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EDITORIAL

Is it time for psychiatry to discuss consensus criteria for euthymia? Clinical, methodological, research, and ethical perspectives

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Euthymia is a word of Greek origin (*eu* meaning good; *thymós* meaning mood) used by ancient philosophers such as Diogenes and Seneca. Its central concept regards a subjective and stoic state of tranquility that often goes beyond the contemporary physicalist and medical concepts of mood and patterns of human behavior. Currently, in medical and research practice, euthymia refers to a status of clinical remission for mood syndromes such as major depression and bipolar disorder (BD).

The DSM, published by the American Psychiatric Association (APA), which is the most prominent compilation of standardized psychiatric diagnostic criteria worldwide, traditionally did not define any diagnostic criteria for euthymia. In its latest (fifth) edition, published just a few years ago, the DSM-5 Task Force made few, if any, significant changes regarding the issue of euthymia or remission in mood disorders. In the last decade, the Research Domain Criteria (RDoC) initiative has been the subject of increasing attention. The RDoC initiative was developed by the U.S. National Institute of Mental Health (NIMH) for new approaches to investigating psychiatric disorders. However, it did not assess extensively the euthymic state of mood disorders. In 2009, the International Society for Bipolar Disorders (ISBD) Task Force published a scientific report on the nomenclature for course and outcome of BD. This report reflects efforts to create an expert consensus for the use of clinical terms such as response, remission, and recovery for mood episodes.[1] In fact, the DSM includes the terms partial and complete remission as specifiers of mood episodes. Thus, there are still no clear and precise descriptions of euthymia, often referred to in scientific publications as ''interepisodic'' or ''remitted'' clinical states.[2] Unsurprisingly, this represents a major problem for researchers and clinicians.

From a clinical perspective, the lack of specific criteria for euthymia or remission hinders evaluation of remitted states in medical practice.[2] This has significant therapeutic implications. For instance, several guidelines and clinical trials of maintenance treatment of BD define euthymia or remission as the absence of criteria for major mood episodes according to the DSM or low scores on mood questionnaires such as the Hamilton Depression Rating Scale (HDRS) and the Young Mania Rating Scale (YMRS).[3] Difficulties persist in the field of clinical research. Over the last 15 years, there has been increasing interest in studying the interepisodic phases of BD. A growing body of evidence shows that BD patients fulfilling criteria for euthymia present a broad range of residual psychopathology, including cognitive impairment and subsyndromal mood and sleep dysfunction.[4] Furthermore, compelling evidence shows that residual symptoms correlate with reduced functionality, quality of life, and poor prognosis and outcome.[5,6] Once again, the criteria for euthymia in these studies has varied immensely. In short, the absence of specific criteria for euthymia imposes enormous difficulties for both clinical and research practice. In this sense, efforts to create a universal and widely used taxonomy for euthymic clinical states in BD, such as the ISBD Task Force for nomenclature, are necessary in order to achieve optimal comparisons between the results of distinct clinical trials. Additionally, it would significantly increase the power of prospective and retrospective studies to detect risk factors, clinical predictors, and prognosis.

Yet, the problems regarding the debate about euthymia continues. At least two more aspects must be mentioned. First, there has been a long methodological debate, at least for BD, on the grounds or foundation of the euthymic state. In this sense, the evidence accumulated over the last decades showing prominent residual psychopathology in euthymic bipolar patients has led many researchers to raise doubts and questions as to the pertinence of the euthymic state itself. Unsurprisingly, several publications define these BD patients without major mood episodes as remitted or interepisodic. Should we change our nomenclature and stop using the term euthymia in favor of the terms remitted or interepisodic? Can we establish a comparison of this situation with known neurological conditions such as

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multiple sclerosis, which classically manifests as clinical relapses and remissions? Is that the case for BD and euthymia? Does the clinical and neurobiological evidence point toward this direction?

A second, and more complex, debate is that regarding ethical aspects of the entire concept of euthymia. Even though defining specific consensus criteria for euthymia would bring advances for clinical and research practice, questions and criticisms may emerge regarding concerns on the standardization of normal human behavior. This may explain the scarce and isolated efforts to define and create specific criteria for euthymia. In an interesting article, Fava & Bech propose the use of a specific scale to measure euthymia, generating a score that ranges from 0-10.[7] Nevertheless, the authors work with a concept of euthymia more related to well-being than to clinical aspects of psychiatric disorders, such as major depression and BD.

Altogether, there are relevant methodological, clinical, research and ethical aspects regarding the concept of euthymia. The lack of clinical and research consensus on the subject imposes several problems, as described in the text. Furthermore, this is not an easy debate to raise, because it carries complex methodological and ethical issues; nevertheless, there is an urgent need for broader discussion.

Disclosure

The authors report no conflicts of interest.

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