

Mood Disorders: Understanding the Patterns of Your Emotions

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June 17, 2026

RECOMMENDED CITATION

mohammad looti (2026). *Mood Disorders: Understanding the Patterns of Your Emotions*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=38618>

Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. The classification is known as mood (affective) disorders in ICD 10.

English psychiatrist Henry Maudsley proposed an overarching category of affective disorder. The term was then replaced by mood disorder, as the latter term refers to the underlying or longitudinal emotional state, whereas the former refers to the external expression observed by others.

Two groups of mood disorders are broadly recognized; the division is based on whether the person has ever had a manic or hypomanic episode. Thus, there are depressive disorders, of which the best known and most researched is major depressive disorder (MDD) commonly called clinical depression or major depression, and bipolar disorder (BD), formerly known as manic depression and characterized by intermittent episodes of mania or hypomania, usually interlaced with depressive episodes.

Classification

Depressive disorders

Major depressive disorder (MDD), commonly called major depression, unipolar depression, or clinical depression, where a person has one or more major depressive episodes. After a single episode, Major Depressive Disorder (single episode) would be diagnosed. After more than one episode, the diagnosis becomes Major Depressive Disorder (Recurrent). Depression without periods of mania is sometimes referred to as unipolar depression because the mood remains at one emotional state or "pole".

Individuals with a major depressive episode or major depressive disorder are at increased risk for suicide. Seeking help and treatment from a health professional dramatically reduces the individual's risk for suicide. Studies have demonstrated that asking if a depressed friend or family member has thought of committing suicide is an effective way of identifying those at risk, and it does not "plant" the idea or increase an individual's risk for suicide in any way. Epidemiological studies carried out in Europe suggest that at this moment, roughly 8.5 percent of the world's population are suffering from a depressive disorder. No age group seems to be exempt from depression and studies have found that depression appears in infants as young as 6 months old who have been separated from their mothers.

Diagnosticians recognize several subtypes or course specifiers:

Atypical depression (AD) is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite ("comfort eating"), excessive sleep or

somnolence (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection. Difficulties in measuring this subtype have led to questions of its validity and prevalence.

Melancholic depression is characterized by a loss of pleasure (anhedonia) in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.

Psychotic major depression (PMD), or simply psychotic depression, is the term for a major depressive episode, particularly of melancholic nature, where the patient experiences psychotic symptoms such as delusions or, less commonly, hallucinations. These are most commonly mood-congruent (content coincident with depressive themes).

Catatonic depression is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporose, and either immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms can also occur in schizophrenia, a manic episode, or be due to neuroleptic malignant syndrome.

Postpartum depression (PPD) is listed as a course specifier in DSM-IV-TR; it refers to the intense, sustained and sometimes disabling depression experienced by women after giving birth. Postpartum depression, which has incidence rate of 10-15%, typically sets in within three months of labor, and lasts as long as three months. It is quite common for women to experience a short term feeling of tiredness and sadness in the first few weeks after giving birth; however, postpartum depression is different because it can cause significant hardship and impaired functioning at home, work, or school as well as possibly difficulty in relationships with family members, spouses, friends, or even problems bonding with the newborn. In the treatment of postpartum major depressive disorders and other unipolar depressions in women who are breastfeeding, nortriptyline, paroxetine (Paxil), and sertraline (Zoloft) are generally considered to be the preferred medications.

Seasonal affective disorder (SAD), also known as "winter depression" or "winter blues", is a specifier. Some people have a seasonal pattern, with depressive episodes coming on in the autumn or winter, and resolving in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times over a two-year period or longer. It is commonly hypothesized that people who live at higher latitudes tend to have less sunlight exposure in the winter and therefore experience higher rates of SAD, but the epidemiological support for this proposition is not strong (and latitude is not the only determinant of the amount of sunlight reaching the eyes in winter). SAD is also more prevalent in people who are younger and typically affects more females than males.

Dysthymia, which is a chronic, different mood disturbance where a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as double depression). The treatment of dysthymia is largely the same as for major depression, including antidepressant medications and psychotherapy.

Depressive Disorder Not Otherwise Specified (DD-NOS) is designated by the code 311 for depressive disorders that are impairing but do not fit any of the officially specified diagnoses. According to the DSM-IV, DD-NOS encompasses "any depressive disorder that does not meet the criteria for a specific disorder." It includes the research diagnoses of recurrent brief depression, and minor depressive disorder listed below.

Recurrent brief depression (RBD), distinguished from major depressive disorder primarily by differences in duration. People with RBD have depressive episodes about once per month, with individual episodes lasting less than two weeks and typically less than 2-3 days. Diagnosis of RBD requires that the episodes occur over the span of at least one year and, in female patients, independently of the menstrual cycle. People with clinical depression can develop RBD, and vice versa, and both illnesses have similar risks.

Minor depressive disorder, or simply minor depression, which refers to a depression that does not meet full criteria for major depression but in which at least two symptoms are present for two weeks.

Bipolar disorders

Bipolar disorder (BD), a mood disorder formerly known as "manic depression" and described by alternating periods of mania and depression (and in some cases rapid cycling, mixed states, and psychotic symptoms). Subtypes include:

Bipolar I is distinguished by the presence or history of one or more manic episodes or mixed episodes with or without major depressive episodes. A depressive episode is not required for the diagnosis of Bipolar I disorder, but depressive episodes are often part of the course of the illness.

