1 Diagnosis and Description of Mood Disorders

Essential Concepts

- Depression is of two types: bipolar and unipolar.
- Unipolar depression is characterized by the absence of any manic or hypomanic symptoms.
- The presence of manic or hypomanic symptoms defines the bipolar spectrum.
- Use the mnemonic SIGECAPS to recall the diagnostic criteria for depression.
- Use the mnemonic DIGFAST to recall the diagnostic criteria for mania/hypomania.

THE IMPORTANCE OF MOOD DISORDERS: THE CONCEPT OF A DIAGNOSTIC HIERARCHY IN PSYCHIATRY

Mood disorders are central to any diagnostic evaluation in psychiatry; this is so because of the concept of a diagnostic hierarchy. Derived from the European tradition in psychiatry, this approach argues that certain diagnoses should not be made (those lower on the hierarchy) if other diagnoses are present (those higher on the hierarchy). In this perspective, mood disorders sit at the top of the diagnostic hierarchy (Table 1.1). Thus, if a patient has a psychotic symptom, such as hearing voices, then a psychotic disorder such as schizophrenia should not be diagnosed unless mood disorders are first ruled out (e.g., the patient is not hearing voices owing to psychotic unipolar depression). Similarly, if a patient appears to have borderline personality disorder, this condition should not be diagnosed unless either mood disorders are shown to be absent or, alternatively, the patient with a mood disorder is currently euthymic (not in an active mood episode). The same issue holds with attention deficit hyperactivity disorder (ADHD). It should not be diagnosed in the presence of an active mood disorder.

TABLE 1.1. The Diagnostic Hierarchy of Psychiatric Disorders

I. Mood disorders
II. Psychotic disorders
III. Anxiety disorders
IV. Personality disorders
V. Other disorders (e.g., ADHD, eating disorders, conversion disorders, dissociative disorders, sexual disorders)

Note: Diagnoses should be made top down; thus, in general, disorders lower on the hierarchy should not be made in the active presence of disorders higher in the hierarchy.

In other words, mood disorders can produce, in addition to their own mood symptoms, almost any other psychiatric symptom; thus mood disorders are the conditions that are most likely to be missed when other symptoms are present. The assessment of a possible diagnosis of mood disorders is important, therefore, not only in persons with mood symptoms but also in persons with any psychiatric symptoms of any kind.

HISTORICAL BACKGROUND

Perhaps the simplest approach to understanding mood disorders is to see them essentially as variations of depression. In some ways, depression is easily understood. Most people can relate to the sorrow of a sad mood, and it only takes some experience and evidence to explain the extra features that are required to diagnose a clinical syndrome. Mood disorders are depressive syndromes that come in various flavors. The two main types of depression are unipolar and bipolar disorders. In unipolar depression, euthymia (i.e., normal mood) is the only mood state (other than depression) experienced by the individual. In bipolar depression, mood states that are better than euthymia (i.e., euphoric, expansive with associated features) also can occur.

This is the simplest breakdown of mood disorders. Some might argue, however, that we should not even make this distinction. In fact, 100 years ago, the mainstream view upheld by Emil Kraepelin was that mood disorders were a single entity with variations on a spectrum. Kraepelin called the overall condition *manic-depressive illness,* and within this concept, he included both those who experienced only depressive episodes (unipolar disorder) and those who also

experienced manic symptoms (bipolar disorder). The current terminology of bipolar versus unipolar conditions did not come into common use until the 1960s and was not codified in mainstream jargon until 1980 (with DSM-III).

What led to the acceptance of this distinction? The first step was the vague relabeling of Kraepelin's manic-depressive illness to *affective disorders*, a term coined by Swiss psychiatrist Eugene Bleuler. The next step was the application of validating criteria to affective disorders to see if any subtypes would stand out.

Validating criteria are an important concept in psychiatry. More consistently than other medical specialties, psychiatry possesses no "gold standard"—no blood test, x-ray, or laboratory value—to definitively establish the "reality" of a given diagnosis. In the absence of a "gold standard," researchers have devised over time a series of validators that, taken together, can approximate something approaching certainty in the validity of a diagnosis. Four standard validating criteria that were implemented in the 1960s are listed in Table 1.2.

