Practical Psychiatry in Medicine

Part 14: Mood Disorders

Of the two major disorders of mood, depression and mania, depression is by far the more common.

Depression is one of the most common, serious disorders to affect mankind; the lifetime likelihood for anyone in the population to have a depressive illness is in the neighborhood of 5 to 10 percent. The ratio of depressed females to males is about 2 to 1. Although depression can occur in the very young it is primarily a disorder of adulthood, probably reaching its peak incidence in the fifth to seventh decades of life. The toll exacted by depressive illnesses in terms of human suffering, functional impairment, and economic loss is unquestionably enormous though difficult to measure. The lifetime risk of completed suicide among depressed patients has been estimated to be about 15 percent.[3]

The Depressive Syndrome

Depression may occur in the apparent absence of a precipitating event but not infrequently its onset follows a psychologically stressful event within a few days or weeks. The type of antecedent stress is frequently of a sort that involves a loss of some kind, such as that posed by separation or divorce, death or serious illness of a loved one, moving to a new place of residence or to a new job, failure to perform satisfactorily at work or school with consequent loss of status or loss of certain hopes for the future, decline in ability to function as a result of illness or aging, and so forth. It is of practical and theoretical importance that some depressive illnesses continue long past the time when one would expect the patient to be getting over the effects of the disappointment or loss. In these cases it is as though the depression, though apparently precipitated by the "loss," continues autonomously just as aspiration pneumonia, which begins when the patient is comatose, continues after the patient is fully awake.

The clinical manifestations of depression may be grouped as follows: (1) subjective change in mood, (2) characteristic attitudes toward the self, (3) characteristic attitudes toward the future, (4) psychomotor symptoms, and (5) physiologic symptoms and somatic complaints.

Subjective Change in Mood

Typically, the patient complains of feeling "low," "down," "despondent," "blue," "sad," "unhappy," or simply "depressed." It is of interest that some patients will not spontaneously complain of the change in mood but will readily and often tearfully acknowledge it when directly asked.

Others may tend to dismiss the depressed mood as unimportant by ascribing it to some other symptom such as pain or fatigue. In such a case, the patient may state, in effect, that anyone would feel unhappy or depressed if he constantly had a particular discomfort such as an ache or pain or fatigue. Such a patient, who thus tends to minimize the subjective mood change of depression, may unknowingly mislead the physician diagnostically.

Still other patients seem to have little or no feeling of sadness even though they show other signs and symptoms of severe depression.

Frequently, the mood change and other symptoms of depression show diurnal variation, being worse in the morning than later in the day.

Attitudes toward the Self

In mild depression, characteristically depressive attitudes toward the self may be sufficiently subtle as to escape discernment in a single interview. With increasing severity, however, the patient manifests unmistakable, highly characteristic attitudes toward himself which take the form of feeling that in one or more ways he has failed to live up to certain standards that he has set for himself. The patient may feel that his relatives and associates share his conviction that he is a failure or, alternatively, he may feel that others would share this perception of himself if they really knew him. The latter notion is often accompanied by the feeling that he has been a phony who has gone through life giving people a false impression of himself.

Typically, the patient conceives of his personal failure as stemming from (one or both) inadequacy and immorality. Thus, the patient may express conviction that he has mismanaged his business; that he is woefully lacking in those qualities

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The following chapter has been selected by the Publisher from its forthcoming book, *Practical Psychiatry in Medicine,* by John B. Imboden, MD and John Chapman Urbaitis, MD, in the hope that it will have immediate usefulness to our readers.

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necessary to being an adequate spouse, parent, friend, or professional; that he has no stamina; and that he lacks the strength of his convictions or that he has no convictions. Some investigators have observed that it is extremely common for the depressed patient to view himself as a "loser," and that this self-perception is often manifested in dreams as well as in the patient's statements.

Notions of being a failure morally are common among depressed patients. The associated feelings of guilt may be rather vaguely rationalized or they may be "explained" on the basis of some "sinful" or immoral behavior, which may strike the observer as being relatively trivial or as having occurred so far in the past that current reactions of guilt seem inappropriate. On the other hand the guilt feelings may be associated with global assertions by the patient that he has been greedy, selfish, inconsiderate of others, incapable of love, and so forth.

The perceptions of the self as inadequate, immoral, or both may be so obviously inappropriate and rigidly held as to clearly constitute delusional thinking. In extreme cases self-debasing attitudes may be presented in the form of gross distortions of body image or somatic delusions. Thus, the patient may have a delusion that his abdominal cavity is empty ("no guts"), his cerebral cortex is necrotic, feces is excreted from the pores in his skin, or he may state that he now sees himself as dirty or ugly when he looks in the mirror. In a peculiarly grandiose way, he may feel guiltily responsible for the misfortunes of others such as the illnesses of other patients on the ward.

Attitudes toward the Future

In varying degrees, the depressed patient has a pessimistic and fearful attitude toward the future.

The patient's pessimism may involve his own illness which he may recognize as being a depression, it may involve some particular symptom such as pain or fatigue, or it may involve one of his fear-laden worries. It is not rare for the patient's pessimism to progress to the point of utter hopelessness. Thus, the patient may feel that he is beyond help, that he is condemned to feeling miserable for the rest of his life, or that one of his worst fears is going to be realized. Patients who feel severely depressed invariably think about death, usually wish for death, and if hope has been replaced by despair, may intend to commit suicide. The assessment of the patient's hopefulness versus despair and passive wishes for death versus active planning to suicide is critically important to management.

It is sometimes clear that the patient's attitude of despair is related to his self-concept as previously described. Thus, the patient who feels intensely guilty may feel that he deserves to suffer even more than he already has. Expectation of punishment may reinforce the patient's fear that some misfortune or catastrophe will happen to him or his loved ones, such as business failure, getting fired, sickness, and accidents.

Psychomotor Symptoms

Decline in interest, inability to experience pleasure, decrease in energy, and chronic fatigue are common features of depression. The patient may note that tasks which normally are easy and routine now seem difficult and burdensome.

Psychomotor retardation frequently occurs in severe depression and refers to a condition in which the patient feels mentally sluggish and is slow to respond to stimuli, both verbally and nonverbally. Speech may be sparse and in a low tone. The patient finds it difficult to concentrate, to take the initiative, and to make decisions. Productivity at home and at work markedly declines. Psychomotor retardation may progress to the point at which the patient becomes almost totally unresponsive and virtually mute, the so-called depressive stupor.

Agitation is sometimes observed in depressed patients. It is possible for the same patient to show predominantly agitation at one time and retardation at another. Agitation may take the form of relatively mild, transient periods of restlessness or relentless pacing back and forth, handwringing, and anxious, clinging behavior.

Physiologic Accompaniments and Somatic Complaints

In addition to psychomotor activity, several other bodily functions are frequently affected in depression, especially sleeping, eating, sexual activity, and bowel function. Insomnia is very common in depression and is often characterized by awakening earlier than usual; difficulty in getting to sleep and sleeping fitfully throughout the night are not unusual. Hypersomnia is occasionally seen. Anorexia and consequent weight loss are frequent accompaniments of depression. Sexual difficulties may range from loss of interest in sex, which seems to be part of a generalized loss of interest in normal pleasurable activities, to erectile impo-

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