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TEXTBOOK OF PSYCHIATRY

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Chapter

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Mood Disorders

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MOOD DISORDERS SPAN A WIDE SPECTRUM of conditions, ranging from reactions to loss and other negative life experiences to severe, recurrent, debilitating illnesses. On one end of the spectrum are the relatively normal states dominated by mood and cognitive disturbances. On the other end are the clinical syndromes in which these subtle symptoms become entangled in a complex of physiological symptoms. The illnesses covered in this chapter generally represent the more moderate to severe end of the spectrum: clinical depression and mania, comprising the mood disorders, and a variety of other conditions.

A vast expanse separates depressive *illness* from normal depressed feelings and thoughts. At its worst, the *illness* pervades the person's life, relentlessly changing day-to-day existence. Thoughts are distorted by self-disgust and hopeless despair, concentration is difficult, and suicidal thoughts intrude. Even when the torment subsides, mental processes remain slow: Memory dwindles and thinking disintegrates. Depressed people lack the energy to act, endure night after night of fitful sleep, and take no interest in life around them. They are in pain, a terrible, inescapable, and ultimately indescribable psychic and physical pain that may drive them to suicide. So intense is their suffering that when some depressed individuals have gone on to develop terminal cancer, they found the pain of cancer easier to bear than the pain of depression.

Mania, in its mild or moderate form (hypomania), is the opposite of depression. Thoughts and associations come quickly and are unusually sharp and creative. People who are going through this stage of mania are infused with a euphoric sense of well-being and omnipotence. They are more productive than usual, and more passionate too. But rarely do these halcyon times last. Quick thinking careens into racing thoughts. Ideas become jumbled. Sexuality and the general level of energy are increased and judgment is impaired. Grandiose plans are formulated. Faced with the objections or resistance of others, the manic person become irritable, hostile, paranoid, assaultive, and, sometimes, psychotic. The consequences of all this manic energy can be terrible—lost loves, lost jobs, lost fortunes.

This chapter begins with a brief description of the clinical features of the mood disorders. The history, epidemiology, clinical course, and subtypes for each condition—that is, major depression, bipolar disorders, and schizoaffective dis-

order—are discussed, and problems in differential diagnosis are considered. Next, biological and psychological theories of depression and mania are presented, along with evidence for their validity. The chapter concludes with a discussion of treatments for mood disorders, both somatic and psychotherapeutic.

Clinical Features of Depression

Viewed longitudinally, the natural history and clinical course of the mood disorders are quite varied. Some forms are episodic, others chronic. The symptom picture is frequently consistent across episodes, but it may differ dramatically from one episode to the next, or even change within an episode. The subjective experience of severe depression was described by one patient as follows:

> When I am my normal self I feel active, alive, able to enjoy things and to participate easily with other people; I eagerly seek them out. There is no question but that life and these experiences have great meaning to me. But when depressed it seems as though my friends require much more from me than I can ever possibly give, I seem a drain and burden on them; the guilt and resentment are overwhelming. Everything I see, say, or do seems extraordinarily flat and pointless; there is no color, there is no point to anything. Things drag on and on, interminably. I am exhausted, dead inside. I want to sleep, to escape somehow, but there is always the thought that if I really could sleep, I must always and again awake to the dullness and apathy of it all. I doubt, completely, my ability to do anything well; my mind has slowed down and burned out . . . it's virtually useless. The wretched thing works only well enough to torment me with a dreary litany of my inaccuracies and to haunt me with the total desperate hopelessness of it all. What is the point of going on like this; it is crazy. (Goodwin and Jamison in press)

The patient who first presents to the physician may show involvement in several clinical domains: affect (emotion), drive and other physical functions, somatic complaints, cognition, and behavior; a suicide attempt may have been made. The following are frequent signs and symptoms from these domains.

Affect—Although the most common emotion expressed in depression is sadness, clinical depression can exist without sadness. A variety of other dysphorias may present themselves, including emptiness, "the blues," ennui, and nervousness.

Cognition—Cognitive processes are characteristically slowed, and cognitive content reflects the low self-esteem that is a hallmark of depression. A depressed person may describe himself as the worst person on the face of the earth or declare that everyone would be better off if he were dead. Depressed people often are very pessimistic, always expecting the worst. They typically experience excessive guilt over minor incidents and may even have delusions of guilt. Their impaired judgment can further diminish their ability to cope with stress, and their difficulty concentrating can hinder already-impaired cognitive performance.

Behavior—The social withdrawal characteristic of depression may be so extreme that patients may not get out of bed at all. Depressed patients frequently appear to be in slow motion, talking and moving slowly. Some, on the other hand, may have a difficult time keeping still, constantly wringing their hands and pacing the floor.

