

Correspondence: Ovidiu ALEXINSCHI
Clinical Psychiatric Hospital "Socola",
Șos. Bucium no. 34, code 700282, Iași, Romania
Email: alexinschi@yahoo.com

Date of Submission: February, 06, 2012 / **Acceptance:** May, 24, 2012

MAJOR DEPRESSIVE EPISODE WITH MELANCHOLIA

Ovidiu ALEXINSCHI, Cristinel ȘTEFĂNESCU, Roxana CHIRIȚĂ, Andrea Di FIORINO

Ovidiu ALEXINSCHI: M. D., Ph. D. Student, University of Medicine and Pharmacy "Gr. T. Popa" Iași; Psychiatrist, Clinical Psychiatric Hospital "Socola", Iași, Romania

Cristinel ȘTEFĂNESCU: M. D., Ph. D., Assistant Professor University of Medicine and Pharmacy "Gr. T. Popa" Iași, Dept. of Psychiatry, Senior Psychiatrist, Clinical Psychiatric Hospital "Socola", Iași, Romania

Roxana CHIRIȚĂ: M. D., Ph. D., Professor, Dept. of Psychiatry, University of Medicine and Pharmacy "Gr. T. Popa" Iași; Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iași, Romania

Andrea Di FIORINO: M. D., Ph. D., Senior Psychiatrist, Department of Psychiatry, Versilia Hospital, Via Aurelia 335, 55043 Lido di Camaiore (LU), Italy

ABSTRACT:

The affective temperament is a specific constitutional disposition, a dimensional construct, and only the extremes can be considered abnormal in statistical and perhaps in a clinical sense. For the definition of the affective temperaments, Akiskal proposed some criteria. Briefly, this is the concept of "fundamental states" of Kraepelin, with the employ of the classical term of "temperament".

The *spectrum* is used to refer to the broad range of such manifestations of a disorder, from core symptoms to temperamental traits. In DSM-III, the expression "Major Depression" replaced the terms of *melancholia* and *endogenous*. The reference to the endogenous has been abandoned because its theoretical implications.

Keywords: affective temperaments, fundamental states, spectrum, melancholia

REZUMAT:

Temperamentul afectiv reprezintă o dispoziție constituțională specifică, un construct dimensional, doar extremele putând fi considerate anormale în statistică și, probabil, într-un sens clinic. Akiskal a propus o serie de criterii pentru definirea temperamentelor afective. Pe scurt, acesta este conceptul de „stări fundamentale” al lui Kraepelin, ce implică termenul clasic de „temperament”.

Spectrul este folosit pentru a desemna o gamă largă de astfel de manifestări ale unei tulburări cu simptome-cheie de trăsături temperamentale. În DSM-III, expresia „depresia majoră” a înlocuit termenii de *melancolie* și *endogenie*. Trimiterea la endogenie a fost abandonată, din cauza implicațiilor sale teoretice.

Cuvinte-cheie: temperamente afective, stări fundamentale, spectrul de frecvențe, melancolie

INTRODUCTION

In DSM-III (APA, 1980), the “Major Depression” term replaced the concepts of “melancholia” and “endogenous”. The reference to the endogenous has been abandoned because of its theoretical implications.

Melancholia has been considered, in DSM-III, “a term of the past”, used, in this manual, to indicate a typically severe form of depression that is particularly responsive to somatic therapy (Nelson *et al.*, 1981).

The criteria of DSM-III are conceived in order to define a sub-classification (Major Depressive Episode with Melancholia).

In the DSM-III, three anamnestic criteria have been added (lack of personality disorders, previous remission of major depressive episodes, and favourable response to antidepressants).

In DSM-IV (1994), the specifier “With Melancholic Features” can be applied to the diagnosis of a Major Depressive Episode in Major Depressive Disorder and in Bipolar I or II Disorder (only if it is the most recent type of mood episodes). The “distinct quality of depressed mood” and excessive or inappropriate guilt has been reintroduced while the natural course and the response to antidepressant medication has been excluded, criteria already included in the definition itself.

Mania seems to maintain a greater terminological stability, where the adjective “maniacal” goes to identify, in the DSM-IV, the episode with the typical characteristics of the phase of excitement. It is likely that to a higher terminological stability, it will correspond to precise and constant phenomenal and phenomenology of mania symptoms, while, in the event of depression, we assist both to an elevated variety of syndromes aggregations and to a more significant clinical evolution and transfiguration happening in the course of time: much more infrequent is the observation of the catatonic and nihilistic types, and much more frequent are the masked types or the atypical characteristics one.