Bipolar II consisting of recurrent intermittent hypomanic and depressive episodes.

Cyclothymia is a form of bipolar disorder, consisting of recurrent hypomanic and dysthymic episodes, but no full manic episodes or full major depressive episodes.

Bipolar Disorder Not Otherwise Specified (BD-NOS), sometimes called "sub-threshold" bipolar, indicates that the patient suffers from some symptoms in the bipolar spectrum (e.g. manic and depressive symptoms) but does not fully qualify for any of the three formal bipolar DSM-IV diagnoses mentioned above.

It is estimated that roughly one percent of the adult population suffers from bipolar I, roughly one

percent of the adult population suffers from bipolar II or cyclothymia, and somewhere between two and five percent suffer from "sub-threshold" forms of bipolar disorder.

Substance induced mood disorders

A mood disorder can be classified as substance-induced if its etiology can be traced to the direct physiologic effects of a psychoactive drug or other chemical substance, or if the development of the mood disorder occurred contemporaneously with substance intoxication or withdrawal. Alternatively, an individual may have a mood disorder coexisting with a substance abuse disorder. Substance-induced mood disorders can have features of a manic, hypomanic, mixed, or depressive episode. Most substances can induce a variety of mood disorders. For example, stimulants such as amphetamine, methamphetamine, and cocaine can cause manic, hypomanic, mixed, and depressive episodes.

Alcohol induced mood disorders

High rates of major depressive disorder occur in heavy drinkers and those with alcoholism. Controversy has previously surrounded whether those who abused alcohol and developed depression were self-medicating their pre-existing depression, but recent research has concluded that, while this may be true in some cases, alcohol misuse directly causes the development of depression in a significant number of heavy drinkers. High rates of suicide also occur in those who have alcohol-related problems. It is usually possible to differentiate between alcohol-related depression and depression which is not related to alcohol intake by taking a careful history of the patient. Depression and other mental health problems associated with alcohol misuse may be due to distortion of brain chemistry, as they tend to improve on their own after a period of abstinence.

Benzodiazepine induced mood disorders

The long-term use of benzodiazepines, such as Valium and Librium, may have a similar effect on the brain as alcohol, and are also implicated in depression. Major depressive disorder can also develop as a result of chronic use of benzodiazepines or as part of a protracted withdrawal syndrome. Benzodiazepines are a class of medication which are commonly used to treat insomnia, anxiety and muscular spasms. As with alcohol, the effects of benzodiazepine on neurochemistry, such as decreased levels of serotonin and norepinephrine, are believed to be responsible for the increased depression. Major depressive disorder may also occur as part of the benzodiazepine withdrawal syndrome. In a long-term follow-up study of patients dependent on benzodiazepines, it was found that 10 people (20%) had taken drug overdoses while on chronic benzodiazepine medication despite only two people ever having had any pre-existing depressive disorder. A year after a gradual withdrawal program, no patients had taken any further overdoses. Depression

resulting from withdrawal from benzodiazepines usually subsides after a few months but in some cases may persist for 6-12 months.

Interferon-alpha induced mood disorders

Combination therapy with interferon- α and ribavirin for chronic hepatitis C virus (HCV) infection may induce major depression. In the study by Leutscher et al., evaluating 325 chronically HCV infected patients undergoing antiviral therapy, it was observed that (1) depressive symptoms among patients undergoing HCV therapy are commonly overlooked by routine clinical interviews, (2) the emergence of depression compromises the outcome of HCV therapy, and (3) the Major Depression Inventory (MDI) scale may be useful in identifying patients at risk for treatment-induced depression.

Origin

A number of authors have suggested that mood disorders are an evolutionary adaptation. A low or depressed mood can increase an individual's ability to cope with situations in which the effort to pursue a major goal could result in danger, loss, or wasted effort. In such situations, low motivation may give an advantage by inhibiting certain actions. This theory helps to explain why mood disorders are so prevalent, and why they so often strike people during their peak reproductive years. These characteristics would be difficult to understand if depression were a dysfunction.

A depressed mood is a predictable response to certain types of life occurrences, such as loss of status, divorce, or death of a child or spouse. These are events that signal a loss of reproductive ability or potential, or that did so in humans' ancestral environment. A depressed mood can be seen as an adaptive response, in the sense that it causes an individual to turn away from the earlier (and reproductively unsuccessful) modes of behavior.

A depressed mood is common during illnesses, such as influenza. It has been argued that this is an evolved mechanism that assists the individual in recovering by limiting his/her physical activity. The occurrence of low-level depression during the winter months, or seasonal affective disorder, may have been adaptive in the past, by limiting physical activity at times when food was scarce. It is argued that humans have retained the instinct to experience low mood during the winter months, even if the availability of food is no longer determined by the weather.

Sociocultural aspects

Kay Redfield Jamison and others have explored the possible links between mood disorders--especially bipolar disorder--and creativity. It has been proposed that a "ruminating personality type may contribute to both and art." The relationship between depression and creativity appears to be

especially strong among poets.

Epidemiology

According to a substantial amount of epidemiology studies conducted, women are twice as likely to develop certain mood disorders, such as major depression. There is an equal number of men and women who are diagnosed with bipolar disorder.

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