Editorial

CONCEPTUAL ISSUES IN MOOD DISORDER: AN UPDATE

Dr. Amrit Pattojoshi[1]; Dr. Sandip Motichand

Abstract

The concept of mood disorders dates back to eternity. This long history of the emotions and their disorders has a fascinating journey. As with any history concerned with disease concepts,the conceptual history of mood disorders must be scrutinised through close attention to nosological texts in tracing how categories were created how they evolved over the time. This article covers the evolution of the concept of mood disorders and its journey from the Hippocratic era to the Kraepelin's dichotomization between dementia praecox (schizophrenia) and manic-depressive insanity (bipolar and unipolar disorders) and its culmination into the contemporary classifications of mood disorders. It also addresses the problem of boundaries between the different mood disorders in terms of their conceptualisation and classification. The shortcomings of the classificatory systems and the current progress in the nosology have also been discussed.

Key words: Mood Disorder, Bipolar Disorder, Conceptual Issues

[1]*Address of correspondence:*
Dr. Amrit Pattojoshi
Associate Professor and Head,
Department of Psychiatry,
Hi-Tech Medical Collage, Bhubaneswar
Mob : 9438148100
Email : dramritp@yahoo.com

Introduction

Disorders of mood are one the most devastating illnesses in psychiatry. They often lead to disability and significant functional impairment with considerable consequences on the quality of life.[1,2] The concept of affective disorder and mania dates back to the antiquity. For example, more than 3,000 years ago, Jewish writings reported extreme mood swings in King Saul, consistent with a bipolar illness.[3] The very first word of Homer's most celebrated epic, The Iliad, is mania, where it is used to describe the uncontrollable rage of Achilles against Agammemnon. Descriptions of both mania and depression also appear elsewhere in the epic, for example in the description of 'Bellerophontes' depression and of Ajax's condition that resembles psychotic mania and great sadness ending to suicide.[4] The medical compendia of ancient India also are replete with references to mood disorders covering a spectrum of diagnoses, classification, conceptualisation and treatment methods.[5] A description of insanity – unmada (oonma-tha) – dating back to 1500 BC exists in the Atharva Veda, the most ancient authentic Indian medical scripture. It also mentions that mental illness may result from divine curses. Descriptions of conditions similar bipolar disorder appear in the Vedic texts.Other traditional medical systems such as Siddha, which recognize various types of mental disorders, flourished in southern India. Great epics such as the Ramayana and the Mahabharata made several references to disordered states of mind and means of coping with them.[6,7]

Close to the roots of Hindu mythology, NajabuddinUnhammad (1222 AD), an Indian physician propagated the Unani system of medicine as he described seven types of mental disorders including Muree- Sauda (depression). The great saga 'Agastya' formulated a treatise on mental diseases called as 'AgastiyarkirigaiNool', in which 18 psychiatric disorders with appropriate treatment methods were described.[8]Thus it is noteworthy that the foundations for the current knowledge base were laid during very early years.[9]

From Hippocrates to the Pre-Kraepelinian era

Medical thinking of ancient Greeks constitutes one of the earliest attempts to move from the demonic or divine aetiology into an attempt towards understanding the underlying biological explanations of various disorders. Hippocrates of Cos (460–377 B.C.) considered that individual characteristics such as temperament and disease were related to the balance among the four main humors of the human body: yellow bile, black bile, phlegm and blood. Melancholia, the term which first appears in Hippocratic scripts, was associated with the excessive-secretion of black bile ("melainachole") from the liver.[10] Also, Hippocrates considered the brain as the site of origin of all emotions and thus rejected the earlier theories advocating that mental phenomena are a due to divine intervention. In addition, Hippocrates had noted that mood fluctuations sometimes had seasonal variations. On the basis of Hippocratic tradition, Galen (129 or 130 –199 A.D.) considered abnormal secretion of black bile as the reason for melancholy. He used the term "hypochondria" to describe a combination of physical illness with psychological symptomatology. For Aretaeus of Cappadocia, the rising of black bile in the stomach was responsible for melancholy, which he considered to have both physical and mental symptoms, such as sadness , psychomotor retardation, and suicidal ideation.[11] He had made the observation that euphoria may follow melancholy, thus describing, for the first time, the two phases and the periodic course of bipolar illness.[12] Melancholy seems to have been constantly recognized during the period between the Classical Times and during the Renaissance the contribution of somatic functions in its aetiology emerged. First, the ancient humoral theories regarding mental disease were combined with theology by Paracelsos (1391–1431), who also described mania as an episodic illness.[4] He believed that the aetiology of mental illness might be endogenous or exogenous. Descartes' theories on human emotions (passions) and mental disorders stressed the division between body and soul (Cartesian dualism). He attempted to explain psychiatric illness as a result of untoward childhood experiences or transmission of feelings from the mother to the unborn child.[13] These theories were among the first ones after medieval times to offer a non-mystical approach to the current understanding of mood disorders.