In a historical excursus from antique books to modern classifications, what emerges for sure is the strait relationship between depression (melancholia) and mania: as classic authors report to frequent passage from one to other types of disease, today’s conception of mania is not thinkable as something separated from the one of depression; similarly, depression is viewed more and more as a manifestation of the bipolar spectrum, yet position of dichotomic type prevailed (unipolar – bipolar) (Cassano, 2002).

According to Cassano *et al.* (1999), there are several reasons for the lower rate of recognition of the subthreshold manic symptoms, when compared to the analogous pure depressive ones. This fact contributes to the frequent under-diagnosis of the bipolar disorder. Attention should also be paid to mild symptomatic manifestations of a manic diathesis. These symptoms are not referred to, as such manifestations may sometimes enhance the quality of life. The term *spectrum* is used to refer to the broad range of such manifestations of a disorder from core symptoms to temperamental traits.

Spectrum manifestations may be present during, between, or even in the absence of an episode of full-blown.

Figueira (2002) has pointed out that accepting the model of spectrum in affective disorders could modify our clinic attitude. A systematic revaluation of the changes of the clinical syndrome is needed. Clinical evidences impose a cautious clinical judgement.

Temperament took a large part in the classic conceptions and in the etiopatogenetic theories from authors such as Hippocrates to our days, but it now seems to dissolve itself and to lose connotation within the present classification systems, phagocytized by the great nosography groups of Axis I and II. In the recent versions of the DSM, is not trace of “irritable temperament” as well as does not appear in the “hyperthymic temperament”: even hypomania, showing among its symptoms various characteristics, which evoke an excessive of a few aspects of the hyperthymia, is delineated like an attenuated type of mania, a phase of mood alteration well distinguished from the typical “modus vivendi” of the individual, an episode of illness that stands out from the usual way of being of that patient.

The Cyclothymic Temperament can be partly assimilated to the present “Cyclothymic Disorder”, the last one consisting of a chronicle mood fluctuation including numerous periods with hypomanic symptoms and with depressive symptoms. Typically, onset of the disorder takes place during the adolescence or in the first adult age, and it is also absorbed to a temperamental type model,

determining itself as a clinical representation fading its origins in the personality and in the character nature of the individual. This temperament can also be observed between the lines of some Personality Disorders, characterized by an extreme mood fluctuation, such as the Borderline Disorders, in which, however, it is possible to find a variety of other psychopathological dimensions that render cyclothymia, only one of the several aspects delineating such a disturbance.

Depressive temperament is less traceable, except for the “Dystimic Disorder with premature onset”, where a chronically depressed mood is present, as well as reduced energy or fatigue, low self-esteem and facility to self-criticism: however, DSM views it as an “unipolar mood disorder”, a clinical entity well distinguished from what is considered to be the personological attitude of the individual.

There is also a syndromic group that DSM-IV defines “Depressive Personality Disorder”, characterized by depressive and pervasive beliefs and behaviours; onset takes place during the first adult age and manifests itself with a propensity to being serious and gloomy, feeling of restlessness, lack of joy, a negative way of looking the future, pessimism, lack of self-esteem and a tendency to feel guilty. Perhaps, among all those in the handbook, “Depressive Personality Disorder” is the one that better seems to recall the characteristics of the Depressive Temperament, even if it concerns a diagnostic entity numbered among new proposed categories, not yet sufficiently verified and validated.

As a result, we have pointed out to the loss of one integral and unitary classification of the Affective Temperaments as classically understood in the contemporary psychiatry; however, from another point of view, we would emphasize that the validity of meanings, that are at the bottom of the definitions of temperaments is not lost, but is quite variously identified, classified and defined in their nuclear elements, meaning that the classic conceptions are neither faded nor exceeded, but re-elaborated and re-shaped like malleable, plastic material always well amalgamated, variously mouldable by different Authors and different cultural and epistemological influences.

