# The American Psychiatric Press Textbook of Psychiatry
## *Second Edition*

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CHAPTER 13

# Mood Disorders

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The terms "mania" and "melancholia," which arose in antiquity and took on varied meanings over the centuries, came into clearer definition in the last 100 years and continue to be refined. According to Berrios (1988), "Historical analysis shows that before the nineteenth century these noble words were but semantic palimpsests in which meanings had been deposited in a staccato fashion" (p. 13). Nonetheless, in about 150 A.D., Aretaeus seemed on target: "The melancholic cases tend towards depression and anxiety only . . . if, however, respite from this condition of anxiety occurs, gaiety and hilarity in the majority of cases follows, and this finally ends in mania" (qtd. in Goodwin and Jamison 1990, p. 58).

Originally, mania was a rather nonspecific term for madness, and melancholia was a subtype of mania associated with a reduction in behavioral output. During the 19th century, the current meaning of these terms took shape. As Berrios (1988) notes, "In 1800 mania meant 'madness' and was the best example of total insanity; in 1900 the term named a specific psychiatric syndrome" (p. 16). In the early 19th century, melancholia attained greater specificity by reflecting a sad affect. Photographer Hugh W. Diamond in 1858 captured the melancholy mood (Figure 13–1; Gilman 1976). By the mid-19th century the word "depression" had become better established as describing conditions associated with low mood. Soon, depression and melancholia were used interchangeably, and eventually melancholia came to represent a severe, endogenous subtype of depression.

In 1854, Falret described *folie circulaire,* and, in the same year, Baillarger, another French physician, characterized *la folie à double form*—both individuals independently recognizing alternating episodes of mania and depression as a single disorder. Falret explained: "We call it *circular insanity* (*la folie circulaire*) because the unfortunate patients afflicted with this illness live out their lives in a perpetual circle of depression and manic excitement interrupted by a period of lucidity, which is typically brief but occasionally long lasting" (Falret 1854, qtd. in Sedler 1983, p. 1129).

Emil Kraepelin differentiated the episodic course and better prognosis of manic-depressive insanity from the chronicity and deterioration of *dementia praecox* (i.e., schizophrenia). In the late 1800s and early 1900s, he expressed the conviction that manic-depressive insanity was "a single morbid process" that included "on the one hand the whole domain of so-called *periodic and circular insanity,* on the other hand *simple mania,* the greater part of the morbid states termed *melancholia* and also a not inconsiderable number of cases of *amentia*" (Kraepelin 1921, p. 1).

In the United States, the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I) appeared in 1952 and reflected the psychobiological influence of Adolph Meyer. Mood disorders that were considered psychotic included "involutional psychotic reaction" and "affective reactions" (i.e., manic-depressive reaction, manic type, depressive type, and other; and psychotic depressive reaction). Also described were a psychoneurotic depressive reaction and cyclothymic personality disturbance (American Psychiatric Association 1952).

In 1968, DSM-II eliminated the term "reaction" and under the heading of major affective disorders (affective psychoses) included involutional melan-

cholia and the manic, depressed and circular types of manic-depressive illness (manic-depressive psychosis) (American Psychiatric Association 1968). It is important to realize that in both DSM-I and DSM-II, an illness characterized exclusively by recurrent depressive episodes was, nonetheless, diagnosed as manic-depressive. In DSM-II, depressive neurosis was defined as an excessive depressive reaction to an internal conflict or an external event. Cyclothymia, characterized by "recurring and alternating periods of depression and elation," remained classified as a personality disorder.

Twelve years later, in 1980, DSM-III (American Psychiatric Association 1980) incorporated Leonhard's concept of monopolar (unipolar) and bipolar disorders and thus divided the major affective disorders into bipolar (mixed, manic, and depressed) and major depression (single episode and recurrent). The "other specific affective disorders" category included cyclothymic disorder (no longer classified as a personality disorder) and dysthymic disorder (previously known as depressive neurosis). The residual categories of atypical bipolar disorder and atypical depression were created to include those disorders for which the above categories were not applicable.

**Figure 13–1.** Melancholia. Reprinted from Gilman SL (ed): *The Faces of Madness: Hugh W. Diamond and the Origins of Psychiatric Photography.* New York, Brunner/Mazel, 1976. Copyright 1976, Royal Society of Medicine. Used with permission.

Only 7 years later the revision of DSM-III appeared (DSM-III-R; American Psychiatric Association 1987). In DSM-III-R the affective disorders of DSM-III were now referred to as mood disorders. Mood was described as "a prolonged emotion that colors the whole psychic state" (American Psychiatric Association 1987, p. 213). Affect had been defined elsewhere as "the outward manifestation of a person's feeling, tone, or mood" (American Psychiatric Association 1984, p. 3). Semantics aside, mood disorders and affective disorders are one and the same, and, practically speaking, the terms are used interchangeably. The diagnostic category of bipolar disorder now includes bipolar disorder, mixed, manic, or depressed; cyclothymia; and bipolar disorder not otherwise specified (NOS). The depressive disorders include major depression, single episode and recurrent; dysthymia (still alternately labeled "depressive neurosis" in deference to psychoanalysts); and depressive disorder NOS. The mood disorders were further categorized according to severity, presence or absence of psychotic features, and seasonal pattern, and major depression was further classified by the presence or absence of melancholia.

