The Concept of "Affective Disorders" in the Currunt Nosological Discipline (A National Evaluation)

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ABSTRACT

A comparitive study has been carried out on samples from the same centre (Kasr El-Eini) representing all psychiatric patients frequenting the out-patient clinic during the first six months of 1973 & 1977 (before and after using the DMPI on a wide scale).

The results showed that there was a tendency to more delineation after following a certain diagnostic discipline. Periodic affective disorders were underdiagnosed in relation to a nonspecific concept related to the term depression. The diagnosis of involutional depression was almost unaffected by the introduction of the diagnostic manual. There was also an inverse proportion between two subcategories, viz. mixed and circular subtypes which could refer to some wrong synonymous use.

The difference in incidence of a certain subcategory could not only depend on variables like cultural factors,... etc. but it can be basically dependent on the theoretical orientation of the diagnosticians and their methodology.

INTRODUCTION

The term affective disorder is still in current use among most psychiatrists in alternation with another commonly used term viz; manic-depressive illness (or psychosis). It usually refers to thymic or emotional disturbances ranging between the two poles of depression and elation with their associated consequences. Although the term "affective" is related linguistically to feelings and emotions without distinction, it does not include, in the current psychiatric use, most other emotions like

anxiety, suspicion or anger. It is currently related only to the repression-elation polarity (Mayer-Gross et al. 1969; Kolb, 1968; Klerman, 1976; Shaheen & Rakhawy, 1977; Okasha et al. 1977).

However, if we go more basically to the term "emotion" itself, we may be astonished when we find that certain authors deny logically any existence of such a phenomenon as we usually think of it (Duffy, 1941). Freud himself, whose theory is based almost exclusively on understanding and interpreting emotional problems, did not introduce an independent theory of emotions, and he seems to consider emotions as dissociative, rather pathological phenomenon. (Rapaport, 1950).

Reviewing the current nosological disciplines available, we find different nomenclatures and subdivisions. While the ICD-8 put the group of affective disturbances under the main heading "Affective psychoses" (296), the DSM-II preferred the term "Major affective disorders" (using the same code 296). The difference is not a superficial one although the included subcategories are more or less the same. It raises the important question; whether such major affective disturbances usually refer to a psychotic metamorphosis or even psychotic quantum or not.

We can also notice a similar contrast between the French classification using the term "psychoses maniaques et depressives" and the Egyptian one in the (DMP-I) using the modification "manic and depressive illnesses."

In the ICD-9 the main category was still labelled as "Affective Psychosis" (296) and the term psychosis was maintained in all the subcategories 296.0-296.9). Affective disorders were also mentioned in other categories of the IDC-9 such as, "other non organic psychosis: depressive type" (298.D), "other non-organic psychosis: excitative type" (298.1) and "neurotic depression" (300-4).

In the DSM III (1980) the main category is cited as affective di-

sorders with an alternative synonym: "Major affective disorder". It includes the bipolar disorder (mixed, manic & depressive); the major depressive (single episode & recurrent); other specific affective disorders and atypical affective disorders. Anxiety disorders are not included but represent a main independent category not included under the abandoned (within this discipline) main category previously known as 'neuroses'.

In the Egyptian Manual (DMP-I, 1975), apart from the main category of the manic and depressive illnesses (06.) including nine subtypes, we meet depressive neurosis (10.4), acute or chronic reactive or situational psychoses including depressive types (09.2 & 09.3) as well as reactive and situational neurosis (depressive type) (10.7).

On the whole, we notice that the term "manic" is less ambiguous. However, while a basic elated mood is assumed to underlie all manic reactions, it is not common or prevailing in their symptomatology (Shaheen and Rakhawy, 1977). Major manic disorders are not presented as independent subcategory in the DSM III, while "Major depressive disorders" exist.

An additional source of ambiguity comes from using such terms as masked depression (Pichot, 1973), depressive equivalents (Lopez Ibor, 1973) and periodical illnesses as special forms of affective disturbances. When using such terms one has to remember that we are usually speaking about the affective disturbance as an underlying psychopathological phenomenon rather than as a presenting cluster of symptoms formulating a specific clinical syndrome.

