Archives of Psychiatry and Psychotherapy
Volume 6, Issue 4, December 2004
pages 5–8

Cothymia: Double mood disorder

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Summary

The syndrome of anxiety and depression is common and has a clinical importance that is not possessed by either diagnosis alone. It is argued that this condition deserves separate diagnostic description since the term 'comorbidity', the implication of separate concurrent disease, is not an appropriate term for two mood disorders that are so intimately associated. The clinical course and treatment implications of the combined condition, cothymia, are described.

Key words: affective disorder, anxiety disorder, classifications, mood disorder, depression, and diagnosis

Introduction

It is no longer possible to be alive without suffering from at least one psychiatric disorder in the DSM group. It may therefore be regarded as an exercise in futility to create even more disorders by joining two or more together and creating a new entity. However, in this paper I would like to convince my Polish colleagues that there is some merit in taking the two most common mental disorders in the world, anxiety and depression, and joining them together in the form of cothymia [1]. Throughout this article I shall be adopting a clinical perspective in defending this position. There are four reasons why the use of this term may constitute a useful diagnosis.

It is a remarkably common condition

Cothymia is the simultaneous presence of an anxiety disorder (apart from simple phobia) and a depressive disorder. It could be argued that the term "mixed anxiety and depressive disorder" also satisfies a description for this, but this has been reserved for so called "sub-syndromal" combinations of anxiety and depression (i.e. those that do not reach the threshold for formal diagnosis if occurring separately) [2]. As the thresholds for diagnosis for DSM-IV are so low, these really only cover a group of people who

have very mild disorders and who in general do not qualify for psychiatric care. The value of such a sub-syndromal diagnosis when there are so many more people with a combined syndromal disorder has always seemed to me to be surprising. The likely prevalence of cothymia can be inferred from a national survey data using the Revised Clinical Interview Schedule (CIS-R) [3] an epidemiological tool that does not follow the current diagnostic guidelines and therefore is somewhat frowned upon by those who wish to compare the data from national surveys internationally. However, it does have the merit of recording anxiety and depressive disorders together, and in studies using this instrument the prevalence of cothymia is likely to be somewhere between 10 and 12% of the population at any one time [4], and constitute the largest proportion of those with neurotic disorder.

The anxiety and depression in cothymia is likely to be part of the same syndrome

One of the reasons for keeping anxiety and depressive disorders apart is that their physiology is very different and the argument is made that each has a different biological basis [5]. In fact, there is now increasing evidence that anxiety and depression are mediated through the same neurotransmitters and have the same genetic basis [6]. This does not mean that they are synonymous, but they so frequently occur together that the combination cannot be ignored as just an example of comorbidity, the simultaneous presence of two separate diseases occurring at the same time.

Treatment and outcome of cothymia is different from that of single anxiety and depressive disorders

The main purpose of any diagnosis is to help the clinician to choose the right treatment and predict the outcome. The problem in ordinary practice is that either the depressive disorder component is considered primary or (more rarely) the anxiety component is, and each is then treated as though the other did not exist. This could be a mistake, as although, for example, there may be very few differences between different anti-depressant drugs in terms of efficacy for depression is unlikely to be true for cothymia. The evaluation of treatments is handicapped because there is no syndromal equivalent of cothymia, which is used in research studies, but there is reason to believe that there are important differences between the effects of antidepressants in the presence or absence of significant anxiety [7]. Similarly, the presence of depression or anxiety may complicate the treatment of cothymia treated by psychological therapies and lead to a poorer outcome [8]. There is also evidence that the long-term outcome of cothymia is significantly worse than the outcome of single anxiety and depressive disorders [9, 10].

Anxiety and depression are often consanguid, not comorbid

Although there have been many attempts to separate anxiety from depressive disorders over the last 40 years they have all failed to show what Kendell [11] terms “a point of rarity” between the conditions. In other words, the distinction between

a depressive and anxiety disorder based on the "proportions of illness" is a purely arbitrary one and, in effect, creates an artificial categorisation that is not justified by the evidence. The problem is that by reifying diagnosis in the standard way, typically using the DSM diagnostic criteria is that treatments are introduced for one or other condition as though they were pure disorders. We have argued elsewhere [12] that this has actually been countered productive for the development of new drugs for the treatment of anxiety and depression. Rather than evaluate new molecules the tendency has been for pharmaceutical companies to look for new "diagnoses" that allow them to have additional indications for their drugs. If these diagnoses are phoney ones that have no validity the only consequence is that the company carries out repetitive studies totally lacking in innovation.

Conclusions

A good diagnosis, in the apt metaphor, is meant to cut nature at its joint so that there is a simple separation of two conditions. Many have tried since 1940 to separate anxiety and depression (before this time they were regarded as the same condition) [13]. Whilst it is perfectly proper for the extremes of anxiety, particularly when associated with behavioural change (agoraphobia) and depression (when clearly part of bipolar disorder) to be separated from cothymia, most of the remainder sit naturally together. The time has come for at least the opportunity for the combined diagnosis to be evaluated again in comparisons of interventions so that we can provide evidence that can help to determine if indeed the diagnosis does deserve to stand separately. My prediction is that such evidence will be forthcoming and that it may well simplify and reduce the number of diagnoses currently in both international classifications systems and is a model for rationalization of many other disorders.

ACKNOWLEDGMENTS: The original work described in this paper was supported by the Mental Health Foundation, London, United Kingdom.

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