Biological theories of depression prevailed throughout the 16th and most of the 17th centuries; the main theories for the causation of depression were attempting to provide biological explanations similar to the Hippocratic ones. [14] At the end of the 17th century, some conceptual changes occurred in psychiatry with emphasis being given to the description of symptomatology and not in the attempts of biological explanations. Different writers like Gullen (1710– 1790)], Pinel (1745– 1826) and Heinroth (1773– 1843), gave various definitions to the word ''melancholy'' at that time. [15]In Pinel'snosographie, mania was considered to be a part of the broader family of insanities and was categorized into delusional and nondelusional. Heinroth, who was Pinel's contemporary considered that "mania'' could be divided into simplex (pure rage), ecstatica (insane), ecnoa (rage accompanied by folly), and catholica (common rage).[16]

During the 19th century, questions were raised among scientists regarding the clusters of mental disorders. Their main hypothesis was that three clusters of mental functions existed, namely, intellectual, emotional, and volitional. Each of these might manifest a disorder independently of the others. Melancholia was considered to be a disorder of the intellectual function, although some other writers such as Esquirol (1772– 1830) negated this idea. He instead believed that the condition was related to temperament.[17] Until the middle of the 19th century, the clinical course was not given mush significance when describing a psychiatric condition, but diagnosis was based on the symptoms manifesting at the time of the examination. However, after many patients started to be hospitalized for long periods of time in the psychiatric asylums established in the second half of the 18th century thus allowing for longitudinal observations of the disorders lead to a change in this approach. Thereafter, Pinel proposed that the course of the disease was important in its description and so did Falret (1794 – 1870) and Baillarger (1809 – 1890) who observed the circularity of mania and depression interspersed with symptom-free periods. Thus they coined the terms "foliecirculaire" and "folie a` double forme ".[18]

The 19th century also saw the development of an integrated nosologic approach for the first time. This approach is best represented by the works of Kahlbaum (1828–1899), who proposed that patients with the same diagnosis should share similar symptoms, common aetiology in terms of biochemical aberrations and pathology. He also noted that these patients ought to have same therapeutic response to particular interventions and a common prognosis. Kraepelin was particularly influenced by this comprehensive description of disease. During the same time, Kahlbaum proposed the terms dysthymia which according to him was a chronic form of melancholia and cyclothymia. He proposed that, cyclic psychoses are separate entities from typical insanity, which was characterized by relentless and progressive course.[15]

The Era of Kraepelin and the First Half of the 20th Century

At the end of the 19th century, keeping in line with the then widely supported "degeneration theory, " Kraepelin (1856–1926), suggested that mental illness should be considered either as "endogenous" (which was believed to be due to a "degeneration of the human seed") or "exogenous." He further divided "endogenous psychoses " into "manic-depressive illness" and "dementia praecox". This was contradictory to his earlier proposal to use of the term "manic-depressive insanity" to describe all forms of recurrent psychoses. "Manic-depressive insanity" was considered to have a good prognosis as it did not evolve into dementia. However the existence of mild residual symptoms after recovery from the episodes was acknowledged.[16] Kraepelin also mentioned that the inter-episode periods were likely to become increasingly shorter after the first three episodes of manic -depressive insanity. Kraepelin's separation of "manic-depressive insanity" from "dementia praecox" was based on symptomatology, course, and family history and is considered to be the basis of modern psychiatric nosology.[16] Another contribution of Kraepelin to modern nosology was the substitution of the term "melancholy" with that of "depression" to describe the mood disorder that is part of the manic-depressive illness. Kraepelin's "melancholia" was not part of manic-depressive illness but could take three forms: simplex (characterized by sadness, without anxiety), active (characterized by sadness with anxiety and psychomotor activation), and atonita with prominent feature of an extreme psychomotor retardation ("stupor") and a prognosis, which resembled that of dementia praecox.[19] Freud and Meyer were among the other influential psychiatrists of the first- half of the 20th century who contributed to our conceptual