Facing this ambiguous situation, we tried to investigate the empirical use of some such labels (or concepts) in a comparative study.

MATERIAL

All cases frequenting the Kasr El-Aini outpatient clinic of psychiatry in the first six months of 1973 and 1977 (i.e. before) and after using

the Egyptian Diagnostic Manual) were studied and compared whenever possible in order to clarify the effect of introducing the national diagnostic manual on using such ill-defined concepts.

RESULTS

The total number of patients was 6632 in 1977 sample, out of which 1112 were included in the manic-depressive illness category (06). The non-manic-depressive category, i.e. depressive neurosis (10.4) and reactive and situational neurosis: depressive type (10.7) were 955, making the total of the affective disturbances 2067 (31% of the total sample). Table I (a & b) shows that in addition to the numbers of the subcategories and their percentages to the corresponding main category (i.e. manic-depressive or non-manic depressive) as well as to the total of the affective disturbances.

In 1973, this distinction to manic-depressive and non-manic-depressive categories was relatively difficult. The total number of affective disturbances in that year was 1690 cases out of the total sample which was 6103 cases (i.e. 27.7%). Table II (a & b) shows the results in this year. Table III shows the results of the Chi-Square test for the significance of difference between the results of the two years.

TABLE I

Affective Disorders in Kasr El-Aini, 1977(1)

(a) Manic and Depressive Illnesses

Diagnosis	No.	% to M.D. group	% to total aff. disorders
06.0 Manic depressive : depressive	325	29.2	15.7
06.1 Manic depressive : manic	167	15.0	8.1
06.3 Manic depressive : circular	11	0.9	0.5
06.4 Involutional Melancholia	77	6.9	3.7
06.5 Depressive illness not elsewhere specified.	123	11.0	6.0
06.6 Manic illness not elsewhere specified	144	12.9	7.0
06.0 Others and unspecified — Manic and depressive illness not clearly subcategorized	6	0.5	0.3
	*165	14.8	8.0
	94	8.4	4.5
Total	**1112(2)**	**100**	**53.87**

(1) Total Sample : N = 6632.

(2) 16.7% of the total sample.

* Unspecified (conditions diagnosed as "depression" only) : (N = 123). Others (N = 42).

(b) Affective Disorders Other than Manic and Depressive Illness

Diagnosis	No.	% to M.D. group	% to total aff. disorders
10.4 Depressive neurosis.	558	58.4	27.0
10.7 Reactive and situational neurosis (depressive type)	397	41.5	19.2
Total	**955(3)**	**100**	**46.2**
Total Affective Disorders	**2067(4)**		**100**

(3) 14.3% of the total sample.

(4) 31% of the total sample.

TABLE II

Affective Disorders in Kasr El-Aini, 1973(1)

(a) Manic and Depressive Illness (psychosis) and Endogenous psychotic) Depression

Diagnosis	No.	% to M.D. group	% to total aff. disorders
— Manic depressive : depressive	26	2.2	1.5
— Manic depressive : manic	58	4.9	3.5
— Manic depressive : circular	1	0.08	0.06
— Manic depressive : mixed	9	0.7	0.5
— Involutional Melanacholia (depression)	169	14.4	10.0
— Endogenous (psychotic) depression	31	2.6	1.8
— Manic and depressive illness not clearly subcategorized.	105	8.9	6.2
— Others and unspecified*	775	66.0	45.9
Total	**1175(2)**	**100**	**69.5**

(1) Total sample : N = 6103. (2) 19.2% of the total sample

* includes conditions diagnosed as "depression" without further clear specification (N = 755 and conditions diagnosed as "state of depression" (N = 20).

(b) Affective Disorders Other than Manic and Depressive Illnesses.

