frontal, temporal, and parietal regions of both brain hemispheres. Additionally, there are imbalances in levels of multiple neurotransmitters, including dopamine, norepinephrine, serotonin, gamma-aminobutyric acid (GABA), glutamate, and acetylcholine. The complex behavioral and psychological manifestations of bipolar disorder are mediated

	by intricate networks of interconnected neural circuits that are impacted by these neurochemical dysregulations and structural brain abnormalities. The cycling between manic and depressive states is hypothesized to arise from disruptions in the regulation of these neurotransmitter systems and their modulation of brain regions governing mood, cognition, and emotional processing.

SIGNS, SYMPTOMS, PATHOMECHANICS (B. Depressive Disorder)

Manifestations that the **Physician/Allied Health Professional** Perceive	● **Disruptive Mood Dysregulation Disorder:** ○ Severe and recurrent temper outbursts (verbally or behaviorally) ○ Persistently irritable or angry mood between outbursts ○ Onset before age 10 ● **Major Depressive Disorder** ○ Depressed mood or loss of interest/pleasure for most of the day, nearly every day ○ Additional symptoms such as changes in appetite, sleep, psychomotor abilities, energy levels, feelings of worthlessness, diminished concentration or indecisiveness ● **Persistent Depressive Disorder** ○ Depressed mood for most days over a period of 2+ years (1+ years for children) ○ Additional symptoms that persist such as poor appetite, insomnia, low energy, low self-esteem, poor concentration ● **Premenstrual Dysphoric Disorder** ○ Mood changes, anxiety, affective lability in the premenstrual phase of the cycle that remit with menses ○ Additional affective/behavioral/physical symptoms premenstrually ● **Substance/Medication-Induced Depressive Disorder** ○ Depressive symptoms that develop during or shortly after substance use that are attributable to the substance/medication ● **Depressive Disorder Due to Another Medical Condition**

	○ Depressive symptoms that are attributable to the physiological effects of another medical condition ● **Other Specified/Unspecified Depressive Disorder** ○ Depressive symptoms that cause distress but do not meet full criteria for a specific depressive disorder
Manifestations that the **Parents/Significant Others** Perceive	● For depression, parents and significant others may observe: ○ Depressive disorder ■ Persistent low mood ■ Loss of interest ■ Changes in behavior ● Social withdrawal, anxiety, restlessness, and nervousness ● Difficulty concentrating and low energy levels ● Changes in sleep or appetite (either increased or decreased) ● Difficulty making decisions ● Irritability, angry outbursts, or feelings of being easily annoyed or frustrated even over small matters ● Engaging in risky behaviors, like drug or alcohol abuse, or self-harm ■ Physical symptoms that do not have physiological explanations ● Frequent headaches ● Stomach Aches ● Fatigue ■ Expressions of hopelessness ● Being self-critical, having a heavy focus on past failures, feelings of guilt ● Admissions of desires to end one's life or hypothesizing nonexistence ● General mentions of suicidal thoughts or attempting suicide
Manifestations that the **Patient** Experiences	● **Disruptive Mood Dysregulation Disorder** ● Severe, recurrent temper outbursts (verbal rages, physical aggression)

	● Outbursts grossly disproportionate to situation ● Outbursts occur ≥3 times per week on average ● Persistent irritable/angry mood observed most of the day, nearly every day ● Symptoms inconsistent with developmental level ● **Major Depressive Disorder** ● Depressed or irritable mood most of the day, nearly every day ● Markedly diminished interest/pleasure in most activities, most of the day ● Significant weight change, insomnia/hypersomnia, fatigue nearly every day ● Observable psychomotor changes, feelings of worthlessness/guilt nearly every day ● Diminished concentration, recurrent suicidal thoughts/behavior ● **Persistent Depressive Disorder** ● Presence of ≥ 2 of: poor appetite/overeating, insomnia/hypersomnia, low energy, low self-esteem, poor concentration, feelings of hopelessness ● **Premenstrual Dysphoric Disorder (PMDD):** ● ≥5 symptoms in final week before menses, improve after menses ● ≥1 symptom: mood lability, irritability, depressed mood, anxiety ● ≥1 additional symptom: decreased interest, concentration difficulty, fatigue, appetite changes, sleep changes, feeling overwhelmed, physical symptoms
Structural & Anatomical Changes	● Drevets (2000) found evidence linked to “neuro physical abnormalities in multiple areas of the prefrontal cortex (PFC), the amygdala, and related parts of the striatum and thalamus” as it relates to major depression. The author states that “some of these abnormalities are mood state-dependent, and appear in regions where cerebral blood flow (CBF) increases during other normal and pathological emotional states”
Pathomechanics	● The exact underlying causes are not fully understood, but research suggests a complex interplay between imbalances in key neurotransmitters like dopamine, norepinephrine, and serotonin, as well as abnormalities in the regulation and sensitivity of their receptors.