understanding of mood disorders. Freud considered melancholy to be due to low self-esteem arising from a disturbed childhood and as the result of the withdrawal of libido invested in the object and retroflexion of the hostility onto the self.[20] Adolf Meyer introduced Kraepelin' s classification in the United States pointing out at the same time that all types of depression should not be considered as a part of manic -depressive insanity.[21]

Modern Classifications and Diagnostic Criteria

Until about the 1960s, Kraepelin's view that all affective illness belonged to the category of manic - depressive insanity dominated diagnostic classification. In 1957, Leonhard proposed a new distinction i.e., unipolar and bipolar illness. This distinction was based on the presence or absence of manic episodes during the course of the disease, thus introducing the element of "polarity" in the classification of mood disorders.[22]Patients who only had depressive episodes were to be considered as unipolar, while patients who ever had a manic episode as bipolar. A patient is still considered to have bipolar illness even if only manic episodes have occurred, as it was considered that the illness was bipolar disorder during which a depressive episode is yet to occurred. Leonhard's suggestion has taken substantial foothold in the modern classification of mood disorders, particularly after being supported by the works of Angst, Winokur and Perris.[23] The diagnosis of bipolar disorder corresponded to an underlying nosologic entity which was much better than that of unipolar disorder. This was further established by several lines of research on its genetics, neurobiology, and response to treatments. For unipolar disorder, it was suggested that at least three episodes of depression need to have taken place before a patient is considered as unipolar. This, however is controversial as many other studies, however, have shown that the possibility of a manic episode after three depressive ones is still in the range of 13 –16 %, dropping to 4% after a fourth depressive episode.[24,25] On the basis of epidemiological and family studies, it was also proposed that recurrent depression with well-defined episodes, clearly separated by periods of unquestionable euthymia, should be considered as a form of bipolar disorder.[26] On the other hand, based on the existing knowledge, there is no distinction between the features of a major depressive episode based on whether it is part of bipolar disorder or part of unipolar major depressive disorder, although there have been some findings that point towards certain differences regarding vegetative symptoms such as sleep, sexual functioning and appetite. [27,28] A systematic effort to improve reliability among mental health professionals for the diagnosis of mental disorders and to develop a homogeneous classification was launched with the introduction, in 1965, of the eighth revision of the WHO International Classification of Diseases (ICD- 8) which was followed by the ninth revision in 1978 (ICD-9).[29,30] Both these systems, however, offered relatively ambiguous diagnostic guidelines and did not help much regarding diagnostic reliability of mood disorders. It must be noted that in ICD-9, the division between unipolar and bipolar affective disorders was occult but not clearly stated, whereas the term bipolar appeared only in the glossary.[30]

The term "mood disorders" was preferred to that of "affective disorders" in DSM-IV and ICD-10 [31]in order to imply that there was a clear distinction between mood disorders and anxiety disorders. Another interesting feature of these two classification systems is that while they retain the notion of unipolar–bipolar distinction, the term unipolar has been dropped in favour of the term ''major depression".[32] The use of modern classification systems and manuals has come along with the development of standardized criteria which enhance the reliability of psychiatric diagnosis. This was

followed by the introduction of various standardized questionnaires and rating scales, usually reflecting the diagnostic guidelines of DSM and ICD or other criteria, such as those introduced by Feighner or Spitzer.[33,34] Several of these questionnaires are accompanied by computer programs for the establishment of diagnosis; most widely known among these is the Present State Examination and its computerized system CATEGO.[35]