Decades ago, with little evidence from treatment response, researchers focused on the course of the illness and family history as independent validators for a diagnosis (beyond traditional signs and symptoms). This research led to the bipolar/unipolar distinction when evidence was found that these two groups of patients could be separated on the basis of those diagnostic validators. Individuals with bipolar disorder tended to have family histories of the same illness or unipolar depression, but individuals with unipolar depression did not tend to have family histories of bipolar disorder. Further, bipolar disorder was recurrent in almost all patients invariably, whereas unipolar depression did not recur (consisted of only one or two episodes) in about half of patients.

Thus the separation of mood disorders into unipolar and bipolar is based on this empirical research. As such, it is liable to alteration based on further empirical research. Some believe that Kraepelin's original broad view of manic-depressive illness still has merit, as I will discuss later.

TABLE 1.2. Criteria for the Validation of a Psychiatric Diagnosis

1. Symptoms
2. Course of illness (age of onset, natural history)
3. Treatment response
4. Family history

DIFFERENTIATING BIPOLAR AND UNIPOLAR DEPRESSION

In contemporary psychiatry, then, mood disorders are either unipolar or bipolar. The distinction involves whether or not manic/hypomanic episodes are present. Depression is rarely absent and is usually common to both conditions.

CLINICAL VIGNETTE

The patient was somewhat sad as a child but was never diagnosed or treated for depression until age 30, soon after the ending of her marriage. She became depressed in mood, uninterested in most activities, gained 20 pounds, was tired most of the time, and sometimes thought life was not worth living, although she never seriously considered harming herself. On careful questioning of her and her mother, no evidence of a single manic or hypomanic episode in the past was found. She responded to sertraline quickly and was tapered off the medication after 1 year. She then did well for 3 years but became depressed again after being laid off, with recovery after resumption of sertraline. She eventually stopped the medication after 2 years and experienced another depression at age 42, with no apparent stressor occurring in her life. The diagnosis is recurrent unipolar depression.

CLINICAL VIGNETTE

The patient is a 34-year-old white man who has been severely depressed for the past year with daily depressed mood; decreased energy, interest, and appetite; and intermittent suicidal ideation. He seeks his first psychiatric evaluation voluntarily. (At this point, all we know is that he has current major depression. We do not know if it is unipolar or bipolar.) On questioning, he denies any known family history of psychiatric illness. He also denies any periods of hyperactivity leading to problems in his life (*mania*), but, on further questioning, reports that he has experienced times where he felt better than average in his mood, lasting 3 to 4 days at the longest, associated with increased energy, decreased sleep, increased talkativeness, and increased activities at school and

at work. (This description meets the definition of *hypomania.*) The last such period occurred 2 years ago. The interviewer diagnoses bipolar depression type II.

CLINICAL VIGNETTE

The patient was diagnosed and treated for depression at age 19 after becoming markedly depressed on arriving at college. He recovered soon after treatment with fluoxetine, and the medication was discontinued 6 months later. One year afterwards, he experienced another period of depression that lasted 4 weeks and resolved on its own, with an apparent stressor of a breakup with his girlfriend. While he denied this, his girlfriend reports that he then experienced 1 month of increased energy, decreased sleep, irritable mood, increased activities, and increasing conflict between him and his friends. His schoolwork suffered during that month because he felt more capable of passing his courses without studying. He was unusually talkative during that period also. He then became markedly depressed again for 2 months, and this responded to lithium alone. The diagnosis is bipolar disorder type I.

It is a common misconception to speak of *depression* and *bipolar disorder* as if they represent two separate groups of patients. This is a mistake. By *bipolar disorder,* people seem to imply mania, and thus the contrast with *depression.* However, I think a more useful way of thinking about this distinction is to view all mood disorders as depression, with bipolar and unipolar variations. In this way, when someone has depression, we will not forget to assess them for bipolarity.

A larger issue is at play here. It is important to emphasize to clinicians and to patients that *depression is not a diagnosis. Depression* is meaningless, diagnostically speaking. To say that someone has depression merely means that he or she has a number of signs and symptoms of the depressive syndrome. This does not give you a diagnosis. Rather, we should recognize this as being similar to an internist saying that someone has a fever and chills. This collection of symptoms is not a diagnosis. The internist needs to work up the illness to determine what kind of diagnosis is producing the fever and chills. Similarly, in mood disorders, it is a tautology to say that someone has

depression. Once we know that someone has depressive symptoms, the diagnostic process involves identifying the illness that is producing it.