	Structural and functional abnormalities have been observed in limbic brain regions such as the amygdala, hippocampus, and dorsomedial thalamus, which are involved in regulating mood and emotional processing. The affective symptoms of depression are thought to arise from disruptions in these neurochemical systems and associated neural circuits.

POSSIBLE SPEECH-LANGUAGE PROBLEMS ASSOCIATED WITH THE CONDITION

a. What are the possible SLP areas (e.g., language, cognition, etc.) affected?

Bipolar and Related Disorders	● **Speech & Language:** ○ Speech can be rapid, pressured, loud, and difficult to interrupt. ○ Flight of ideas with abrupt shifts between topics, which can lead to disorganized and incoherent speech. ○ Compared to depression and euthymia, switching and clustering abnormalities were found in manic and mixed states, mimicking symptoms like flight of ideas. (Weiner et al., 2019) ● **Pragmatics/Social Communication** ○ Individuals may talk continuously and without regard for others' wishes to communicate, often in an intrusive manner or without concern for the relevance of what is said. Speech is sometimes characterized by jokes, puns, amusing irrelevancies, and theatricality, with dramatic mannerisms, singing, and excessive gesturing. ● **Cognition:** ○ Distractibility, which can make it difficult to hold a rational conversation or attend to instructions ○ Inflated self-esteem and grandiose beliefs that may impact judgment and decision-making

Depressive Disorder and Related Disorders	● **Language:** ○ Changes in affect, cognition, and neurovegetative functions during major depressive episodes, which could impact language production and communication ○ Increasing depressive severity has been linked to longer individual pause durations (but not the number of pauses), greater overall pause duration while speaking, decreased speaking rate and reduced pitch variability (Mundt et al., 2007, as cited in Tan et al., 2023) ○ Depressed patients have also been shown to demonstrate reductions in the prosodic measures of emphasis and inflection (Alpert et al., 2001, as cited in Tan et al., 2023) ● **Cognition:** ○ Cognitive changes that can significantly affect the individual's capacity to function during a major depressive episode ○ Persistent irritability and difficulty regulating emotions in disruptive mood dysregulation disorder, which may impact cognitive processes ● **Social-Pragmatic Aspect:** ○ Disruptions in interpersonal functioning and relationships during a major depressive episode ○ Severe, persistent irritability and frequent temper outbursts in disruptive mood dysregulation disorder, which can impact social interactions

b. What are the characteristics of these affected SLP areas?

Bipolar and Related Disorders	● Speech Characteristics: ○ Varied: rapid and pressured during manic/hypomanic episodes, slowed or monotonous during depressive periods.

	○ Content reflects mood state, ranging from grandiosity to sadness. ○ Intrusiveness, loudness, and dramatic mannerisms are common. ● Pragmatics: ○ Impaired social engagement and communication during depressive phases. ○ Excessive talking, interrupting, and difficulty in following conversational norms during manic/hypomanic phases. ○ Reduced ability to filter out irrelevant stimuli, leading to distractibility. ● Cognition: ○ Fluctuating cognitive performance influenced by mood swings. ○ Impaired concentration, memory, and decision-making during depressive episodes. ○ Racing thoughts, impulsivity, and distractibility during manic/hypomanic episodes.
Depressive Disorder and Related Disorder	● Speech Characteristics: ○ Speech may be slowed, monotonous, or lacking in energy. ○ Alternatively, it can also be rapid and pressured, particularly during agitated states. ○ Content may reflect depressive themes such as sadness, hopelessness, or self-criticism. ○ In severe cases, speech may become nearly non-existent. ● Pragmatics ○ Social interactions may be significantly impacted, with individuals withdrawing from social activities and exhibiting reduced engagement. ○ Conversations may be limited, with individuals showing decreased interest in communication. ○ Difficulty in interpreting social cues and inappropriate responses may lead to interpersonal conflicts or misunderstandings. ● Cognition ○ Cognitive functioning is often impaired, characterized by difficulties in concentration, attention, and memory. ○ Individuals may experience negative cognitive biases, where they interpret information in a pessimistic or self-critical manner. ○ Decision-making abilities may be compromised, and individuals may struggle to problem-solve or plan for the future.

