INTRODUCTION

The Triad of Psychiatry

Sigmund Freud, considered the father of psychoanalysis and modern psychiatry, provided 2 approaches to conceptualizing the human mind: the structural schema and the topographic schema (see Chapter 13). Adding a diagnostic schema (Table) provides the clinician an overview of the major psychiatric disorders.

Freud's Structural Schema	*Freud's Topographic Schema*	*Goldman's Diagnostic Schema*
• Id	• Conscious	• Mood Disorder
• Ego	• Preconscious	• Anxiety Disorder
• Superego	• Unconscious	• Thought Disorder

Table. Goldman's Diagnostic Schema

Affective/Mood Disorder	Anxiety Disorder	Thought Disorder
Adjustment disorder	Panic disorder (with or without agoraphobia)	Brief reactive psychosis
Major depressive disorder (with or without psychotic features)	Generalized anxiety disorder	Schizophreniform disorder
Dysthymic disorder	Specific phobia	Schizophrenia
Cyclothymic disorder	Social phobia	
Bipolar disorder	Acute stress disorder/post-traumatic stress disorder	
	Obsessive-compulsive disorder ----------→	Delusional disorder

Affective/Mood Disorder ↑---------- **Schizoaffective Disorder** ----------↑ **Thought Disorder**

Goldman's Diagnostic Schema illustrates the overarching construct of psychiatry divided into the disorders of mood, anxiety, and thought. These 3 separate categories sometimes become blurred. A mood disorder is often intertwined with anxiety; an anxiety disorder often begets a mood disorder. A mood disorder can become so severe that thought processes become disorganized, as in major depressive disorder with psychotic features. Obsessive-compulsive disorder can become so overwhelming and entrenched that it can look and feel like a delusional disorder, a form of thought disorder.

Diagnoses are not always clearly discrete. The above-listed categories of mood, anxiety, and thought intersect and interweave. While many psychiatric diagnoses fall outside the confines of the categories of mood, anxiety, and thought, it is these 3 categories that constitute the overarching construct of psychiatry. The purpose of this book is to assist in understanding and simplifying the complexities of the diagnoses and to facilitate treatment approaches.

CHAPTER ONE

Recognition and Treatment of Mood Disorders

Mood disorders are best considered in a progression from the least severe of conditions to the most disruptive of conditions. Euthymia is the baseline that equates to balanced mood, and mood disorders are disruptions above and below this balance. Psychiatry assesses the descents and elevations in mood (Figure 1).

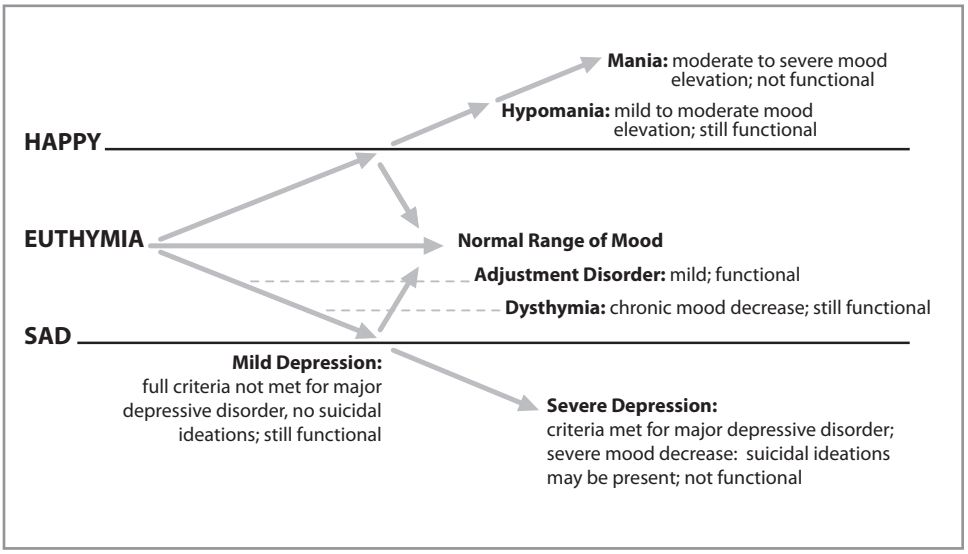

Figure 1. The Goldman Mood Map

TYPES OF MOOD DISORDERS

Moods Below Euthymia

Adjustment Disorder. Externalized psychosocial stressors, such as failing an examination, losing a job, experiencing a divorce, or losing a loved one, can disrupt life outlook. Individuals may experience difficulty in adjusting