TIP

Any depressed patient is not diagnosable until past mania or hypomania is ruled out. To say that someone has *depression* is diagnostically meaningless. *Depression* is not a diagnosis; it is merely a collection of symptoms. It is like saying that someone has a fever. The relevant diagnoses are unipolar or bipolar depression, with attendant differences in treatment.

In this process, there are three steps (Fig. 1.1). First, the clinician needs to determine if the depressive syndrome is *primary* or *secondary.* If it is secondary, there is an unequivocal cause (most commonly substance abuse), followed by medical illness (such as hypothyroidism). If an etiology cannot be established definitively, which is usually the case, then primary depression is diagnosed.

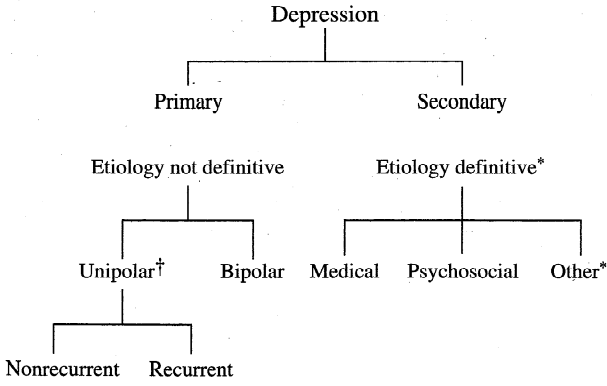

FIG. 1.1. The differential diagnosis of depression.
*A definitive etiology means almost absolute evidence of causation; otherwise, probable or possible relationships represent triggers and not clear etiologies (e.g., necessary and sufficient by itself to produce the outcome).
**For example, substance abuse.
†Primary unipolar depression is a diagnosis of exclusion once all other possible depressive syndromes have been ruled out

KEY POINT

It is important to emphasize that various factors, medical and psychosocial, are often associated with primary depression, but unless they are definitively etiologic by themselves, secondary depression is not diagnosed.

Once primary depression is diagnosed, the clinician then needs to determine if it is of the unipolar or bipolar subtypes based on whether or not the patient has experienced a past episode of mania or hypomania.

KEY POINT

Only one single spontaneous manic or hypomanic episode ever is required to diagnose bipolar rather than unipolar depression. An individual could have many depressive episodes, but the onus is on the clinician to rule out a single manic/hypomanic episode before diagnosing unipolar depression.

Thus the differential diagnostic process involves first ruling out secondary depression and then ruling out bipolar depression before a diagnosis of unipolar depression is made.

TIP

The diagnosis of unipolar depression is a diagnosis of exclusion, made after ruling out secondary and bipolar depression.

Unfortunately, it appears to be common practice for patients to go to clinicians who identify depression and then diagnose "depression." Since "depression" is identified with unipolar depression, in this approach, secondary and bipolar depression will tend to be underdiagnosed.

SUBTYPES OF MOOD DISORDERS

There are a number of subtypes for bipolar and unipolar disorders. Subtypes of depressive syndromes (whether bipolar or unipolar) are listed in Table 1.3.

TABLE 1.3. Subtypes of Depressive Syndromes

1. Typical
2. Atypical
3. Psychotic
4. Melancholic

1. *Typical* depression is characterized by decreased sleep and energy and a diurnal variation in mood in which depression worsens as the day progresses.
2. *Atypical* depression is characterized by increased sleep and energy, a personality style of rejection sensitivity, and preserved reactivity of mood (the ability to feel better briefly). This type of depression is less responsive to tricyclic antidepressants (TCAs) than to monoamine oxidase inhibitors (MAOIs) or possibly serotonin reuptake inhibitors (SRIs). Atypical depression is somewhat more frequent in bipolar than unipolar types of depression.
3. *Psychotic* depression is characterized by the presence of delusions or hallucinations along with standard depression criteria. Such patients also tend to have severe psychomotor retardation or agitation and marked guilt. Psychotic depression responds better to atypical than typical antipsychotic agents and usually requires combination treatment with antipsychotics and antidepressants. It can be misdiagnosed as schizophrenia (where the depressive component is missed) or depression (where the psychotic component is missed). It also is more common in bipolar than in unipolar depression.

