FROM TEMPERAMENT TO MOOD DISORDER SPECTRUM

The assessment, management and treatment of mood disorders require careful observation of the signs and symptoms already in all disease states. Affective disorders are currently classified into well-defined diagnostic categories in the Diagnostic and Statistical Manual for Mental Disorders – Fifth Edition (DSM-5) and in International Classification of Diseases – 11th Version (ICD-11).

However, the complex symptom system that accompanies these disorders often poses a diagnostic challenge to clinicians. The risk of a superficial clinical examination is to focus only on some aspects of the mood disorder.

Indeed, there is often a tendency to focus on the main symptoms of mood, depression and euphoria, excluding the wide range of phenomena that would lead to a more in-depth diagnosis such as, for example, bipolar disorder or mixed states (Tavormina 2021). In many cases, the "simple" depressive episode represents only a phase of the broader "bipolar mood spectrum".

In 1978 Akiskal began to revolutionize the clinician's approach to the depression and mood disorders; he wrote: "The diagnostic usage of the concept of "neurotic depression" may no longer be clinically meaningful, since it lacks sufficient phenomenological characterization and refers to a heterogeneous group of disorders… Depressive disorders probably represent the most common group of psychiatric maladies for which physicians are consulted. It is the impression of many clinicians that the incidence of these disorders is on the rise ..." (Akiskal et al 1978).

Following what Akiskal had described, we can emphasize the importance of the correct approach of the clinician to temperaments and their knowledge. Within a symptomatic continuum there are different forms of temperament which are subthreshold forms of bipolar disorder (Tavormina 2019). Temperaments are considered stable personality traits with reference to biological rhythms, social environment, and their variations.

Akiskal (1996) first described five types of temperament: cyclothymic, depressive, hyperthymic, irritable and anxious. The same author observed the fluctuation of the various temperamental traits belonging to a broader symptom spectrum: the bipolar spectrum (Akiskal 2002).

The discussion becomes more complex since some authors believe that schizophrenic and bipolar spectrum disorders are not disorders with distinct diagnostic entities but part of a complex system of disorders belonging to a single diagnostic entity (Malhi & Porter 2016). Current research has gone so far as to consider an overlap of schizophrenia and bipolar disorder in terms of symptoms, familial patterns, risk genes, outcome, and treatment response (Jiang et al. 2022, Yamada et al. 2020). To support the dimensional model the National Institute of Mental Health (NIMH) has proposed the Research Domain Criteria (RDoC) system. "*RDoC provides a framework that excludes categorical diagnoses, and adopts dimensional evaluation based on genetic, neural and behavioral indicators. The system consists of six research domains and eight analysis units*" (Yamada et al. 2020).

Numerous research fields are validating the dimensional model and the model of a single Big Spectra. Research on cognitive deficits is gaining momentum from the consideration that these deficits are the core feature of schizophrenia and mood disorders (Franza et al. 2018).

However, also in this field the overlap of the deficits in the different cognitive domains is evident. In fact, both individuals with schizophrenia and individuals with affective disorders have an alteration in attention, verbal learning, and executive function.

The cognitive deficits are the same. The difference is only quantitative and not qualitative. The situation became complicated when some recent studies identified the same quantitative deficits as affective disorders in control groups of healthy individuals (Keramatian et al. 2022, Torres et al. 2020). These observations indicate the complexity of the clinical approach to affective disorders. The clinician must first consider the dimensionality of the symptom complex without dwelling only on the most evident phenomena. As a consequence of this complexity, there is a need for integrated intervention in which the various professional figures interact. This intervention (psychiatric, psychotherapeutic, rehabilitation, educational) must aim to act on the different symptom groups. It must act on the phenomena that arise along a continuum to try to arrive at a targeted, precise, patient-centered intervention. Mental health professionals need to start from temperament treatment to more complex symptoms such as psychotic disorders.

The 3rd National Congress of EDA Italia Onlus and the 4th Workshop of Psychiatric Studies Centre, held in Olbia, Italy from, 29-30th September to 1st October 2022 have brought together the knowledge, experience and professionalism of many Health Care Workers. The integration of different professions can lead to the development of new knowledge and new therapeutic tools. The aim is to place the patient at the center of our working universe to provide with all that is necessary for the care and well-being.

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