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EDITORIAL

Jules Angst, Guest editor

The history and concept of recurrent brief depression

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Although the diagnostic concept of recurrent brief depression (RBD) is relatively recent (Angst and Dobler-Mikola 1984, 1985), episodes of brief depression have been documented since the 19th century.

In his excellent monograph on melancholia, Pohl (1852) described a female patient who had developed a recurrent melancholic disorder over a period of 2 years, displaying symptoms of depression, anxiety, loss of appetite, insomnia, and an inability to work. After "recovery", she developed multiple brief depressive episodes, which lasted no more than 2 days but which recurred constantly. This led Pohl to formulate the question: "is this periodic melancholia?" (p. 124).

Head (1901) described cases of brief depression in considerable detail: the symptoms only lasted for a period of a few or more hours, but the patient would frequently recall the depression as having persisted for 1 or 2 days. Head stressed, however, that the condition usually did not remain stable over the period of days but ebbed and flowed in attacks of varying duration. Such brief depression was frequently linked with ideas of suicide or with an impulse for self-destruction and suicide (p. 364).

Gregory (1908, 1915) of the Bellevue Hospital, New York, drew attention to the great clinical relevance of what he described as "transient attacks of manic-depressive insanity," attacks which might be of some days' or even of only a few hours' duration, were quite frequently observed, and which he termed "atypical". Gregory made the significant observation that these fleeting attacks were independent of menstruation. He also ascribed many sudden and unexpected suicides to them. Gregory pointed out that such attacks often went unrecognized, even by the patient himself, who frequently interpreted them as some common physical ailment. He identified some cases as "somatic phases of manic-depressive psychoses" (p. 1043). In other instances, he reported a close association with dipsomania, which he explained as a special form of the recurrent transient attacks of depression.

Paskind's (1929) investigation of the histories of 633 cases of recurrent attacks of manic-depressive depression in the private records of his colleague Patrick (1929), found 13.9% of cases with a history of an attack lasting from a few hours to a few days. He observed that such diminutive attacks of manic-depressive depresssion were rarely recognised for what they were. Describing the typical symptoms of such illnesses, he stressed the fact that most patients were not seen by physicians and that "consequently [the attacks] may be repeated for decades without skilled observation until the first protracted depression" (p. 133). Like Gregory, Paskind noted the risk of suicide among these patients, a risk also emphasised by Patrick (1929) and Read (1929). Paskind considered the treatment for the brief attacks to be the same as that for the long ones.

Busse et al. (1955) also observed recurrent brief depression as a frequent disorder amongst the elderly in the community. The authors state (p. 897): "...The depressive periods... occurred at least once a month, and their duration varied from a portion of an hour to a few days. The subjects reported that these episodes of depression had not occurred in their younger years." Nevertheless, "a significant portion of our subjects reported a definite increase in frequency and depth of depressive episodes".

As early as 1899, Kraepelin classified short, mild depressive and hypomanic states bordering on normality in the group "manic-depressive insanity." Yet such short states of depression, frequently severe rather than mild, have been consistently neglected by psychiatric research although they are common.

Since 1980, brief depressive episodes have become the focus of renewed attention. Clayton et al. (1980) described the syndrome of "very brief depression" (VBD), which was observed in a study of affective disorders among professional women. VBD was characterised as a depressed mood of 3–7 days' duration, with three or more depressive symptoms and a change in mood or personal-

Jules Angst (✉)
Psychiatric University Hospital Zurich, P.O. Box 68,
CH-8029 Zurich, Switzerland

ity that was recognised by others. Clayton stressed that such episodes were not systematically associated with the premenstrual phase in females.

Prospective observation studies were carried out in London by Montgomery and Montgomery (1982, 1983) and Montgomery et al. (1989, 1990) on psychiatric patients with a history of several suicide attempts, and brought to light some important clinical findings. The patients were given long-term treatment, aimed at preventing further suicide attempts. During treatment, they experienced irregular episodes of brief depression, which manifested itself as multiple short-lived depressive mood swings of 3 days median duration, most of them severe and sometimes associated with suicidal intentions.

In 1978, a longitudinal, epidemiological cohort study of young adults assessing subthreshold psychiatric morbidity was launched in Zurich, Switzerland. An analysis of the continuum from normal to pathological depresive mood swings (Angst and Dobler 1984) showed the frequent occurrence of depressive episodes lasting not more than 8 days. Three subgroups of brief depression were distinguished: non-recurrent, low recurrent and highly recurrent.