In the pursuit of identification of the clearest possible nosologic entities, Bipolar disorder is sub-divided , into bipolar I (patients who needed hospitalization and /or had loss of role functioning) and bipolar II.[36] The periods of manic symptoms of bipolar II patients, who have not required hospitalization nor have lead to a significant impairment in role functioning , are considered as "hypomanic" episodes. In other words, a patient is considered as bipolar II when, hypomanic and depressive episodes have occurred. On the same lines, it has been proposed to consider as "bipolar III" the patient who had episodes of depression only, but has a family history of mania, or has developed hypomania following the use of antidepressants, other somatic therapies, or the abrupt discontinuation of a mood stabilizer.[22] Patients with a history of major depressive but not manic or hypomanic episodes who are outside their periods of depression extroverted, cheerful, optimistic, confident, and energetic ("trait hypomania " or "hyperthymic temperament ") are classified as part of the bipolar spectrum, perhaps as bipolar type IV . It is, however, questionable to which extent these subgroups of bipolar disorder patients correspond to true nosologic entities , given the fact that even bipolar II disorder seems to be heterogeneous with some patients resembling bipolar I, some unipolar, and some ''breeding true''.[37,38,39] Other subdivisions that have been proposed for bipolar disorder are based on the presence or absence of psychotic features (congruent and incongruent), whether the episode frequency shows a rapid cycling pattern , the age of onset, the overall severity of the disease, and presence or absence of deterioration, the symptom pattern , and the co-morbidity with other disorders. Particularly for rapid cycling bipolar disorder, the DSM-IV listed clear criteria for its definition while it is supported that patients prone to rapid cycling usually exhibit higher depressive morbidity than other bipolar patients and are at high risk for serious suicidal attempts. It is however unclear whether the patient with rapid cycling can be considered as belonging to a separate group, as the pattern is a transient phenomenon in the majority of cases.[40]

Similar uncertainty exists for another distinction, that of the "mixed states, " which is considered to be the co-existence of manic and depressive symptomatology in the same episode and can be viewed as temperament intruding into an episode of the opposite polarity.[41] Finally, it has been suggested that instead of attempting to divide mood disorders into a number of distinct and mutually exclusive categories a dimensional approach could be used.[42] It follows the premise that, due to heterogeneity of psychiatric disorders, labelling an individual to strict diagnostic criteria derived from standardized instruments, and ascribing a patient to a taxonomic group may result in a dearth of information. Based on this approach, it was proposed that each patient could be described by a number of different descriptive dimensions of symptomatology. [42] The dimensional approach provides useful information for research into developing new diagnostic concepts and categories, but it is too complex to be applicable in clinical practice; an additional disadvantage of it being that, nosologists are used to function within a typological or categorical model, which deliberates illnesses as discrete entities.[43]

Bipolar and related conditions in ICD-10

The ICD-10 categorises bipolar disorders as: Manic Episode (F30) and Bipolar Affective Disorder (F31). In ICD-10, manic episode can be coded separately from bipolar affective disorder. Manic episodes are subcategorized into "hypomania" and "with or without psychosis". Hypomania is defined by at least a four-day disturbance characterized by irritable or elevated mood that is "definitely abnormal for the individual" and at least three additional symptoms that cause interference with daily activities, which may include: increased activity or physical restlessness; increased talkativeness; difficulty in concentrating and distractibility; decreased need for sleep; increased sexual energy; mild spending sprees or other types of reckless or irresponsible behavior; and increased sociability or over-familiarity. A manic episode is similarly defined, although has additional both primary and secondary symptoms, as well as a different temporal requirement. Namely, a manic episode requires at least one week (unless hospitalization is required) of prominent and sustained elevated, expansive or irritable mood, with three or four (if mood is only irritable) of the following symptoms: increased activity or physical restlessness; increased talkativeness ("pressure of speech"); flight of ideas or the subjective experience of thoughts racing; loss of normal social inhibitions resulting in behavior which is inappropriate to the circumstances; decreased need for sleep; inflated self-esteem or grandiosity; distractibility or constant changes in activity or plans; behavior which is foolhardy or reckless and whose risks the subject does not recognize (e.g., spending sprees, foolish enterprises, reckless driving); and marked sexual energy or sexual indiscretions.[31]

Mania can occur with (F30.2) or without (F30.1) psychotic symptoms. In mania with psychosis, the delusions and hallucinations permitted are "other than those listed as typical schizophrenic (i.e. delusions other than those that are completely impossible or culturally inappropriate and hallucinations that are not in the third person or giving a running commentary)". The ICD-10 also recognizes Other Manic Episodes (F30.8) and Manic Episode, Unspecified (F30.9), diagnostic guidelines for which are not provided.