to these occurrences and their results. An adjustment disorder involves a readily identifiable psychosocial stressor occurring within 3 months of the decline in life outlook. Typically, return to baseline functioning should occur within 6 months of resolution of the life event. The adjustment disorder can last longer than 6 months, however, if it is a response to a chronic stressor or one with continuing consequences. An adjustment disorder is milder than a major depressive disorder. Individuals with an adjustment disorder typically remain functional in their daily lives, yet recognize the need for help.

Dysthymic Disorder (Dysthymia). Presenting as a long-term mild-to-moderate decline in mood, dysthymia manifests in adults as a chronic decreased mood lasting for most of the day, every day, for 2 years or more. In children or adolescents, the diagnosis should be suspected if 1 year of chronic decreased mood or irritability has occurred. Along with decreased mood, 2 of the following must also be present:

- Change in appetite
- Change in sleep patterns
- Decrease in concentration or memory
- Decrease in energy
- Decrease in self-esteem
- Feelings of hopelessness

Dysthymia is hallmarked by a loss of interest in life activities and decreased mood that does not meet the criteria for a major depressive disorder. It presents as a milder form of chronic depression. Unfortunately, while its day-to-day symptomatology may not be as severe as that found in major depressive disorder, because of its long-term chronicity, it can have more devastating results in someone's social and occupational life. Individuals suffering from dysthymia may experience episodes of major depressive disorder as well. When these individuals suffer superimposed episodes of major depression, it is termed *double depression*. To make this diagnosis, there cannot be an absence of the symptoms for more than 2 consecutive months (during the 2 year period for adults/1 year period for children).

Major Depressive Disorder. **The hallmark of major depressive disorder is the major depressive episode.** Individuals suffering a major depressive episode experience at least 5 of 9 of the below listed symptoms as disruptions in their lives most of the day, every day, for 2 consecutive weeks:

- Changes in motor functioning (either agitation or retardation)
- Changes in sleep patterns (either increased or decreased sleep)
- Changes in weight (either weight loss or gain)
- Depressed mood
- Disturbance in the ability to concentrate or remember things
- Feelings of worthlessness, guilt, or shame
- Loss of daily energy
- Loss of interest in life activities
- Thoughts of dying, including suicidal thoughts

To meet the criteria of a major depressive episode, at least one of the life disruptions must be either loss of interest in life activities (anhedonia) or a depressed mood. The impact of the combination of the disturbances leaves the individual marginally functional at best, nonfunctioning at worst.

Moods Above Euthymia

Bipolar Disorder. The disease of bipolar disorder is comprised of either a manic episode with or without a depressive episode, or a hypomanic episode with one or recurrent depressive episodes. Hypomania and mania are the hallmark components for diagnosing bipolar disorder, differentiating it from a unipolar depression which is limited to mood below euthymia.

Hypomanic and Manic Episodes. Hypomania involves either mild-to-moderate elevation of mood or irritability. Individuals with a mildly or moderately elevated or irritable mood lasting at least 4 days who concurrently experience at least 3 (4 if irritable) of the behaviors listed below are having a hypomanic episode. If the elevated mood or irritability lasts a week or more along with the additional symptoms, the person should be diagnosed as having a manic episode:

- Subjective feeling of racing thoughts
- Disturbance in concentration and focus
- Inappropriately elevated self-esteem
- Uncharacteristic risk-taking behavior
- Increase in motor activity
- Increase in pursuing goals and tasks
- Increase in talkativeness
- Less need for sleep

THE DIAGNOSIS AND TREATMENT OF DEPRESSION

Diagnosing Depression

In major depressive disorder, there is disturbance in the individual's SAMCEL(S) (Box 1) all day, every day for at least 2 weeks. There are 2 types of depression, typical depression, affecting 52% to 58% of depressed individuals; and atypical depression, affecting 42% to 48% of depressed individuals.