TYPES, COURSE, & PROGNOSIS

Types	**Bipolar and Related Disorders** ● Bipolar I disorder ● Bipolar II disorder ● Cyclothymic disorder ● Substance/medication-induced bipolar and related disorder, ● Bipolar and related disorders due to another medical condition, ● Other specified bipolar and related disorders ● Unspecified bipolar and related disorder. **Depressive Disorders** ● Disruptive mood dysregulation disorder ● Major depressive disorder ● Persistent depressive disorder (dysthymia) ● Premenstrual dysphoric disorder ● Substance/medication-induced depressive disorder ● Depressive disorder due to another medical condition ● Other specified depressive disorder ● Unspecified depressive disorder
Severity	Severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability. 1. **Mild:** Few excess symptoms, manageable intensity, minor impairment.(Two symptoms) 2. **Moderate:** Symptoms and impairment between mild and severe. (Three symptoms) 3. **Severe:**Substantial excess symptoms, seriously distressing and unmanageable, marked interference with functioning. (Four or Five symptoms)

Course: Bipolar and Related Disorders	● **Initial Onset:** Bipolar disorder often shows up in late teens or young adulthood, but it can develop at any point in life. The initial signs might appear slowly or come on suddenly. ● **Episodic Nature**: People with bipolar disorder experience swings between feeling very up (manic or hypomanic) and very down (depressed). These swings are broken up by periods of normal mood. ● **Severity Can Differ:** The intensity and length of these mood episodes can vary greatly. Some people have mild experiences, while others face severe symptoms that disrupt their lives. ● **Risk of Recurrence:** Bipolar disorder is a chronic condition, meaning episodes tend to come back over time. The frequency and pattern of these episodes can differ from person to person. ● **Potential for Psychosocial Impairments:** The mood swings in bipolar disorder can significantly impact work, school, relationships, and everyday activities. This is especially true during depressive episodes. ● **Long-Term Management:** Managing bipolar disorder requires a combination of approaches, often including medication, therapy, and lifestyle changes. Treatment aims to stabilize mood, prevent future episodes, and minimize the impact of mood swings on overall well-being. ● **Risk of Co-occurring Conditions:** People with bipolar disorder are more likely to experience other mental health conditions like anxiety or addiction, as well as physical health problems.
Course: Depressive Disorder	● **Initial Onset:** Depression can appear at any age, but it often starts in the late teens or young adulthood. Symptoms may creep in slowly or hit suddenly, and sometimes worsen over time. ● **Episodic Nature:** Depressive disorders involve periods of feeling down, losing interest in things you used to enjoy, and experiencing other symptoms like sleep or appetite changes, fatigue, worthlessness, or trouble focusing. These episodes can vary in length and intensity. ● **Recurrence:** Depression tends to come back throughout a person's life. Some may experience single episodes, while others face repeated bouts or even long-lasting depressive symptoms. ● **Inter-Episode Periods:** Between depressive episodes, things might improve or even go back to normal for a while. However, some low mood or lingering symptoms can still stick around during these times. ● **Chronicity**: In some cases, depression becomes a chronic condition, with symptoms lasting for two years or more. Chronic depression can be trickier to treat and might require ongoing management.

	• **Risk of Co-occurring Conditions**: People with depression are more likely to experience other mental health issues like anxiety or addiction, as well as physical health problems. • **Impact on Functioning:** Symptoms of depression can significantly affect work, school, relationships, and taking care of oneself. Severe episodes can even lead to difficulty functioning or disability. • **Response to Treatment**: Treatment for depression often involves a combination of medication, therapy, and lifestyle changes. What works best for one person might not work for another, and it may take time to find the most effective way to manage symptoms.

What is the outcome of this condition if left treated and/or untreated?	
Outcomes for Bipolar Disorder if Untreated	**Outcomes for Depressive Disorder if Untreated**
Although many individuals with various Bipolar disorders return to a fully functional level between mood episodes, impairments in work role functions may be present, resulting in lower socioeconomic status. Poorer performance in cognitive tests and the presence of cognitive impairments is also noted. These may contribute to vocational and interpersonal difficulties and persist throughout the lifespan.	Chronic, severe irritability is associated with marked disruption in a person's family and peer relationships and school performance. They may be unable to participate in activities generally enjoyed by others, with significant effects on their general lives. Individuals may also develop impairments ranging from mutism to complete incapacity and an inability to attend to basic self-care needs, severely affecting the lives of themselves and their families.

HEALTHCARE RESOURCES AVAILABLE FOR BIPOLAR & DEPRESSIVE DISORDER

Medical/Surgical
What healthcare resources (e.g., medical, surgical, rehabilitation, etc.) should the patients with this condition receive?