Diagnosis	No.	% to non M.D.	% to total aff.
— Depressive neurosis	214	41.4	12.7
— Reactive depression	218	42.2	12.9
— Depression-anxiety neurosis	84	16.2	5.0
Total	**516(3)**	**100**	**30.5**
Total Affective Disorders	**1690(4)**		**100**

(3) 8.4% of the total sample.

(4) 27.6% of the total sample.

TABLE III

Results of the Chi-Square Test (X^2) for the Significance of Difference Between the Results of 1977 & 1973

Diagnosis	No. of Patients		X2	S.S.
	K.A.— 1977	K.A.— 1973		
— Manic depressive : depressive	325	26	323.19	.001
— Manic depressive : manic	167	26	65.47	.001
— Manic depressive : circular	11	1	9.05	.01
— Manic depressive : mixed	77	9	59.93	.001
— Involutional Melanacholia (depression)	123	169	5.67	.02
— Depressive illness not elsewhere specified	144	—	—	—
— Manic illness not elsewhere specified	6	—	—	—
— Others and unspecified	165	775	581.11	.001
— Manic and depressive illness not clearly subcategorized	94	105	.16	N.S.
— Endogenous (psychotic) depression (+ Manic depressive depressive)(1)	325	57	225.38	.001
	558	214	38.62	.001
— Depressive neurosis	397	218	05	N.S.
— Reactive and situational neurosis (depressive type)	397	218	05	N.S.
— Depression-anxiety neurosis (+ Depressive neurosis)(2)	558	298	.05	N.S.

S.S. = Statistical significance. N.S. = Non Significant.

(1) Significance of difference estimated for manic depressive-depressive (N = 325) of 1977 versus the sum of manic depressive-depressive (N = 26) and endogenous depression (N = 31) of 1973.

(2) Significance of difference estimated for depressive neurosis (N = 558) of 1977 versus the sum of depressive neurosis (N = 214) and depression-anxiety neurosis (N = 84) of 1973.

DISCUSSION

We can notice that in 1973 the term "depression" without any further specification was used to diagnose 775 cases (i.e. 45.9% of all affective disturbances). The same vagueness is met with in a late survey of psychiatric morbidity among a sample of Egyptian university students (Okasha **et al.,** 1977) in the scholastic year 1974/75 just before the generalized application of the Egyptian Manual (DPM-I) in 1975. The authors tabulated two distinct categories in this survey; "neurotic depression" and "depression", and while they identified the former with reactive depression in the "text", the latter was identified independently as affective disorder. In a previous survey of an Egyptian outpatient sample, Okasha (1967) categorized the affective disorders in three distinct groups; reactive depression, manic depressive psychosis and involutional depression. Also, in a survey by Shaheen **et al.** (1971), in Kasr El-Aini hospital on 1000 patients, the term "depression" was presented as such without any further specification. We can, thus, conclude that prior to the use of the Egyptian Manual, there was no common language and nosological comparisons had to prove futile.

At any rate, we are in a position to postulate that the increase in this unspecified depression is at the expense of both the neurotic type and the manic depressive : depressive type. Both categories are most elevated in 1977 sample, with a corresponding drop in the unspecified category.

The term manic and depressive illness was used in most of the cases in 1977 but in 1973 the term manic-depressive psychosis alternates with manic depressive illness irregularly. The term endogenous depression was only used in 1973. However, the ICD-9 (WHO, 1977) recommends including endogenous depression under the category 295.0 i.e. Manic-depressive psychosis : depressive type. Even though, if we compare the manic and depressive illness : depressive type in 1977 with the corresponding category of 1973, i.e., manic-depressive psychosis (or illness): depressive type or even with the sum of this category and "endogenous depression" put together, the difference is still highly significant in both

comparisons, where the manic depressive-depressive type in 1977 surpasses all corresponding categories. We can assume that the increase in this category indicates that there is a tendency to include much of the previously labelled "depression" without specification in this category (Manic and depressive illness depressive type). This tendency seems to have become internationally justified where the ICD-9 includes under this title, in addition to the classically described group, terms like: depressive psychosis, manic depressive reaction, monopolar depression, endogenous depression, psychosis depression and even involutional depression. It is proved by this research and elsewhere, approved independently by the international tendency, that this category is becoming the depression's waste basket.