Bipolar affective disorder is a separate diagnosis from mania, although it is ultimately dependent on the presence of either a current or past mania or hypomania and at least one other affective episode. Bipolar affective disorder is subcategorized based upon the current affective episode (hypomania, mania with or without psychosis, mild or moderate depression, severe depression with or without psychosis, mixed episode and in remission). Again, subtypes of Other Bipolar Affective Disorders (F31.8) and Bipolar Affective Disorders, Unspecified (F31.9) are available, but are not operationalized.[44]

ICD 11 PROPOSAL

The international classification of diseases 11th (ICD-11) revision is due by 2015. The ICD-11 beta draft has been released recently, which includes a prospective change in the content of mood disorders. The ICD-11 may separate the disorders into bipolar and depressive disorders as a consequence of an evaluation for the feasibility of a meta-structure for mental and behavioral disorders. In addition, the bipolar disorders may be divided into type I and II disorders. The depressive disorders may include new diseases, i. e., disruptive mood dysregulation disorder, mixed depressive anxiety, and premenstrual dysphoric disorder. Epidemiological data from patients with mood disorders diagnosed using the ICD-10 or DSM-IV have proven their utility in clinical use, and suggested a required revision for the criteria of the diagnosis. A part of persistent mood disorders, such as cyclothymia and dysthymia, seem to be the prodromal state of bipolar disorders. The mixed affective episode

may be deleted in the new version, because data also indicate that this episode is a rare clinical state. Moreover, it appears that patients with bipolar II disorder diagnosed by the DSM-IV show heterogeneous clinical properties, such as the onset age and interval between the first depressive and first hypomanic episode. After a worldwide and intensive discussion, it appears that the newly revised ICD-11 will be an advanced scientific tool for psychiatry.[44]

DSM-5 and Beyond

Bipolar and related disorders is placed under bipolar spectrum in the DSM-5. Although there are shared specifiers and episodes in bipolar and depressive disorders, they are placed as separate entities in the DSM-5. In the DSM-IV-TR, they were both under the wide Mood Disorders diagnostic class. From the viewpoint of the description of hypomanic episodes with respect to Cyclothymic disorder, it is suggested that numerous periods of hypomanic symptoms do not meet the criteria of a hypomanic episode (or depressive) which was earlier a contradiction present in bipolar disorders as not otherwise specified as per DSM- IV-TR.[45] There are specifiers for mood disorders in DSM-5 namely, anxious distress, mixed features, mood-congruent and incongruent psychotic features. In the DSM-IV-TR, there was a mixed episode which was applicable exclusively to bipolar disorders. Classic mixed depression is observed in manifestations of early onset, with heavier family history loading, and clearer diagnosis of Bipolar Disorder II(BD) than Major Depressive Disorder(MDD).[46] The Kraepelinian idea was that recurrent depression was infact a part of the bipolar sphere, which was nonetheless refuted in the DSM-III when it included polarity.[47] Therefore, the mixed symptom specifier should be a common area between two MDD and BD, which has been rightly reflected in the DSM-5.[48.49]

Another major change in the nosological conceptualisation of depressive disorders in DSM-5 is the incorporation of the specifier "with anxious distress". [50] Inclusion of Disruptive mood dysregulation disorder also would limit overdiagnosis and treatment of bipolar disorder in children. In the classic category of Major depressive disorder (MDD), the differentiation between the single and recurrent episode no longer exists. Priority is given to course of illness, so chronic forms of MDD (over two years of continuous illness) and Dysthymic disorder (DD) are integrated under the new rubric of Persistent depressive disorder (Dysthymia) (PDD). It is in the specification where it indicates whether to treat dysthymia (pure dysthymic syndrome), a persistent major depressive episode, or two intermittent types depending on whether the major depressive episode is present at the time of assessment.[51]

