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Leaving melancholia: disruptive mood dysregulation disorder

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Abstract
This chapter outlines the importance of critically reflecting on the diagnos- tic criteria for DMDD now included in DSM-5. In so doing, it mounts the argument that DMDD is a new and problematic inclusion to the 'Depressive Disorders' in an extremely influential manual of psychiatric disorders. Sig- nificantly, the inclusion of this new 'disruptive' and 'energetic' disorder as a form of 'depression' has yet to meet with substantive critique. DMDD crite- ria include 'tantrums', a point that has been hotly debated. For instance, as Wakefield (2013) pointed out, 'Children tend to outgrow these temper tantrum problems, so treatment and stigma may be applied unnecessarily to large num- bers of children' (2013, p. 150). It is unknown how this new child disorder will impact, positively or negatively or even if it will afford the clarity that it is hoped to deliver. As Gitlin and Miklowitz (2014) concluded, 'whether this new category will advance diagnostic clarity and/or more appropriate treat- ment is unknown' (2014, p. 89). The chapter demonstrates how historically informed analysis can be drawn upon to reflect on how interpretations and representations of melancholia and depression are very much connected to the political, the discursive, and, in the 21st century, to the authors of one manual of mental disorders. For a simple summary of the implications for practice, see Table 10.1.

Keywords
mood, leaving, melancholia, dysregulation, disruptive, disorder

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Leaving Melancholia: Disruptive Mood Dysregulation Disorder

Valerie Harwood

Introduction

This chapter provides a theoretical examination of the constitution of contemporary discourses of depression in childhood and adolescence, focusing on a new depressive disorder described in the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) (American Psychiatric Association, 2013). Termed 'disruptive mood dysregulation disorder' (DMDD), this is a depression filled with energy and agitation, a new mental disorder characterised by 'temper outbursts' and that can only be diagnosed between the ages of 6 and 18 years (with an age onset of under 10 years). As such, this is not only a new disorder for children and young people, it is also a depressive disorder that appears to depart from the most commonly understood character of depression: the lifelessness or low energy characterised by the figure of Melancholia. Following this diagnostic formula, depression may be read into the temper outbursts of children.

In this chapter, I consider this change in the contemporary moment by using two striking literary and artistic figures, Melancholia and Orestes, as a means to bring to the fore the variations in the discourses of melancholia and depression. Melancholia is arguably familiar to us with a characteristic immobile and downward-looking figure. Orestes, on the other hand, is a figure that at times might remind us of melancholia and, at other times, is startlingly energetic and agitated.

DSM-5 has been met with considerable debate in relation to the new disorders added and those that have been changed (or unchanged) and those now omitted from the manual (Gitlin & Miklowitz, 2014). Notably for children and young people, the former chapter 'Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence' in *DSM-IV-TR* has been removed, and *DSM-5* now has a chapter on neurodevelopmental disorders (Halter, Rolin-Kenny, & Dzurec, 2013).

DSM-5 has also arguably instilled child and adolescent depression with extreme agitation. While it is the case that 'child and adolescent' versions of depression in the previous DSMs (e.g. *DSM-IV-TR*) made links between depression and the disruptive disorders (American Psychiatric Association, 2000), these links are comparatively 'tame' when compared to the DMDD. Widely circulated comments by former chair of the DSM-IV Task Force, Allen J. Frances openly criticised DMDD: 'I very much oppose the inclusion of this new "disorder" – fearing that DMDD would medicalise temper tantrums in children and run the risk of exacerbating the already shameful overuse of antipsychotics' (Frances, 2011). While there is a slowly growing critical literature about DMDD, most of this takes issue with this new disorder, but appears to ignore its placement in *DSM-5* in a chapter on depressive disorders.