Physical functioning—Perhaps the most characteristic abnormalities associated with depression are disturbances in regulation of basic bodily function. These include problems with sleep, such as difficulty falling asleep and middle-of-the-night or early-morning awakening (sometimes two to three hours prior to the individual's normal wake-up time). Changes in appetite are frequent, most often a loss of appetite and weight, but in some forms a substantial increase in both; depressed patients often complain that food has no taste and holds no interest for them. Libido suffers and may be completely lost. The ability to experience pleasure can also be so diminished that nothing is enjoyable.

Neuroendocrine functioning is disturbed in some patients. Endocrine responses to such tests as insulin challenge are often abnormal. Many abnormalities occur in the metabolism and presumed function of central neurotransmitters. Circadian and other body rhythms are typically disturbed.

Somatic functioning—Depression is often missed in primary care clinics because patients complain of somatic problems, such as constant fatigue, headaches, or gastrointestinal upsets, rather than depressed mood.

Suicide—Approximately 15 percent of seriously depressed individuals may eventually kill themselves.

Clinical Features of Hypomania and Mania

Mania in its milder forms represents the opposite of depression. Severe mania is, however, quite dysphoric and the simultaneous occurrence of depres-

sion and mania, called *mixed states*, is commonly associated with frank mania. This is how one patient described it:

> The fast ideas become too fast and there are far too many. . . overwhelming confusion replaces clarity . . . you stop keeping up with it—memory goes. Infectious humor ceases to amuse—your friends become frightened . . . everything is now against the grain . . . you are irritable, angry, frightened, uncontrollable and trapped in the bleakest caves of the mind—caves you never knew were there. It will never end. Madness carves its own reality. (Goodwin and Jamison in press)

Affect—The predominant mood is elevated, expansive, or irritable.

Cognition—A hallmark of hypomania is an acceleration of cognitive processes, progressing (in mania) to racing thoughts and flight of ideas. In conversation, the person jumps from one topic to another in a seemingly random fashion without returning to the original topic and is also easily distracted. Inflated self-esteem can lead to grandiose ideas and the belief that he or she is unique and in possession of special powers.

Behavior—Very disturbed behavior is a hallmark of mania. Increased psychomotor activity is accompanied by general restlessness. Patients tend to be very talkative and verbally intrusive, and their speech has a pressured quality. They will typically go on wild buying sprees, get involved in sexual indiscretions, pursue foolish business investments, and drive recklessly.

Physical Functioning—Patients with mania usually need less sleep and, indeed, may not sleep at all for days at a time. Their increased activity level appears to be driven by boundless energy. A heightened sexual drive may lead to uncharacteristic promiscuity. In the milder stages, the ability to experience pleasure is enhanced; appetite for food may become voracious. As in depression, abnormalities occur in neuroendocrine functioning, body rhythms, and neurotransmitter metabolites. These abnormalities are sometimes reciprocal with those found in depression, but sometimes are identical.

☐ DIAGNOSIS

Modern approaches to diagnosis of depression began with Emil Kraepelin, the German psychiatrist who pioneered classification of psychiatric disorders early in this century. Following a medical model, Kraepelin emphasized both longitudinal history and the pattern of current symptoms. He proposed that manic-depressive illness constituted a genetic spectrum of disorders, including what we now call bipolar disorder, recurrent major depression, cyclothymia, and some patients with dysthymia.

Kraepelin differentiated manic-depressive illness from dementia praecox (that is, schizophrenia) because the group he called manic-depressive shared a periodic or episodic course, a relatively benign prognosis, and family history of similar disorders. Schizophrenia, by contrast, was marked by a chronic, deteriorating course and no family history of manic-depressive illness. His views were codified in a series of textbooks that were very influential throughout Europe. His approach formed the basis for the diagnostic system developed by the St. Louis group of Robins, Winokur, and Guze (Feighner 1972), which evolved into the *Diagnostic and Statistical Manual of Mental Disorders (Third Edition) (DSM-III*; American Psychiatric Association 1980).

In the United States, psychiatry began this century quite unlike it did in Europe. Adolph Meyer, who exerted great influence during the first half of the century, saw psychiatric disorders as primarily the outcome of interactions between the individual and the environment. Although he acknowledged a role for genetics and other biological contributions, his methods and teaching clearly emphasized psychosocial factors. On the basis of careful life histories that he constructed of each patient, Meyer related important life experiences to the development and expression of illness.

Meyer's views contrasted with Kraepelin's medical model, which posited that clinical phenomena in a given patient were understandable in terms of a given disease and its specific natural history and pathophysiology. This model had been very successfully used with general paresis secondary to central nervous system syphilis and with organic syndromes associated with vitamin deficiencies. However, until the advent of specific pharmacological treatments a half century later, it was not considered particularly useful as a basis for treatment approaches for the functional psychoses.

In 1957 Karl Leonhardt, another German psychiatrist, enlarged upon Kraepelin's unitary concept of depression. He proposed that manic–depressive illness be separated into "bipolar" (pa-

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