To summarize, the most significant development in DSM-5 with regards to mood disorders is the introduction of psychopathology dimensions within and across different disorders. This has set the stage for an etio-pathophysiological classification system in the even in upcoming ICD 11. Most remarkably, boundaries between different types of mood disorders have been better clarified to reduce spurious comorbidity.[52]

Critical analysis of some changes in DSM 5

The mixed symptom specifier is common to both depression and bipolar disorder in DSM 5. However, if this is coherent with this starting point, the error in the DSM-5 is in considering that the symptoms of this specifier are euphoria, impulsive behavior and grandeur, when they should really have beeen irritability or reactivity. [48]

Another glaring criticism is that a non-setspecifier, such as in the Persistent depressive disorder, is lacking. This is especially relevant, since about a third of the severest cases (more suicides,

psychotic symptoms) begin before 18 years of age with wide comorbidity. [49]

Premenstrual dysphoric disorder already widens the firstline of mental disorders (in the DSM-IV-TR, it was among the unspecified forms and research criteria). Arguments have been made against its inclusion, in the sense that it is a manifestation fabricated by pharmaceutical companies. [53] What is true is that research has not been sufficiently conclusive, for its inclusion in DSM 5 [54] and that criteria that the symptoms appear in atleast two cycles, but not consecutive, will lead to unnecessary diagnosis.

One of the most debated questions refers to bereavement and possible risk of over-diagnosis in what has been called 'medicalization of bereavement'. The DSM-IV-TR was clear in excluding bereavement from major depressive episode (Criterion E). There was a possibility that a diagnosis of MDD was indicated if the symptoms were lasting (persisting for longer than two months) and especially, with aggravation of symptoms (e.g., suicidal ideation or marked psychomotor retardation).[55]More so, it was suggested that MDD could takeplace starting with a severe psychosocial stressor, such as the death of a loved one or divorce, which made bereavement equivalent to other stressors. Therefore, bereavement is not a disorder and is diagnosed when the presentation is severe and characteristic of MDD. But the heart of the problem is that in major depressive episode the DSM-5 does not specify the exclusion of bereavement, which indicates that the diagnosis of MDD will increase,[56] when in reality, the symptomology comes from a normal reaction of bereavement. The problem lies in the DSM-5criteria: Reactive distress to the death, persistent yearning/longing for the deceased, social/identity disruption, which break with the idea of the previous edition of the DSM and pose terms of doubtful diagnostic validity since they refer rather to a process of bereavement that can be lengthy, but not necessarily pathological.[45]

Conclusion

Earliest conceptualisation of mania and depression dates back to the Hippocratic School. Historical conceptualisations largely relied on symptom manifestation and were vague but gradually they systematized in the nineteenth century, culminating in the Kraepelinian nosology. Over the centuries our understanding of mood disorders has been refined on the firm foundations of scientific principles. Mood disorders are composed of depressive and/or manic episode(s) that can be conceptualized as unipolar or bipolar disorders. After a de-emphasis of the medical disease model during the psychoanalytic period of influence in the mid-twentieth century, the current nosology has returned to a neo-Kraepelinian structure that is better supported by empirical research. The DSM-5 has rekindled the hope that diagnostic criteria will not only be more useful to patients and clinicians but will also provide a firm platform in integrating genetic and neurobiological information for a better conceptualisation of these conditions.

References:

1. Angst J, Sellaro R. Historical perspectives and natural history of bipolar disorder. Biol Psychiatry. 2000; 48: 445–457.
2. Chen YW, Dilsaver SC. Lifetime rates of suicide attempts among subjects with bipolar and unipolar disorders relative to subjects with other axis I disorders. Biol Psychiatry. 1996; 39: 896–899.
3. Ben-Noun L. What was the mental disease that afflicted King Saul? Clinical Case Studies 2003;2:270 82.