The manic-depressive illness: manic type was represented higher in 1977 sample than in 1973 sample (sig. at 0.001). Okasha (1967) noticed that "...wherever separate figures are given for mani-depressive forms, it seems that in Africa the majority are manics". He could not confirm this finding in his survey, where less than 1/5 th of his manic-depressive patients presented with a manic picture.

In our study the figures of the manic type are 4.9% and 15%, in the 1973 and 1977 samples respectively. This may refer to a cultural difference between the Africans and the Egyptians (still Africans).

The difference between the 1973 and 1977 samples in this category still indicates the tendency to differentiate whenever a glossary is available. However, we cannot exclude a therapeutically oriented tendency, just as that observed in the increasing tendency to diagnose mania after the introduction of lithium therapy (Lehmann, 1971). The circular type, though representing the historical parent of the whole group, is becoming, as it seems, a rarity (0.9% in 1977 and 0.08% in 1973). It is possible, however, that the diagnostician overlooks that a single attack to the opposite side justifies the diagnosis of this types, as the Egyptian Manual states "...it is distinguished by the occurrence of at least one attack of both...". This rarity might also indicate that "brief compensatory rebound

mood swings" are not considered as justifying criteria for the diagnosis of a circular type. This finding is also congruous with the absence of major manic disorders as independent subcategory in the DSM III.

The specific phase of the current attack was not specified since the used manual does not include such fourth digit. The DSM-II had added a fifth digit (296.33 and 296.34) for this purpose and this modification was admitted by the ICD-9 later on.

As regards using the term manic and depressive illness without any further qualification into manic or depressive, it was equally met with in both samples. This may refer to a constant difficulty or looseness with or without using a diagnostic manual related to specifying this category.

The involutional depression shows moderate difference within the two samples (11% and 14.4%) of the manic and depressive group in 1977 and 1973 respectively with a difference significant at 0.02. This can indicate that this category with a distinct history and specific features is clear in the teaching and practice in this clinic before as well as after using the manual.

The ill-defined category "Depressive illness not elsewhere specified" is also controversial. It is identified partly by exclusion and partly by specific criteria as cited in the Egyptian DMP-I (06.5). The criteria mentioned are nearest to the so called "psychogenic depressive psychosis" depressive type in the ICD-9. Shaheen and Rakhawy (1977) have equated this category as the depressive waste basket while it seems here not to be so. It represents 12% of the manic depressive group in the 1977 sample and no corresponding category could be separated in the 1973 sample. We can now recommend a better distinction of this category in the next revision of the used manual avoiding the diagnosis of this category by exclusion and perhaps changing its name to an affirmative one (rather than "not elsewhere"... etc").

The other major group of the affective disturbances was the neurotic group. In 1977, it was represented by the depressive neurosis (10.4) and reactive (and situational) neurosis of the depressive type (10.7).

In 1973 an extra term was met with i.e. depression-anxiety or depression with anxiety. Probably this mixed category was differentiated in 1977 into either anxiety neurosis or depressive neurosis according to the predominant features as recommended in the manual's definition of neurosis. In the ICD-9 it is recommended that "... mixed states of anxiety and depression should be included here (i.e. under neurotic depression 300.4). Once again we meet a national tendency that was approved independently by an international inclination later on.

The difference between the 1977 and 1973 samples was met with only in the neurotic depressive group. This may indicate that at least part of the huge group labelled "depression" in 1973 is but neurotic depression.

We have to comment that the general tendency to differentiate through attachment to an available diagnostic label is not necessarily advantageous although Leff (1977) states that "Is is all too easy... for a diagnostic framework to become a tautology from which it is impossible to escape, even when it bears little relation to the observable phenomena".