A return to Kraepelin Schema

Akiskal takes from Kraepelin the concept of “fundamental states”, but employing the classical term of temperament. The affective temperament is a specific constitutional disposition, a dimensional construct; only the extremes being considered abnormal in statistical and perhaps in a clinical sense. He proposed some criteria for a better and shared definition of the affective temperaments (Akiskal *et al.*, 1979). We cite the criteria for the definition of the cyclothymic temperament as an example (table I).

Tab. I: *Criteria for the cyclothymic temperament definition*

The cyclothymic temperament
Biphasic mood swings-abrupt from one phase to the other, each phase lasting for a few days at a time, with infrequent interphase euthymia.
At least four of the following features constitute the habitual long-term baseline of the subject: 1. Lethargy alternated with eutonia; 2. Shaky self esteem alternated between low self-confidence and overconfidence; 3. Decreased verbal output alternated with talkativeness; 4. Mental confusion alternated with sharpened and creative thinking; 5. Unexplained tearfulness alternated with excessive punning and jocularity; 6. Introverted self-adsorption alternated with uninhibited people-seeking.

According to Akiskal, the temperament has an important role in determining the clinical picture of the affective episodes and the longitudinal course of the illness. Unlike Kraepelin, he attributes to temperamental dispositions an important role in the pathogenesis of mixed states (Akiskal *et al.*, 1998) (Table II).

Tab. II: *The mixed states according to Kraepelin and Akiskal*

The mixed states	
Kraepelin (1904)	Akiskal (1998)
Unsynchronized transition between the two phases; the patient is “trapped in the switch process”.	Intrusion of an affective episode into an opposite affective temperament or into one with a high degree of chronic instability, such as in the cyclothymic temperament.

To acknowledge temperamental dispositions could be also very important in order to make the patients with such features more accessible to the effective therapies in the connected treatment.

Temperamental dimensions include relatively stable aspects of individual differences, thought constitutionally based (Buss, 1991). Personality: as temperament upon which are overlaid cognitive structures, motivational and behavioural patterns, that incorporate these basic styles or inclinations in a more or less well socialized manner, and emotional expression (Buss and Plomin, 1975).

From a biological point of view, the proposal of Robert Cloninger has obtained a great success: he tried to correlate character with specific neurotransmitters and elaborated an instrument called “The Temperament and Character Inventory (TCI)” for the assessment of the personality dimensions linked to the different biological pathway (table III, figure 1) (Cloninger *et al.*, 1993; 1994).

Tab. III: *The dimensions of temperament and character according to Cloninger*

Temperamental traits	Biological correlation
Harm avoidance (HA)	Serotonergic system
Novelty seeking (NS)	Dopaminergic system
Reward dependence (RD)	Noradrenergic system
Persistence (P)	
Characterial traits	
Self-directedness (SD)	
Cooperativeness (C)	
Self-transcendence (ST)	