TIP

A young person (<25 years of age) with psychotic depression also has a significant likelihood of having bipolar disorder (will later manifest mania).

4. *Melancholic* depression is characterized by typical depressive features but with marked anhedonia (i.e., lack of interest in all activities), no reactivity of mood (i.e., inability to feel better even briefly), and reversed diurnal variation in mood (i.e., feeling more depressed in the morning and better as the day progresses). Melancholia is usually conceptualized as a rather severe version of typical depression. This subtype responds better to TCAs than to SRIs, and often requires hospitalization.

TABLE 1.4. Subtypes of Unipolar Depressive Conditions

1. Dysthymia
2. Major depressive disorder (recurrent, single episode, chronic)

Subtypes of unipolar depressive conditions are listed in Table 1.4.

1. *Dysthymia* is defined as mild depressive symptoms (at least two DSM-IV neurovegetative criteria but not more than four) occurring more often than not (meaning more than 50% of the time) for a period of at least 2 years in adulthood or 1 year in adolescence without any period of stable euthymia lasting 1 month or longer. This definition is actually quite strict, and an important clinical mistake to avoid is to simply call someone dysthymic who has current mild depressive symptoms or who has mild depressive symptoms between major depressive episodes. Pure dysthymia requires the absence of any major depressive episode ever. This is quite uncommon. More frequently, dysthymia occurs along with recurrent major depression (*double depression*).
2. *Major depressive disorder* is the DSM-IV term for what I will call *unipolar depression* throughout this book. It consists of major depression in the absence of mania or hypomania and has three varieties: single episode (which occurs in about 50%), recurrent (the other 50%), and chronic (based on whether the episode lasts 1 year or longer). It is important to distinguish chronic unipolar depression from dysthymia. In chronic depression, criteria for major depression are met (five or more neurovegetative symptoms); in dysthymia, they are not. A common mistake is to call a depressive condition dysthymia because it is long lasting.

Subtypes of bipolar disorder are listed in Table 1.5.

1. In *bipolar disorder type I*, at least one manic episode is identified, with or without major depression.
2. In *bipolar disorder type II*, not a single manic episode is identified, at least one hypomanic episode is identified, and at least one major depressive episode is identified.
3. In *cyclothymia*, major depressive symptoms do not reach the threshold for diagnosis of a major depressive episode, and mood elevation symptoms, while present, do not reach the threshold for diagnosis of a manic episode.

TABLE 1.5. Subtypes of Bipolar Disorder

1. Bipolar disorder type I: Mania, with or without depression
2. Bipolar disorder type II: Hypomania, with major depression
3. Cyclothymia: Hypomanic symptoms plus subthreshold depressive symptoms for 2 years
4. Pure mania: Euphoric or irritable mood
5. Mixed mania: Depressed mood
6. Rapid cycling: Four or more mood (of any polarity) episodes in a year

TIP

The key difference between mania and hypomania is that mania is associated with significant social or occupational dysfunction (e.g., spending sprees, sexual indiscretions, reckless driving, and impulsive traveling), whereas hypomania is not.

Bipolar disorder not otherwise specified (NOS) is a controversial but potentially important diagnosis because it helps to define patients on the bipolar spectrum who are atypical; that is, they do not meet classic criteria for bipolar disorder types I or II, but they also do not meet classic criteria for major depressive disorder or dysthymia. These are generally individuals with major depressive episodes who have some features of bipolarity (e.g., family history of bipolar disorder, hypomanic symptoms that last fewer than 4 days, antidepressant-induced mania or hypomania, and so on). I have listed features of bipolarity in Table 1.6 and will discuss them further in Chapter 3.