Pharmacotherapy (Medication)	● Antidepressants (i.e., Selective Serotonin Reuptake Inhibitors [SSRIs]) ● Mood stabilizers (i.e., lithium, anticonvulsant drugs, etc.) ● Antipsychotics (i.e., aripiprazole)
Psychotherapy	A type of treatment that can help individuals experiencing a wide array of mental health conditions and emotional challenges.
Psychoeducation	Psychoeducation refers to the process of providing education and information to those seeking or receiving mental health services, such as people diagnosed with mental health conditions (or life-threatening/terminal illnesses) and their family members.
Lifestyle Modifications	
Other Treatments may include:	● Electroconvulsive Therapy (ECT) ● Transcranial Magnetic Stimulation (TMS) ● Light Therapy

SLP THERAPY & EVALUATION

BIPOLAR AND OTHER RELATED DISORDERS	
SLP Areas	*Strategies*
● **Executive Functioning** ● **Language Processing** ● **Social Communication** ● **Voice Quality**	● Cognitive rehabilitation techniques ● Social communication training ● Communication partner training ● Voice therapy

DEPRESSIVE DISORDERS	
SLP Areas	*Strategies*
• **Expressive language** • **Cognitive functioning** • **Pragmatic language** • **Voice quality**	• Cognitive Rehabilitation Techniques • Communication Skill Training • Expressive Language Therapy • Augmentative and Alternative Communication (AAC)

**Note: SLP intervention should be in collaboration with a mental health professional.*

THE HEALTHCARE TEAM FOR BIPOLAR AND OTHER RELATED DISORDER

Psychiatrist	• A psychiatrist, a medical doctor specialized in mental health, diagnoses and treats mental health conditions. They prescribe medications, monitor their effects, and adjust treatment plans as necessary.
Psychologist	• Psychologists offer psychotherapy (talk therapy) to assist individuals with bipolar disorder in developing coping mechanisms, managing symptoms, and identifying triggers for mood episodes.
Licensed Therapist	• Similar to psychologists, licensed therapists provide various forms of psychotherapy such as cognitive-behavioral therapy (CBT) and family therapy to address emotional and behavioral aspects of bipolar disorder.

Case Manager	● Case managers offer support in coordinating care, accessing resources, managing medication schedules, and ensuring adherence to treatment plans.
Patient Advocate (Optional)	● A patient advocate can offer support and guidance to patients and their families in navigating the healthcare system, understanding treatment options, and advocating for their needs. While not typically part of a conventional healthcare team, they can be a valuable resource.

THE HEALTHCARE TEAM FOR DEPRESSIVE DISORDER

Psychiatrist	● Much like with bipolar disorder, a psychiatrist plays a central role in diagnosing and treating depression, prescribing medication, and monitoring progress.
Psychologist or Licensed Therapist	● Psychotherapy is essential in treating depression. Psychologists or therapists offer various therapy approaches to help individuals understand and manage negative thoughts and behaviors associated with depression.
Primary Care Physician (PCP)	● In some instances, a primary care physician (PCP) can manage mild to moderate depression in collaboration with a mental health professional. PCPs can also offer valuable support in monitoring physical health and potential medication interactions.
Social Worker	● Social workers play a crucial role in connecting patients with social support services, addressing social determinants of health that may contribute to depression, and providing counseling and support for individuals and families.

MEDICAL PRECAUTIONS FOR SPEECH-LANGUAGE THERAPY

1. The clinician must learn about the symptoms of the condition
2. The clinician must avoid making assumptions about the client's condition and their symptoms.
3. Know when a referral to another professional is called for.

SUPPORT SYSTEMS FOR PEOPLE WITH BIPOLAR AND DEPRESSIVE DISORDER

Support System	
Mental Health Act (RA 11036)	• Places guidelines for the care of individuals with mental health issues such as depression, and provides services for their care.
Organization	
American Psychiatric Association (APA)	A national medical and professional organization whose physician members specialize in the diagnosis, treatment, and prevention of mental disorders. It was founded in 1844 as the Association of Medical Superintendents of American Institutes for the Insane and renamed the American Medico-Psychological Association in 1892. They are dedicated to promoting mental health through research, education, and advocacy.
The Depression and Bipolar Support Alliance	The Depression and Bipolar Support Alliance, formerly the National Depressive and Manic Depressive Association, is a nonprofit organization providing support groups for people who live with depression or bipolar disorder as well as their friends and family.
National Alliance on Mental Illness (NAMI)	Provides a range of programs designed to educate you and your family about bipolar disorder, including a peer-to-peer program specifically for adults living with mental health conditions.

Mental Health America (MHA)	Conduct public awareness campaigns to help reduce stigma and advocate for research to enhance our understanding and management of this diagnosis.
International Bipolar Foundation	Provides a range of educational tools, including informative webinars and detailed blogs to help you — and your loved ones — understand and manage your condition more effectively.
National Institute of Mental Health	A rich source of information about bipolar disorder, they maintain an extensive collection of educational materials on their website, providing in-depth insights into the symptoms, causes, diagnostic process, and treatment methods related to the disorder.

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