Utilizing SAMCEL(S) provides the data to differentiate between the 2 types of depressive disorder. The individual is asked a series of questions as follows:

- How is your sleep? Do you have any difficulty in:
  - ❑ Initiating sleep?
  - ❑ Maintaining sleep?
  - ❑ Awakening/not feeling rested on awakening?
- How is your appetite?
  - ❑ Increased?
  - ❑ Decreased?
  - ❑ The same as usual?
- How is your memory?
  - ❑ Increased?
  - ❑ Decreased?
  - ❑ The same as usual?
- How is your concentration?
  - ❑ Increased?
  - ❑ Decreased?
  - ❑ The same as usual?
- How is your energy?
  - ❑ Increased?
  - ❑ Decreased?
  - ❑ The same as usual?
- How is your libido (interest in sexual activity)?
  - ❑ Increased?
  - ❑ Decreased?
  - ❑ The same as usual?
- Are you having any suicidal thoughts? Do you
  - ❑ Want to hurt yourself?
  - ❑ Want to kill yourself?
  - ❑ Want to die?

Box 1. SAMCEL(S) the Psychiatric Vital Signs

In other medical specialties, the individual's baseline state of health is reflected in the vital signs of blood pressure, body temperature, and heart rate. In psychiatry, 6 neurovegetative functioning inventory indices represent the individual's psychiatric vital signs and can be remembered via the acronym SAMCEL(S):

- **S**leep
- **A**ppetite
- **M**emory
- **C**oncentration
- **E**nergy
- **L**ibido

Plus

- **S**uicidal ideations

Plus ID

- **I**nterest lost in life activities
- **D**epressed mood

Utilizing SAMCEL(S) at each individual session helps assess the individual in a rapid, logical, organized fashion providing a clearer global perspective and a record of the individual's progress. SAMCEL(S) plus ID capture the criteria for major depressive disorder found in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-TR*.

In typical depression, the individual will describe difficulty falling asleep, loss of appetite, decrease in memory and concentration, energy that is nervous and nonproductive, and loss of libido. Suicidal thoughts may or may not be present. In atypical depression, individuals describe excessive sleepiness, excessive appetite, decrease in memory and concentration, absence of energy,

and loss of libido. Suicidal thoughts may or may not be present (Table 1). The 3 important distinguishing elements of atypical depression are:

- Hypersomnia (excessive sleeping)
- Hyperphagia (excessive eating)
- Anergia (lack of energy)

Table 1. Typical Versus Atypical Depression: Assessing the 6 Neurovegetative Functioning Inventory Indices

Indices	Typical Depression	Atypical Depression
Sleep	⇓ Individual reports thinking all night about what is bothering him or her	⇑⇑ Individual reports sleeping all the time and awakening still tired
Appetite	⇓	⇑⇑ Individual reports being on the "see-food diet": I see food and I eat it
Memory	⇓	⇓
Concentration	⇓	⇓
Energy	⇑ Individual reports increased nonproductive energy	⇓⇓ Individual describes feeling like a slug
Libido	⇓	⇓
Suicidal ideations	+/0 Individual may or may not have suicidal thoughts	+/0 Individual may or may not have suicidal thoughts

⇑= increase; ⇑⇑ = dramatic increase; ⇓ = decrease; and ⇓⇓ = dramatic decrease.

Treating Depression with Medication

Note: Before initiating any therapy, the clinician should obtain informed consent from the patient, parent, or guardian (see Appendix 1).

To understand the use of antidepressant medications, it is important to understand the biological theory of depression, in particular, the monoamine