TABLE 1.6. Features of Bipolarity

- Characteristics of depressive episodes
  - Brief (<3 months' duration)
  - Recurrent (>5 episodes)
  - Atypical (especially in age <25)
  - Psychotic (especially in age <25)
- Treatment resistant (failed three or more antidepressants)
- Antidepressant-induced mania or hypomania
- Family history of bipolar disorder type I (possibly substance abuse and SZ)
- Hyperthymic personality (between episodes)

Rapid-cycling bipolar disorder identifies a course of numerous mood episodes, defined as four or more episodes in a year. It is a course criterion, not a subtype of bipolar disorder.

DEFINING DEPRESSION AND MANIA

Diagnosing Major Depression

In order to diagnose a major depressive episode, an individual must have depressed mood ("sad, down, blue") most of the day, nearly every day, for at least 2 weeks continuously, along with four of the eight depressive neurovegetative symptoms. Or an individual may have anhedonia (i.e., complete loss of interest in all or almost all of one's activities) most of the day, nearly every day, for at least 2 weeks continuously, along with four of the other seven depressive neurovegetative symptoms. Thus one can have a major depressive episode without having depressed mood per se.

The neurovegetative symptoms of depression can be remembered easily with the mnemonic derived from staff at Massachusetts General Hospital: *SIG E CAPS*, meaning prescribing energy capsules (Fig. 1.2).

S: Sleep. Sleep is either decreased or increased, nearly every day.
I: Interest. Loss of interest in all or almost all of one's activities, nearly every day, or being unable to enjoy what one used to enjoy, nearly every day.

S	**I**	**G**	**E**	**C**	**A**	**P**	**S**
L	N	U	N	O	P	S	U
E	T	I	E	N	P	Y	I
E	E	L	R	C	E	C	C
P	R	T	G	E	T	H	I
	E		Y	N	I	O	D
	S			T	T	M	E
	T			R	E	O	
				A		T	
				T		O	
				I		R	
				O			
				N			

FIG. 1.2. SIGECAPS mnemonic for depression.

G: Guilt. Feeling excessively guilty about things one has done or not done, or feelings of worthlessness (not simply loss of self-esteem), nearly every day.
E: Energy. Marked loss of energy, nearly every day.
C: Concentration. Decreased concentration. This differs from the distractibility of mania (see Note below).
A: Appetite. Appetite is either decreased or increased, nearly every day.
P: Psychomotor changes. Psychomotor retardation represents moving or thinking more slowly than usual, and psychomotor agitation represents physical restlessness.
S: Suicide. Suicidal ideation may be present.

All these criteria contain a severity aspect (i.e., marked, significant, or appreciable) that reflects the concept that they are not brief or transient; they should occur most of the time most days in the 2-week or longer period (with the exception of suicidality, which, even when brief, is counted as a depressive criterion).

TIP

Any amount of suicidality is abnormal, should never be ignored, and should elicit a careful search for other depressive symptoms.

Mania

What is mood elevation? It is irritable or euphoric mood, with the right number of the cardinal symptoms of mania. *Note:* It is not just euphoric mood. While many persons with mania report "high" or "happy" mood, many have only irritable mood. Sometimes clinicians make the mistake of identifying mania with euphoria, whereas one can have mania without any euphoric mood at all. Manic episodes can be classically euphoric, or they can be characterized by only irritable mood. Either type is still described as pure mania. Depressed mood can also co-occur with manic symptoms, which, with other depressive neurovegetative symptoms, can meet the criteria for a mixed episode. Mixed manic episodes are as common as pure manic episodes.

To be diagnosed with a manic episode, an individual must experience irritable or euphoric mood with three (if euphoric) or four (if irritable) of the seven cardinal symptoms of mania

D	**I**	**G**	**F**	**A**	**S**	**T**
I	N	R	O	C	P	H
S	S	A	I	T	E	O
T	O	N		I	E	U
R	M	D		V	C	G
A	N	I		I	H	H
C	I	O		T		T
T	A	S		I		L
I		I		E		E
B		T		S		S
I		Y				S
L						N
I						E
T						S
Y						S

FIG. 1.3. DIGFAST mnemonic for mania.
FOI = flight of ideas; mania = euphoric mood + three criteria or irritable mood + four criteria for 1 week (or hospitalized) + significant social/ occupational dysfunction.

for 1 week. The cardinal symptoms of mania are easily remembered by another Massachusetts General Hospital mnemonic: *DIGFAST*, reminding one of the excessive activity of mania (Fig. 1.3).

