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CHAPTER 13

MOOD DISORDERS

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One knows not whether there can be human compassion for anemia of the soul. When the pitch of life is dropped and the spirit is so put over and reversed that only is horrible which before was sweet and worldly and of the day, the human relation disappears.

—Oliver Onions

Mood disorders can be relatively straightforward, or they can assume complex forms that can be difficult to treat. In this chapter, we review the epidemiology, diagnosis, comorbidity, and treatment of the wide variety of affective syndromes that are encountered in psychiatric practice.

EPIDEMIOLOGY

Estimates of the incidence and prevalence of mood disorders vary. In the United States, the lifetime risk of a major depressive episode is said to be around 6%, and the lifetime risk of any mood disorder is said to be around 8% (Cassem 1995; Kashani and Nair 1995). The prevalence of major

depression ranges from 2.6% to 5.5% in men and from 6.0% to 11.8% in women (Fava and Davidson 1996). The prevalence of dysthymia is 3%–4% (Keller et al. 1996). Some reports suggest that as much as 48% of the United States population has had one or more lifetime mood episodes (Cassem 1995). Most studies have found unipolar depression in general to be twice as common in women as in men (Reynolds et al. 1990). The meaning of the gender difference remains to be clarified. Gender does not appear to affect the prevalence of bipolar disorder (Reynolds et al. 1990). The incidence of major depression is higher in separated or divorced people than in married individuals, especially men, and in medically ill patients (Lehtinen and Joukamaa 1994; Reiger et al. 1988), and depression is associated with greater use of general health services

(Weissman et al. 1988b). The prevalence of major depression in primary care practice is 4.8%–9.2%, and the prevalence of all depressive disorders is 9%–20%, which makes mood disorders the most common psychiatric problems in primary care (McDaniel et al. 1995).

The effects of culture and stress on the prevalence of depression were illustrated by the Cross-National Collaborative Group study of 10 countries, which used the Diagnostic Interview Schedule to make DSM-III (American Psychiatric Association 1980) diagnoses (Weissman et al. 1996). In this study, the lifetime rate for major depression varied from a low of 1.5 cases/100 adults in Taiwan to as many as 19.0/100 in Beirut, and the annual rate of depression was as low as 0.8 cases/100 in Taiwan and as high as 5.8/100 in New Zealand.

The prevalence of bipolar disorder is generally reported as being between 1% and 2.5% (Akiskal 1995b; Angst 1995; Bebbington 1995; Kashani and Nair 1995); however, some studies suggest rates for bipolar mood disorders of 3%–6.5% (Akiskal 1995b; Angst 1995). The frequency with which bipolar disorder is diagnosed probably depends on how it is defined; broader definitions produce significantly higher rates (Akiskal 1995b; Angst 1995). Most prevalence studies require the presence of mania for a bipolar diagnosis to be recorded, but the bipolar II variant, which is characterized by episodes of hypomania but not mania, is more common than the bipolar I variant (Cassano et al. 1989; Simpson et al. 1993). If bipolar spectrum disorders (Akiskal 1995b), or subsyndromal and complex forms of bipolar disorder (discussed later in this chapter), are also considered, the incidence of bipolar mood disorder is substantially higher. Roughly 10%–15% of patients with a diagnosis of unipolar depression will eventually receive a revised diagnosis of bipolar disorder (Olie et al. 1992).

When conservative criteria are used, between 5% and 15% of cases of adult depression are found to be bipolar (Bebbington 1995; Geller et al. 1996). Akiskal's group (Cassano et al. 1989) found that one-third of patients with primary depression met their criteria for bipolar spectrum disorders. The risk of bipolarity is higher in juvenile major depression—at least 20% in adolescents and 32% in children ages less than 11 years (Geller et al. 1996). The lifetime rate of bipolar disorder is relatively consistent across cultures, ranging from 0.3/100 in Taiwan to 1.5/100 in New Zealand (Weissman et al. 1996).

In all industrialized countries in the world, the incidence of depression, mania, suicide, and psychotic mood disorders has been increasing in every generation born after 1910 (Cross-National Collaborative Group 1992; Klerman 1988; Klerman et al. 1985). For unknown reasons, there was an abrupt jump in the rate of increase for

people born after 1940—a true increase in the incidence of mood disorders (cohort effect) and not a function of better recognition (Cross-National Collaborative Group 1992; Klerman 1988; Klerman et al. 1985). Not only are mood disorders becoming more common, but they are appearing at an earlier age (especially bipolar mood disorders) (Lasch and Weissman 1990).

Suicide is an obvious public health problem that complicates mood disorders more frequently than other conditions. The lifetime risk of suicide in mood disorders is 10%–15% (Barklage 1991; Guze and Robbins 1970; Mueller and Leon 1996), and the risk of attempted suicide was increased 41-fold in depressed patients compared with those with other diagnoses in the Epidemiologic Catchment Area survey (Petronis et al. 1990). It is well known that women attempt suicide more frequently than men, but men are more likely to succeed. In one study, however, the excess risk of completed suicide in men was entirely accounted for by a higher prevalence of substance abuse in men and a greater likelihood that women have primary responsibility for children under age 18 (Young et al. 1994). The risk of suicide is high in mania as well as in depression. Patients with mixed bipolar states characterized by a combination of depression, rage, and grandiosity may be more likely to involve others in a suicide attempt—for example, through gunfights with the police. As many as 4% of people who commit suicide murder someone else first.