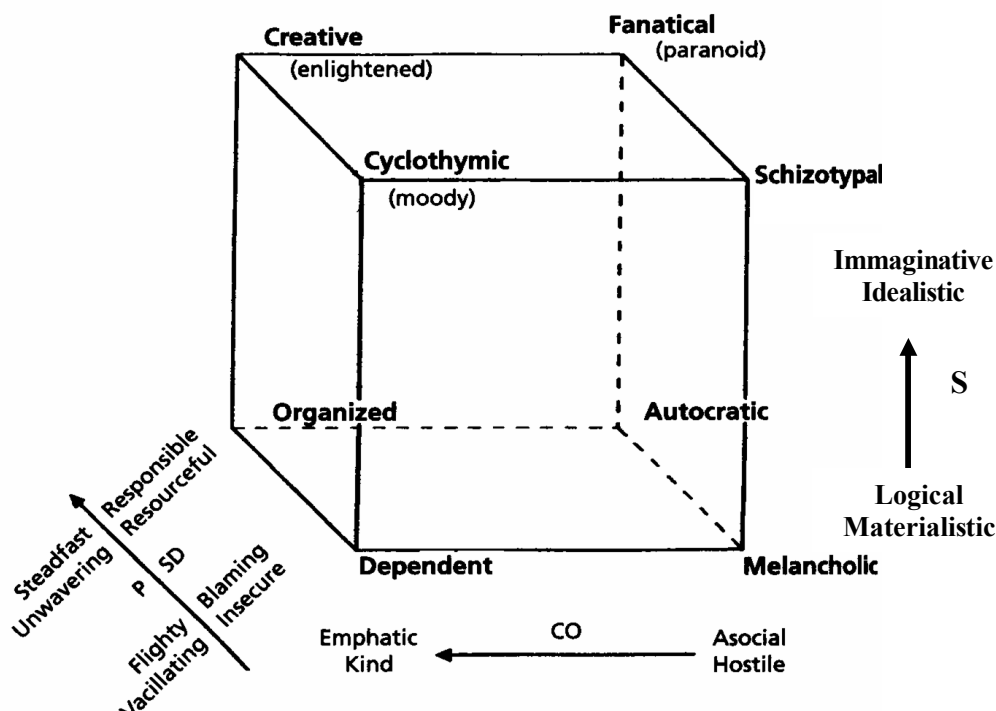


Fig. 1: *The character cube: eight possible configurations of high or low scores on three TCI character dimensions (from Cloninger, 1999, modified)*

Recent theories (e. g. those of Cloninger or Akiskal) combine different aspects. After reviewing the historical temperament concepts, we present underlying factors which are linked to affective disorders (such as emotional reactivity, cyclicity or trait affectivity). Ehrt *et al.* (2003) illustrate the importance of temperament concepts in the research of affective disorders.

ACKNOWLEDGMENTS AND DISCLOSURE

The authors declare that they have no potential conflicts of interest to disclose.

REFERENCES:

1. Angst, J. (1966). *Zur Aetiologie und Nosologie Endogener Depressiver Psychosen. Eine Genetische, Soziologische und Klinische Studie*. Berlin, Springer.
2. Akiskal, H. S. *Introduction in Comprehensive Textbook of Psychiatry*, Kaplan H. I., Sadock B. J. (Eds.), 1995, Williams & Wilkins.
3. Cloninger, C. R. (1999). *Personality and Psychopathology*. American Psychiatric Press, Inc.; Washington, D.C.
4. Cloninger, C. R., Svrakic, D. M., Przybeck, T. R. (1993). A psychobiological model of temperament and character. *Arch Gen Psychiatry*, 50: 975.
5. Cloninger, C. R., Przybeck, T. R., Svrakic, D. M. *et al.* (1994). *The Temperament and Character Inventory (TCI): A Guide to Its Development and Use*. Center for Psychobiology of Personality, Washington University, St Louis, MO.
6. Ehrt, U., Brieger, P., Marneros, A. (2003). *Temperament and affective disorders-historical basis of current discussion* *Fortschr Neurol Psychiatr*. Jun;71(6):323-31.
7. Figueira, M. L. (2002). *Syndromes, Symptoms and Spectra*. In Maj M, Akiskal HS, Lopez-Ibor JJ, Sartorius N (eds): *Bipolar Disorder*. World Psychiatric Association Series Evidence and Experience in Psychiatry. London, John Wiley & Sons.
8. Janzarik, W. (1968). *Schizophrenie Verläufe: Eine Strukturdynamische Interpretation*. Berlin, Springer.
9. Jaspers, K. (1959). *Allgemeine Psychopathologie*. Berlin, Springer Verlag.
10. Hecht, H., van Calker, D., Berger, M., von Zerssen, D. *Personality in patients with affective disorders and their relatives*. *J Affect Disord*. 1998 Oct;51(1):33-43.

11. Hecht, H., van Calker, D., Spraul, G., Bohus, M., Wark, H. J., Berger, M., von Zerssen, D. *Premorbid personality in patients with uni- and bipolar affective disorders and controls: assessment by the Biographical Personality Interview (BPI)*. Eur Arch Psychiatry Clin Neurosci. 1997;247(1):23-30.
12. Nelson, J. C., Charney, D. S., Quinlain, D. M. (1981). *Evaluation of the DSM-III Criteria for Melancholia*. Arch. Gen. Psychiat., 38, 555-559.
13. Kraepelin, E. (1904). *Lehrbuch der Psychiatrie*, ed.7. Leipzig, J. A. Barth.
14. Kraepelin, E. (1921). *Manic-Depressive Insanity*, English translation of the Eighth edition of *Lehrbuch der Psychiatrie*. Leipzig, transl. R. M. Barclay, E & S. Livingstone, Edinburgh.
15. Jaspers, K. (1959). *Allgemeine Psychopathologie*. Berlin, Springer Verlag.