- *D: Distractibility. This is the most common manic symptom but also the most subjective. It represents being unable to maintain one's focus on tasks for an extended duration of time. It differs from the decreased concentration of depression, as described in the note below.*
- *I: Insomnia. By this I mean decreased need for sleep, unlike depressive insomnia, which is simply decreased sleep. The best way to differentiate the two is to ask about the patient's energy level. In manic insomnia, despite decreased sleep, the energy level is average or high. In depressive insomnia, it is low.*
- *G: Grandiosity.*
- *F: Flight of ideas. Racing thoughts represent rapid progression in one's thought process.*
- *A: Activities. This represents increased goal-directed activities, which are functional and often appear useful; they fall into four categories: (1) social—increased socializing, calling friends, going out more than usual; (2) sexual—increased libido or hypersexuality; (3) work—increased productivity, cleaning the house more than usual; and (4) school—producing many projects, studying more than usual. In all cases, usual levels of activity need to be based on a comparison with activity levels during the euthymic state.*
- *S: Speech. Pressured speech or increased talkativeness. Pressured speech may be present in the mental status examination. If not, rate increased talkativeness, or ask the patient to report his or her level of talkativeness in the time period being assessed compared with euthymia.*
- *T: Thoughtlessness. Pleasure-seeking activities that do not display usual judgment and thus, unlike increased goal-directed activities, are dysfunctional. There are four common varieties: (1) sexual indiscretions, (2) reckless driving, (3) spending sprees, and (4) sudden traveling.*

TIP

The most reliable and useful manic criterion is decreased need for sleep. Identify such a period first during the interview, and then assess other manic symptoms carefully in that time frame.

As noted previously, for a diagnosis of a manic episode, in addition to the preceding criteria, there also must be *significant social or occupational dysfunction* arising from the preceding symptoms. If there is no social or occupational dysfunction, then the diagnosis is a hypomanic episode. Also, for a diagnosis of a manic episode, the symptoms must last at least 1 week (or lead to hospitalization). If they last less than 1 week but at least 4 days, then the diagnosis is a hypomanic episode.

KEY POINT

To diagnose hypomania, you must rule out any significant social or occupational dysfunction. Otherwise, the diagnosis is mania.

TIP

By definition, hospitalization implies significant dysfunction. Therefore, there is no such thing as a hypomanic hospitalized patient.

TIP

You do not need to have *classic* manic symptoms of dysfunction, such as sexual indiscretions or spending sprees, to be diagnosed with mania; *any* kind of significant social or occupational dysfunction is sufficient.

2 The Unipolar Depressive Spectrum

Essential Concepts

- The three major types of unipolar mood disorders are dysthymia, chronic depression, and recurrent major depressive disorder.
- Single-episode major depressive conditions are common.
- Depressive symptoms can occur in other conditions, such as bipolar disorder, posttraumatic stress disorder, anxiety disorders, and schizophrenia.
- Secondary depression always should be ruled out, the most common causes being substance abuse and neurologic conditions.

DYSTHYMIA

Dysthymia is a condition of chronic mild depressive symptoms. Historically, the category of dysthymia was included in DSM-III owing to a conflict between some members of the DSM-III task force, who wanted simply to have a category for major depression, and many practitioners, who did not feel that the category of major depression adequately captured persons with mild depressive symptoms, previously termed *neurotic depression*. Officially, in DSM-IV, *dysthymia* is defined as possessing at least two mild depressive criteria, as shown in the mnemonic *CHASE-E* (Table 2.1).

This means that the individual must have some depressive symptoms but not enough to meet the full criteria for a single episode of major depression. Further, these depressive symptoms must be chronic and frequent; the DSM terminology calls for the symptoms being present more often than not without any period of euthymia lasting 1 month or longer in a 2-year period. Thus you must assess a 2-year period. Depressive symptoms must be present more than 50% of the time ("more often than not"), and there must not be any stretches of less than this level of depression (basically *euthymia*) lasting more than a month.

Now this is in fact an exacting standard. Yet I frequently observe my colleagues making the diagnosis of dysthymia in