Although many clinicians agree on factors that increase the risk of suicide, formal attempts to predict suicide have been disappointing (Oxley and Van Meter 1996). This is not surprising; suicide is such a rare event (in the United States, the rate is about 11/100,000) that a prohibitively large number of patients would have to be followed prospectively to demonstrate that a constellation of features predicted an increased risk. In addition, no consensus exists about how long to follow a depressed patient before a conclusion can be made that suicide will not occur. There may be a statistically significant association between suicide and traditional risk factors such as older age, recent loss, male sex, bipolar depression, psychosis, comorbid substance abuse, history of a suicide attempt (especially if it was dangerous), and family history of suicide, but this association is not necessarily helpful in predicting suicide in an individual patient.

Despite the demonstrated inability of mental health professionals to predict (or prevent) suicide in any systematic manner (H. L. Miller et al. 1984), patients, families, and courts expect them to be able to do so. In an evaluation of immediate suicide risk, factors summarized in Table 13-1 can be considered (Oxley and Van Meter 1996; Pokorny 1993; Young et al. 1994). However, these factors

TABLE 13-1. Factors suggesting an increased risk of suicide

Demographic factors
Male sex
Recent loss
Never married
Older age
Symptoms
Severe depression
Anxiety
Hopelessness
Psychosis, especially with command hallucinations
History
History of suicide attempts, especially if multiple or severe attempts
Family history of suicide
Active substance abuse
Suicidal thinking
Presence of a specific plan
Means available to carry out the plan
Absence of factors that would keep the patient from completing the plan
Rehearsal of the plan

at best suggest increased immediate risk. In addition, it is not known whether one risk factor is more important than another or how risk factors may interact with each other (Oxley and Van Meter 1996). Given the current state of knowledge, it is probably impossible for anyone to predict with any accuracy the long-term risk of completed suicide.

MOOD DISORDERS IN SPECIAL POPULATIONS

Postpartum depression occurs in about 10% of mothers; risk factors include a history of a mood disorder, unwanted pregnancy, unemployment of the mother, lack of breast-feeding, and the mother as head of the household (J. Hopkins et al. 1984; Warner et al. 1996). Postpartum depression increases the chance of alcohol and illicit drug use in teenage mothers (Barnet et al. 1995). There is some evidence that depression in a mother adversely affects temperament (C. T. Beck 1996) and cognitive development (Hay and Kumar 1995) in the infant. Depressed mothers of preschoolers have more negative perceptions of and interactions with their children (Lang et al. 1996).

Estimates of the prevalence of major depression in elderly people range from 2%–4% in community samples to 12% of medically hospitalized patients to 16% of geriatric patients in long-term care (Blazer and Koepsell 1996). Geriatric

depression is associated with an increased likelihood of cerebrovascular disease and enlarged ventricles and may be more likely than depression in younger patients to be accompanied by prominent cognitive complaints (Soares and Mann 1997).

Major depressive disorder (MDD) is said to occur in as many as 18% of preadolescents, with no gender differences (Kashani and Nair 1995). However, mood disorders are often underdiagnosed in this population because many clinicians still do not believe that depression occurs in children and because depression may be more difficult to recognize in children than in older patients. Among adolescents, the prevalence of MDD has been reported to be 4.7% in 14- to 16-year-olds (Kashani and Nair 1995). By this age, depression is more common in girls than in boys (Kashani and Nair 1995). In nonclinical samples, up to one-third of adolescents reported some depressive symptoms (Kashani and Nair 1995). Major depression in adolescents is associated with substance abuse and antisocial behavior, both of which sometimes obscure the affective diagnosis (Kashani and Nair 1995). The lifetime prevalence of bipolar disorder was 0.6% in 150 adolescents who were not psychiatrically referred (Kashani and Nair 1995). As discussed later in this chapter, many cases of bipolar disorder in younger patients may be overlooked because many depressed children and adolescents have not yet had time to exhibit mania and because manic symptoms, when present, may be confused with behavior disorders and attention-deficit disorder.

ECONOMICS OF MOOD DISORDERS

Depression produces more impairment of physical functioning, role functioning, social functioning, and perceived current health, is associated with more bodily pain, and causes patients to spend more days in bed due to poor health than hypertension, diabetes, arthritis, and chronic pulmonary disease (Wells et al. 1989). In a study of general medical patients in a health maintenance organization, patients with depressed mood or anhedonia of 2 weeks' duration but with an insufficient number of additional symptoms to meet full criteria for MDD still had 7.7 times as much impairment of social, family, and work functioning as did patients without any depressive symptoms (Olfson 1996). The total cost of depressive disorders in the United States is generally estimated at \$44 billion (Hall and Wise 1995). This is equivalent to the total cost of coronary heart disease, a condition that is no more prevalent and less readily treatable than depression. The direct costs of treating depression are about \$12 billion, only \$890 million of which is accounted for by the price of antidepressants (Hall and Wise 1995). Yet tremendous effort is being

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