The study revealed a general tendency to differentiate after using the manual. It also referred to the undue enlargement of a limited category (i.e. manic-depressive : depressive type) which was probably as a waste basket more than the categories "not elsewhere specified" or "others". The circular type was rarely diagnosed and the involutional melancholia proved to be stable and unaffected by the use of the manual. The manic type was represented minimally in contrast with the possibility that is surpassed depressive subcategories in African samples.

By now we come to conclude that :

1. Subcategories included in the concept 'Affective Disorders' are definitely still representing ill-defined concepts.

2. A diagnostic frame of such categories could help in facilitating a certain degree of communication, but should not the least be thought of as satisfactory for fulfillment of many clinical, structural or dynamic requirements.

3. The differences in the incidence of a certain subcategory do not only depend on variables like cultural factors, etc. but they are basically dependent on the theoretical orientation and diagnostic discpline followed by the group of diagnosticians.

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الموجـــز

مفهوم « الاضطرابات العاطفية » فى القاعدة التصنيفية المتداولة (تقييم محلى)

أجريت هذه الدراسة على جميع المرضى المترددين على العيادة النفسية بالقصر العينى كعينات خلال الستة الشهور الأولى من عامى ١٩٧٣ ، ١٩٧٧ بهدف المقارنة الطويلة بين تقييم « كيفية » تطبيق ما تفيده مفاهيم الاضطرابات العاطفيـــة .

وقد أظهرت نتائج الدراسة اتجاها عاما الى تحديد التشخيص بعـــد استعمال التقسيم المصرى ، وقد أشارت الدراسة كذلك الى التضخم الأكثر من اللازم فى تشخيص بند محدود (وهو بند الاكتئاب المتفرع من أمراض الهوس والاكتئاب) والذى كان يستعمل على الأغلب كسلة مهملات تشخيصية أكثر من البند « ليس موصوفا فى مكان آخر » أو « أخرى » . وقد وجـــد أن النوع الدورى كان نادرا ما يشخص ، فى حين أن اكتئاب سن اليأس أثبتت استقراره وعدم تأثره باستعمال التقسيم ، وقد ظهر أن نوع الهوس ممثـــل بدرجة قليلة على العكس مما هو محتمل فى العينات الأفريقية حيث يتغلب الهوس على الاكتئاب فى مدى انتشاره .

ونستطيع أن نستنتج فى النهاية أو وجود اطار تشخيصى يساعد عـــلى تحديد الأنواع والبنود ولكنه قد يصبح قيدا لا يمكن الهروب منه وأن الفروق فى نسبه حدوث فئة فرعية معينة قد ترجع بصفة رئيسية الى الاطار النظرى للتشخيص والطريقة المتبعة فى البحث ، ولا تعتمد فقط على عامل البيئة وغيره من العوامل الأخرى المعروفة .

ABSTRAIT

Le concept de "Troubles affectifs" dans la discipline nosologique courrante. (Une évaluation nationale)

Une étude comparative a êté porté sur des échantillons représentatifs des malades psychiatriques fréquentant la clinique d'un même centre (Kasr El-Aini) durant les six premiers mois de 1973 et de 1977) (avant et après l'utilisation du DMPI Manuel diagnostique des troubles psychiatiques sur une large échelle.

Les résultats ont montré qu'une tendance à plus de délimitation s'est faite remarquée après avoir suivi une certaine discipline diagnostique.

Les troubles affectifs périodiques étaient sous-diagnostiqués par rapport à un concept non-spécifique attaché au mot dépression.

Le diagnostique de dépression involutionelle n'était presque pas influencé par l'introduction du manuel diagnostique.

Nous avons trouvé aussi une proportion inverse entre deux sous-catégories: viz sous-types mixte et circulaire qui pourrait s'expliquer dans une utilisation synonyme erronée.

Cette différence dans la fréquence de certaines sous-catégories ne pouvait pas dépendre seulement de variantes tels que les facteurs culturels... etc., mais elle dépendait surtout de l'orientation théorique des psychiatres et de leur méthodologie.