4. Angst J, Marneros A. Bipolarity from ancient to modern times: conception, birth and rebirth. J Affect Dis. 2001; 67: 3–19.
5. Thara R, Padmavati&Srinivasan TN Focus on psychiatry in India. Brit J Psychiat. 2004; 184: 366-373.
6. Weiss M. History of Psychiatry in India. Samiksa. 1986; 11: 31-45.
7. Bhugra D. Psychiatry in Ancient Indian texts: A review. Hist Psychiatry 1992.3: 167-186.
8. Parkar SR, Dawani VS, Apte JS. History of psychiatry in India. J Postgrad Med 2001; 47:73-6.
9. Nizamie SH, Goyal N. History of Psychiatry in India. Indian J Psychiatry. 2010; 52: S7-12.
10. Lewis AJ. Melancholia: a historical review. J Ment Sci. 1934; 80: 1–42.
11. Kotsopoulos S. Aretaeus the Cappadocian on mental illness. Compr Psychiatry. 1986; 27: 171–179.
12. Georgotas A. Evolution of the concepts of depression and mania. In: Georgotas A; Cancro R, (Eds.) Depression and Mania. Elsevier, New york. 1988; 3-12
13. Albuquerque J, Deshauer D, Grof P. Descartes' passions of the soul—seeds of psychiatry? J Affect Dis. 2003; 76: 285–291.
14. Burton R. The anatomy of melancholy. In: Dell F, Jordan-Smith P, eds. New York: Tudor Publishing Co.1621
15. Baethge C, Salvatore MD, Baldessarini RJ. "On Cyclic Insanity" by Karl Ludwig Kahlbaum, MD: a translation and commentary. Harv Rev Psychiatry. 2003; 11: 78–90.
16. Berrios GE, Hauser R. The early development of Kraepelin's ideas on classification: a conceptual history. Psychol Med. 1988; 18: 813–821.
17. Baillarger J. De la folie a` double-forme. Ann Med Psychol (Paris). 1854; 6: 367–391.
18. Pichot P. The birth of the bipolar disorder. Eur Psychiatry. 1995; 10: 1–10.
19. Lanczik M, Beckmann H. Historical aspects of affective disorders. In: Feighner JP, Boyer WF, eds. The Diagnosis of Depression. Chichester: John Wiley & Sons Ltd: 1991;pp 1–16.
20. Freud S. Mourning and Melancholia. In: Strachey J, ed. Standard Edition of the Complete Psychological Works of Sigmund Freud. Vol. 14. London: Hogarth Press. 1957.
21. Meyer A. The problems of mental reaction types, mental causes and diseases. Psychol Bull. 1908; 5: 245.
22. Depue RA, Monroe SN. The unipolar–bipolar distinction in the depressive disorders. Psychol Bull. 1978; 85:1001–1029.
23. Perris C. A study of bipolar (manic-depressive) and unipolar recurrent depressive psychoses. ActaPsychiatr Scand. 1966; 42 (suppl 194):172–188.
24. Smeraldi E, Negri F, Melica AM. A genetic study of affective disorders. ActaPsychiatr Scand. 1978; 56:382–398.
25. Perris C. The distinction between bipolar and unipolar affective disorders. In: Paykel ES, ed. Handbook of Affective Disorders. Edinburgh: Churchill Livingstone. 1982; 43–58.
26. Angst J. Historical aspects of the dichotomy between manic-depressive disorders and schizophrenia. Schizophrenia Res.2002; 57: 5–13.
27. Kasper S. Issues in the treatment of bipolar disorder. EurNeuropsychopharmacol. 2003; 13:37–41
28. Papadimitriou GN, Dikeos DG, Soldatos CR. Sleep disturbance in unipolar and bipolar depression: Relationship to psychiatric family history. Neuropsychobiology. 2003; 48:131–136.
29. World Health Organization. Mental Disorders: Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death. Geneva: World Health Organization. 1967.
30. World Health Organization. Mental Disorders: Glossary and Guide to Their Classification in Accordance with the Ninth Revision of the International Classification of Diseases. Geneva: World Health Organization. 1978.
31. World Health Organization. ICD-10 classification of mental and behavioral disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.
32. Stefanis CN, Stefanis NC. Diagnosis of depressive disorders: a review. In: Maj M, Sartorius N, eds. Depressive Disorders. Chichester: John Wiley & Sons Ltd. 1999; 1-51.
33. Feighner JP, Robins E, Guze SB, Woodruff RA, Winokur G. Diagnostic criteria for use in psychiatric research. Arch Gen Psychiatry. 1972; 26:56–73.
34. Spitzer RL, Endicott J, Robins E. Research diagnostic criteria: Rationale and reliability. Arch Gen