Project overview: Disruptive mood dysregulation disorder

It is difficult to ignore the presence of the child-focused DMDD in *DSM-5*. Producing this new disorder, which was originally called 'temper dysregulation disorder with dysphoria' (Wakefield, 2013), has prompted considerable reaction. Especially, as Rao (2014) pointed out, there is 'limited empirical data available' (p. 12) about this new disorder, and as Wakefield (2013) stated, it is a 'largely untested diagnosis' (p. 150). DMDD is justified as a means to restrict the alarming rates of bipolar disorder diagnosis in children. These rates have been reported to have had a '40 fold' increase 'in the past decade' (Rao, 2014, p. 3). This is explicitly declared in the introduction to the chapter 'Depressive Disorders' in *DSM-5*:

> In order to address concerns about the potential for the overdiagnosis of and treatment for bipolar disorder in children, a new diagnosis, disruptive mood dysregulation disorder, referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age. Its placement in this chapter reflects the finding that children with this symptom pattern typically develop unipolar depressive disorders or anxiety disorders, rather than bipolar disorders, as they mature into adolescence and adulthood.
>
> (American Psychiatric Association, 2013, p. 155)

Emphasis on the 'correction' of incorrect diagnoses of bipolar disorder is then reiterated in the DMDD criteria section (pp. 156–160) of the 'Depressive Disorders' chapter, which includes the note that 'disruptive mood dysregulation disorder was added to *DSM-5* to address the considerable concern about the appropriate classification and treatment of children who present with chronic,

persistent irritability relative to children who present with classic (i.e. episodic) bipolar disorder' (American Psychiatric Association, 2013, p. 157).

As these statements make clear, not only does this new disorder address concerns with overdiagnosis of bipolar disorder, it anticipates a trajectory of future adult disorder, namely 'unipolar depressive disorders'. A key stepping stone to DMDD was the proposal of 'severe mood dysregulation' (SMD) disorder. SMD was proposed by Leibenluft et al. (Leibenluft, Charney, Towbin, Bhangoo, & Pine, 2003) 'as an alternative diagnosis [to bipolar disorder] for those with chronic irritability' (Pliszka, 2011, p. 8).

DSM-5 describes major depressive disorder as the '*classic condition* in this group of disorders' (American Psychiatric Association, 2013, p. 155, emphasis added). Other disorders listed in 'Depressive Disorders' of *DSM-5* are persistent depressive disorder; premenstrual dysphoric disorder; substance/medication-induced depressive disorder; depressive disorder due to another medical condition; other specified depressive disorder; and unspecified depressive disorder (American Psychiatric Association, 2013).

Referring to major depressive disorder as the *classic condition* attests this is the category with which the colloquial term 'depression' is commonly associated. In *DSM-5*, major depressive episode 'is characterized by discrete episodes of at least 2 week's duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions' (American Psychiatric Association, 2013, p. 155).

'Depressive Disorders' stands as a newly separated (and distinct) chapter in *DSM-5*, with 'the former "Mood Disorders" chapter . . . now divided into two chapters, "Bipolar Disorders" and "Depressive Disorders" ' (Wakefield, 2013, p. 141). In the previous edition, *DSM-IV-TR*, 'Depressive Disorders' were placed under the category 'Mood Disorders', a category that also included 'Bipolar Disorders' (American Psychiatric Association, 2000). Indeed, as Wakefield (2013) surmised:

> Depressive disorders experienced the most changes and the most controversy of any chapter . . . [this] include[s] elimination of the major depression bereavement exclusion, introduction of the new category of disruptive mood dysregulation disorder in children, introduction into the main listing of premenstrual dysphoric disorder, introduction for further study of the new category of persistent depressive disorder, and introduction of a new major depression specifier, 'with anxious distress'. (p. 148)

Placed in this category, DMDD sits with a well-known contemporary, major depressive disorder, a disorder said to widely affect the populations of many countries. According to the US National Institute of Mental Health, '11% of adolescents have depressive disorder by the age of 18' (National Institute of

Mental Health, 2008). DMDD thus joins a category that houses some of the most commonly diagnosed – and popularly known – mental disorders.

Meeting melancholia

For several centuries, the image of physical lack has pervaded as a signature of melancholy, and arguably, depression. This image is famously portrayed in Albrecht Dürer's engraving, *Melancholia I* (see Figure 10.1).

Figure 10.1 'Albrecht Dürer: *Melancholia I*' (1514) (43.106.1)
Source: In *Heilbrunn Timeline of Art History*. New York: The Metropolitan Museum of Art http://www.metmuseum.org/toah/works-of-art/43.106.1. (October 2006) [OASC].

