CHAPTER 11

Mood Disorders: Unipolar and Bipolar

Lynn P. Rehm, Alisha L. Wagner, and Carolyn Ivens-Tyndal

Diagnostic Distinctions and Clinical Phenomenology

Unipolar–Bipolar Distinction

A historical review of the conceptualization, diagnosis, and categorization of psychopathology reveals a series of attempts to develop meaningful distinctions or subcategories to reduce the heterogeneity of affective disorders. Kraepelin (1921) subsumed most major forms of depression under the rubric of “manic-depressive illness,” which he distinguished from dementia praecox (schizophrenia). This classification scheme prevailed for several decades and was reflected in the Diagnostic and Statistical Manual of Mental Disorders, 2nd edition (DSM-II; American Psychiatric Association [APA], 1968) which remained in use until 1980. Under this diagnostic approach, individuals with recurrent depressions and those with depressions plus manic episodes were both considered manic-depressive. Only involutional melancholia, psychotic-depressive reaction, and depressive neurosis were differentiated from manic-depressive illness, chiefly on the basis of recurrence of depressive episodes.

As early as 1957, Leonhard suggested that individuals with depressions plus manic episodes (bipolar) should be distinguished from persons with only recurrent depressive episodes (unipolar) on the basis of differences in various clinical dimensions. During the following three decades, studies of clinical, familial, genetic, pharmacological, and biological factors supported such a distinction, resulting in a reversal of the old classification and conceptual framework such that current theories, diagnostic schemes, and treatment strategies treat unipolar and bipolar affective disorders as distinct entities. Among specific distinctions, age of onset for bipolar disorder tends to be significantly earlier than for unipolar depressions (Angst et al., 1973; Burke, Burke, Regier, & Rae, 1990; Gershon, Dunner, & Goodwin, 1971; Perris, 1966), and genetic factors have a more important role in the occurrence of bipolar disorder than that of unipolar disorder (Allen, 1976). Differences in specific depressive-episode symptoms have been observed; unipolar depressives are more commonly characterized by agitated psychomotor activity (Beigel & Murphy, 1971; Bunney & Murphy, 1973; Kupfer et al., 1974), hyposomnía (Detre et al., 1972; Hartmann, 1968; Kupfer et al., 1972), somatic complaints (Beigel & Murphy, 1971), and anger at self and others (Beigel & Murphy, 1971), and depressed bipolar subjects are characterized by psychomotor retardation, hypersomnía, fewer
somatic complaints, and mild or no anger. Although these data support the unipolar–bipolar distinction at a number of levels and in a number of arenas, including clinical presentation of depressive symptoms, the current diagnostic system, DSM-IV (APA, 1994), distinguishes between unipolar and bipolar mood disorders solely on the basis of a history of mania. There is no attempt to differentiate bipolar from unipolar depressive states on any other grounds.

**Unipolar Depression Criteria**

According to DSM-IV, criteria for a major depressive episode are (1) the presence of either depressed mood (in children or adolescents, depressed or irritable mood) or loss of interest or pleasure in all or most activities for a minimum of 2 weeks and (2) the presence of at least four criterion symptoms for a period of at least 2 weeks. The criterion symptoms include appetite disturbance; change in weight; sleep disturbance; psychomotor agitation or retardation; decreased energy; feelings of worthlessness or excessive or inappropriate guilt; difficulty with thinking, concentrating, or decision making; and recurrent thoughts of death or suicidal ideation or attempts. Symptoms must represent a change from previous functioning, be relatively persistent during the minimum 2-week period, and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Historically, a distinction has been made between depressions believed to be caused by some external event (termed reactive or exogenous) and those believed to be caused primarily by internal biological factors (termed endogenous). Endogenous depressions are believed to be more severe and to be characterized by prominent somatic symptoms. Because the identification of an external cause is unreliable and because the identification of internal causes in other cases is only inferred from the lack of an external cause, this distinction was not included in DSM-II). However, DSM-III (APA, 1980), DSM-III-R (APA, 1987), and DSM-IV substituted major depressive episode, melancholic type, as a subgroup of unipolar depression defined in terms of current symptoms rather than a putative cause. The specific symptoms include (1) the presence of either loss of pleasure in all or almost all activities or a lack of reactivity to usually pleasurable stimuli and (2) three or more of the following symptoms: distinct quality of depressed mood (a different kind of feeling than, for example, what is experienced after the death of a loved one); a diurnal variation of mood with a depression worse in the morning; early morning awakening (at least 2 hours before the usual time); marked psychomotor retardation or agitation; significant anorexia or weight loss; and excessive or inappropriate guilt.

Dysthymia, referred to as “depressive neurosis” by previous diagnostic systems, is also a common unipolar depressive disorder. Symptoms are fewer and typically less severe than in major depressive episodes, but these symptoms generally cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The essential features of dysthymia are depressed mood (or irritable mood in children and adolescents) for most of the day during most days for at least 2 years (1 year for children and adolescents), and the presence of at least two of the criterion depressive symptoms described before as part of the unipolar diagnosis. As a stable and enduring disorder, dysthymia (along with cyclothymia, discussed later) was earlier considered among the personality disorders. Debate as to its status continues. The relationship between dysthymia and major depression is complex. The DSM system allows making both diagnoses simultaneously, sometimes referred to as double depression. In DSM-IV, sequence is also important. If the 2-year period begins with an episode of major depression, then the milder continuation is assumed to be part of the major depression, and the diagnosis is major depression in partial remission, not dysthymia.

A residual category of depressive disorder, not otherwise specified, is included in DSM-IV for disorders with depressive features that do not meet the criteria for any specific mood disorder, or for adjustment disorder with depressed mood. Examples of depressive disorder NOS include premenstrual dysphoric disorder; minor depressive disorder; recurrent brief depressive disorder; postpsychotic depressive disorder of Schizophrenia; and a Major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder NOS, or the active phase of Schizophrenia. Adjustment disorder with depressed mood is not classified as a mood disorder, despite the primary features of depressive symptoms, because adjustment disorders, it is assumed, cover temporary maladaptive reactions of