RBD was thereafter the subject of further investigations (Angst and Dobler-Mikola 1985). The first operational definition applied different symptom thresholds for males and females (Angst and Dobler-Mikola 1985, 1988) but was later revised by Angst (1988). According to this definition, the manifestation of a fully developed major depressive syndrome, with four out of eight symptoms (DSM-III) or five out of nine symptoms (DSM-III-R) is crucial to a diagnosis of RBD (Angst et al. 1989, 1990). Approximately 90% of RBD episodes last on average 1 to 3 days. They recur irregularly and frequently. A minimum frequency of 12 per year is required for a diagnosis of RBD. In order to avoid over-diagnosing in population surveys, subjective work impairment is also required as a diagnostic criterion.

The Zurich Study demonstrated the clinical relevance of recurrent brief depression, its social consequences, and rates of treatment, and established the high risk of attempted suicide and the social disability associated with it. A positive family history was present in RBD subjects, as in the case of major depressives. RBD and major depression also share comorbidity with anxiety disorders and substance abuse. RBD and major depression are often present longitudinally in the same subjects, without there being any systematic preference as to sequence. It was concluded that RBD does not form a special psychiatric disorder but belongs to the spectrum of mood disorders, as Kraepelin (1899) suggested. He erroneously unified bipolar and unipolar depression, whereas RBD belongs in the majority of cases to the unipolar group.

More recently, community studies (Maier et al. 1992; Lépine 1992) and the comprehensive WHO study of primary care patients carried out in 15 treatment centres in 14 countries worldwide, have confirmed the existence of RBD. Their findings have corroborated the high prevalence of the disorder in the general population and in general practice and confirmed its comorbidity with attempted suicide, other forms of depression, anxiety disorders and substance abuse. Another study (Staner et al. 1992) reported abnormalities in neuroendocrine functions and changed sleep patterns in patients with RBD and found a relatively low overlap with personality disorders (axis-II diagnoses).

It is surprising that a condition that is so common should have received such scant scientific attention over the past century. An explanation for this was suggested by Paskind (1929) when he observed that "Very likely, most patients subject to brief attacks alone are not seen by physicians or are seen only by general practioners, since these illnesses are short, may appear at long intervals and apparently yield to some simple remedy. Consequently they may be repeated for decades without skilled observation until the first protracted depression." (p. 133)

Fortunately, RBD was integrated as a new diagnostic category in ICD-10 (1992) with a slightly softer frequency criterion; however, in DSM-IV (1994) it is still listed, together with minor and other depression, as a subcategory of depressive disorders "not otherwise specified."

Over the past few years, important new data on RBD have been collected and are now being published *in this special issue* of our journal. The WHO Study mentioned earlier on psychological problems in general health care is of paramount importance in this respect. It is form this important study, carried out in 14 countries, that Weiller et al. report prevalence rates of recurrent brief depression and describe the practical relevance of this subtype of depression in general practice. The current prevalence rate of roughly 10% in primary care confirms the results of earlier community studies carried out in Zurich and in Mainz (Maier et al. 1992).The papers in this special issue also deal with the presently available diagnostic criteria and discuss whether or not they should be revised. Here the main focus is on two questions: the frequency criterion of RBD, i.e. whether the episodes should have occurred monthly over 1 year or (new) 6-monthly or even (new) less frequently, and on the impairment criterion. The diagnostic criteria may, indeed, require further improvement in the future; however, in order to avoid overdiagnosis, changes will need to be based on empirical data and validated by community studies.

RBD shows some seasonality; there may even be a subclass of seasonal RBD disorder, as suggested by Kasper et al. in this issue.

The treatment of RBD remains an unsolved problem and is an increasing challenge. By definition, we are dealing with a "rapid cycling," brief unipolar depressive illness, which is apparently difficult to treat, as illustrated by the pioneering studies carried out by Montgomery et al. (1979, 1983). Their most recent results are presented in this issue. Unfortunately, none of the studies which they have so far conducted has been able to find a prophylactic effect of antidepressants against the recurrence of brief depression.

Despite the now extensive research into recurrent brief depression, many questions remain unanswered: Can we improve the definition? Is the assessment reliable? Is there

a prophylactic treatment? Are there any psychosocial risk factors? What is the relationship between RBD and personality disorders? Nevertheless, it is now established that recurrent brief depression belongs to the spectrum of mood disorders, is a frequent condition and a major – not a minor – form of affective illness, and that it is found across cultures. As such, RBD deserves much greater attention.

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