Psychiatry. 1978; 35:773–782.
35. Wing JK, Cooper JE, Sartorius N. The Measurement and Classification of Psychiatric Symptoms. London, New York, Melbourne: Oxford University Press. 1974.
36. Fieve RR, Dunner DL, Kumbaraci T, Stallone F. Lithium carbonate prophylaxis of depression in three subtypes in primary affective disorder. PharmakopsychiatrNeuropsychopharmakology. 1976; 9:100–107.
37. Coryell W, Winokur G, Shea T, Maser JD, Endicott J, Akiskal HS. The long-term stability of depressive subtypes. Am J Psychiatry. 1994; 151:199–204.
38. Coryell W, Keller M, Endicot J, Andreasen N, Clayton P, Hirschfeld R. Bipolar II illness: course and outcome over a five-year period. Psychol Med. 1989; 19:129–141.
39. Angst J. The course of major depression, atypical bipolar disorder, and bipolar disorder. In: Hippius H, Klerman GL, Matussek N, eds. New Results in Depression Research. Berlin: Springer. 1986; 26–35.
40. Coryell W, Solomon D, Turvey C, Keller M, Leon AC, Endicott J. The long-term course of rapid cycling bipolar disorder. Arch Gen Psychiatry. 2003; 60:914–920.
41. Marneros A. Origin and development of concepts of bipolar mixed states. J Affect Dis. 2001; 67:229–240.
42. Andreasen NC. Concepts, diagnosis and classification. In: Paykel ES, ed. Handbook of Affective Disorders. Edinburgh: Churchill Livingstone. 1982; 25–44.
43. Goldberg D. Plato vs. Aristotle: categorical and dimensional models for common mental disorders. Compr Psychiatry. 2002; 2(suppl 1):8–13.
44. Strakowski SM. Bipolar disorders in ICD-11. World Psychiatry. 2012; 11(Suppl. 1):31-36
45. Rodríguez-Testala JF, Senín-Calderónb C, Perona-Garcelán S. From DSM-IV-TR to DSM-5: Analysis of some changes. Int J Clin Health Psychol. 2014; 14: 221-231
46. Benazzi F. Mixed depression and the dimensional view of mood disorders. Psychopathology. 2007; 40: 431-439.
47. Ghaemi SN. Bipolar Spectrum: A Review of the Concept and a Vision for the Future. Psychiatry Investig. 2013; 10: 218-224.
48. Koukopoulos A, Sani G, Ghaemi SN. Mixed features of depression: Why DSM-5 is wrong (and so was DSM-IV). Br J Psychiatry. 2013; 203: 3-5.
49. Colom F, Vieta E. The road to DSM-V. Bipolar disorder episode and course specifiers. Psychopathology. 2009; 42: 209-218.
50. Axelson DA, Birmaher B, Strober MA, Goldstein BI. Ha W, Gill MK. Course of subthreshold bipolar disorderin youth: Diagnostic progression from bipolar disorder not oth-erwise specified. J Am AcadChildAdolescPsychiatry. 2011; 50: 1001-1016.e3.
51. Rhebergen D, Graham R. (2014). The re-labelling of dysthymicdisorder to persistent depressive disorder in DSM-5: Old wine innew bottles? CurrOpin Psychiatry. 2014; 27: 27-31.
52. Tandon R. Mood disorders in DSM-5: Best diagnoses today and a bridge to tomorrow. Asian J Psychiatr. 2013: 279–280
53. Hartlage SA, Breaux CA, Yonkers KA. Addressingconcerns about the inclusion of premenstrual dysphoricdisorderin DSM-5. J Clin Psychiatry. 2014; 75: 70-76.
54. Gómez-Márquez C. García-García M, Benítez-Hernández M, Bernal-Escobar L, Rodríguez-Testal J. Retrospective and Prospective Study of Premenstrual Symptomatology in the General Population. Ann of Clin and Health Psych. 2007; 3: 41-62.
55. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Text Revision. DSM-IV-TR Washington DC: APA. 2000.
56. Maj M. Clinical judgment and the DSM-5 diagnosis of major depression. World Psychiatry. 2013; 12: 89-91.