Contemporary Treatment Approaches to Major Depression and Bipolar Disorders

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KEYWORDS

• Unipolar depression • Bipolar disorder • Antidepressants • Mood stabilizers
• Stressors • Suicide • Cognitive behavioral therapy

KEY POINTS

- Mood disorders are common, recurring psychiatric disorders that are associated with nonadherence to treatment and when left untreated are contributors to physical morbidity and mortality.
- Mood disorders have a high incidence of coexisting psychiatric, substance use, and physical disorders.
- Unipolar and bipolar disorders are linked to vast chronic physical disorders (ie, cancer, diabetes, immunologic disorders).
- A comprehensive biopsychosocial assessment, precluded by medical assessment, is critical to determine a definitive diagnosis.
- Evidence-based treatment for mood disorders includes pharmacotherapy and psychotherapeutic interventions that are governed by person-centered, strength, and recovery-based principles.

INTRODUCTION

Mood disorders are common and recurrent psychiatric disorders. Unipolar or major depressive and bipolar disorders are major categories of mood disorders. Major depressive episodes in each category refer to a sad or depressed mood and alterations in concentration, appetite, sleeping patterns, and functional performance.[1] In comparison, manic episodes manifest as expanded, elated, or irritable mood; decreased need for

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sleep; racing thoughts; inflated self-esteem; and pressured speech.[1] Overall mood disorders have become important contributors to morbidity and mortality related to coexisting physical disorders and suicide risk.[2,3] The high morbidity and mortality of mood disorders are frequently linked to nonadherence to medications. Nonadherence to a treatment regimen is significantly high in patients with mood disorders, particularly those with bipolar disorders. When left untreated or unrecognized, mood disorders are likely to impact quality of life and functionality and contribute to deleterious clinical outcomes. Given the enormity of deleterious clinical outcomes associated with mood disorders, early identification of individuals at risk for coexisting psychiatric, substance use, and physical disorders must be a health care priority.

Prevalence

According to the World Health Organization,[2] major depression is one of most common psychiatric disorders and carries the highest burden of disability among all psychiatric disorders. The prevalence of mood disorders transcends race, ethnicity, socioeconomic class, gender, and age. The onset of depression is around 25 years of age in Western countries, and women are more likely to experience depression than men.[4] Gender, life span, hormonal and environmental factors, and psychosocial- and trauma-related events purportedly expand the risk of depression in women. Significant personal losses, coexisting physical disorders, cognitive deficits, social isolation, life satisfaction, and adjustment to aging are associated with depression in older adults.[5]

Twin and family studies indicate that mood disorders are highly heritable and run in some families. Brain imaging studies implicate alterations in neuroanatomical brain structures and functions in the genesis of unipolar and bipolar disorders.[6] Environmental and psychosocial factors and gender are also linked to the origins of mood disorders. These underpinnings are principal biomarkers and treatment targets and are believed to underlie the onset, maintenance, and recurrence of mood disorders.[7]

Consistent data from large epidemiologic studies point a 1% prevalence of bipolar I disorder and an additional 3% for bipolar II disorder.[4,8,9] Data from the National Comorbidity Study indicate a lifetime prevalence of about 4% for bipolar disorder. Symptoms of bipolar disorder usually emerge in adolescence or early adulthood and rarely in late adulthood.[10] Bipolar disorder is more prevalent in women than men at a ratio of 3:2. The average age for women to have bipolar disorder diagnosed is 25 years and earlier in men. According to researchers, major gender differences in the bipolar disorders include an earlier onset and coexisting substance use disorders (ie, alcohol use) in men compared with higher rates of depression and coexisting psychiatric disorders in women.[11] Concurrent psychiatric, substance use, and physical disorders are more the rule than the exception in patients with bipolar disorder.[12] Similar to unipolar depression, bipolar disorders consume enormous health care resources, but they are more costly in patients with bipolar disorders.[13] A large percentage of patients with mood disorders seek health care services through primary care settings.[14] The high prevalence of patients seeking these services in primary care makes it critical for providers to accurately discern symptoms of mood disorders and coexisting disorders to ensure early and appropriate treatment. High health care costs, including failure to collaborate with a mental health professional and monitor treatment responses, are owing to the impact of these disorders on functional, physical, psychosocial, cognitive and occupational impairment. According to researchers, patients with mood disorders seek services in several health care settings, and average time to receive initial treatment is 10 years. The high incidence of these disorders also contributes to the alarming suicide risk in this population.[2,3,15] Timely recognition, accurate diagnosis, and