The year 1994 has brought further diagnostic sophistication with the introduction of DSM-IV (American Psychiatric Association 1994). DSM-IV still refers to mood disorders, with some modifications from DSM-III-R (Table 13–1). Major depression is now known as major depressive disorder. Dysthymia has become dysthymic disorder, and its alternative appellation, "depressive neurosis," has finally been put to rest. Depressive disorder NOS has incorporated conditions such as premenstrual dysphoria disorder, minor depressive disorder, and recurrent brief depressive disorder, all of which failed to achieve separate categoryhood, and postpsychotic depression of schizophrenia.

In DSM-IV the bipolar disorders have been further refined to remove bipolar II disorder (i.e., recurrent major depressive episodes with hypomania) from the bipolar disorder NOS residual category and give it individual status.

Three new diagnostic categories have been established under mood disorders: mood disorder due to a general medical condition, substance-induced mood disorder, and mood disorder NOS. The first two are transfers from the organic mental disorders section in DSM-III-R, and the last may have been

created for more ambivalent diagnosticians.

Finally, that apparently large group of patients seen most commonly in primary care with a mixture of anxiety and depressive symptoms that does not meet diagnostic criteria for a mood disorder are addressed in DSM-IV in the category anxiety disorders NOS. The diagnostic and treatment implications of this decision remain to be determined (Liebowitz et al. 1990).

## ■ DEPRESSION: GENERAL CHARACTERISTICS

> In this condition self-reliance is absolutely gone, extreme modesty is common or even habitual, a featherweight will crush one to the dust, and even greatest good fortune will fail to cheer.
>
> Alexander Haig (1900)

Depression is a term with meanings ranging from the transient dips in mood that are characteristic of life itself, to a clinical syndrome of substantial severity, duration, and associated signs and symptoms that is markedly different from normal. Grief, or bereavement, encompasses features of a depressive syndrome but is usually less pervasive and more limited in duration.

The clinical features of depression fall into four broad categories:

1. **Mood (affect):** sad, blue, depressed, unhappy, down-in-the-dumps, empty, worried, irritable.
2. **Cognition:** loss of interest, difficulty concentrating, low self-esteem, negative thoughts, indecisiveness, guilt, suicidal ideation, hallucinations, delusions.
3. **Behavior:** psychomotor retardation or agitation, crying, social withdrawal, dependency, suicide.
4. **Somatic (physical):** sleep disturbance (insomnia or hypersomnia), fatigue, decreased or increased appetite, weight loss or gain, pain, gastrointestinal upset, decreased libido.

These findings are reflected in the DSM-IV criteria for depressive disorders (given later in this chapter).

### □ Recognition

When many of the above-mentioned symptoms are prominent, depression is easily recognized. This is not always the case, however, because patients may present with prominent somatic manifestations while minimizing or denying the mood and cognitive components. Studies have found that over 50% of clinically important depression goes unrecognized in primary care. Diagnosis is further complicated in the presence of medical illnesses and medication side effects that may produce "pseudodepressive" manifestations (e.g., insomnia secondary to pain, weight loss from malignancy, lethargy caused by medication).

### □ Impact

#### *Mortality*

Depression is a potentially lethal disorder: about 15% of individuals with a primary affective disorder eventually kill themselves. Approximately 50% of persons who commit suicide have a primary diagnosis of depression (Barklage 1991). Factors associated with an early (defined as within 1 year of

**Table 13–1. Mood disorders (DSM-IV)**

- Depressive disorders
  - Major depressive disorder
    - Single episode
    - Recurrent
  - Dysthymic disorder
  - Depressive disorder not otherwise specified (NOS)
    - Examples:
      - Minor depressive disorder
      - Recurrent brief depressive disorder
      - Postpsychotic depression of schizophrenia
- Bipolar disorders
  - Bipolar I disorder
    - Single manic episode
    - Most recent episode hypomanic
    - Most recent episode manic
    - Most recent episode mixed
    - Most recent episode depressed
    - Most recent episode unspecified
  - Bipolar II disorder (recurrent major depressive episodes with hypomania)
- Cyclothymic disorder
- Bipolar disorder not otherwise specified (NOS)
  - Examples:
    - Recurrent hypomania without depression
    - Manic episode superimposed on delusional disorder
- Mood disorder due to a general medical condition
- Substance-induced mood disorder
- Mood disorder not otherwise specified (NOS)

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