In *Melancholia I*, the central *adult* figure sits limp and forlorn, lacking energy or motivation, and unable to move. This is not the figure of a child; it is an adult, one placing the representation of depression as that of a grown figure. In this woodcut engraving, Dürer famously depicted the tension between 'melancholy, creativity, knowledge' (Sullivan, 2008). Strewn aside, the tools and implements surrounding melancholia tell of the vanished adult creativity, and the star on the horizon is suggestive of the role of divine inspiration. Drawing on Hippocrate's humoral theory, Dürer's engraving portrays immobility; the figure's potency lost from within, (which explained melancholia in terms of 'an imbalance in the humours: the more severe the imbalance, the more severe the symptoms of melancholia' (Lawlor, 2012, p. 26)).

The image of immobility echoes across the interpretations of melancholy, and again, these are adult images of the melancholic. Analysing a period of melancholy's immobility, Foucault's *The History of Madness* contributes instructive observations on melancholy. Based on his researches into 17th-century medicine, Foucault announces that 'melancholy never attains frenzy; it is a madness always at the *limits of its own impotence*' (2006, p. 266, emphasis added).

The Anatomy of Melancholy, first published in 1621, describes melancholy as either 'disposition or habit' (p. 83). This famous book was written by Robert Burton, who by his own admission busied himself writing his book as a means to avoid melancholy. Disposition refers to a 'transitory melancholy which goes and comes upon every small occasion of sorrow, need, sickness, trouble, fear, grief, passion, or perturbation of the mind, any manner of care, discontent, or thought, which causeth anguish, dullness, heaviness and vexation of spirit' (Burton, 1621/2004, p. 218). It is marked by its opposition to specific emotions, including feelings such as 'pleasure, mirth, joy, delight' and can cause 'frowardness in us, or a dislike' (p. 219) (in the *Oxford Dictionary* 'frowardness' is stated as having origins in Old English, meaning 'leading away from' (Soanes & Stevenson, 2013)). To describe melancholy of habit, Burton said, 'we call him melancholy that is dull, sad, sour, lumpish, ill disposed, solitary, any way moved, or displeased' (Burton, 2004).

The Anatomy of Melancholy, encyclopaedic in its references across literature, mentions violence, but it is overwhelmingly violence directed upon the self (and again, when this occurs it is an adult violence). Instances of violence towards others are few; the picture of melancholy is one of impotence. It is certainly not a melancholy that could house the likes of DMDD.

The idea that melancholy cannot attain the vigour possible in other ailments is clearly demonstrated in Foucault's recount of the descriptions provided by the 17th-century anatomist and physician Thomas Willis (1672, 1683). Foucault describes Willis' account of melancholy, in which 'the spirits are carried away by an agitation, but a *weak* agitation that lacks power or violence

a sort of impotent upset that follows neither a particular path nor the *aperta opercula* [open ways] but traverses the cerebral matter constantly creating new pores' (2006, p. 266). This description draws a picture of movement without direction but with a telos of dissipation. In this movement, 'the spirits do not wander far on the new paths they create, and their agitation dies down rapidly, as their strength is quickly spent and motion comes to a halt' (2006, p. 266). This 'melancholic experience' extends from the physiological to the soul, a view that prompts Jeremy Schmidt (2007) to conclude that for Willis, the mind and the body are both involved in the melancholic condition. The melancholy described by Willis is one of diminishing strength, reduction in agitation. It is, again, one of impotence and not a reference to disruption, agitation, or tantrums.

Surveying medical accounts of the 18th century from the work of English physician Robert James (1743/1745) and Paris physician Anne-Charles Lorry (1765), Foucault points out that while certain explanations vary and symptoms shift, there is a conceptual unity that writes the story of melancholy. What we have is an organizational apparatus that assembles symptoms, one that crafts explanations and faithfully portrays the idea of melancholy. The image of melancholy as impotent pervades, one of immobility, reduction, and loss of power.

For much of the 'clinical history' of medicine over the last several centuries, impotence has been readily discernible in the imagery of melancholia. Indeed, what perhaps earmarks depression as appearing as though it has a 'continuous history' with melancholia (Foucault, 1977) is the association with recurring depictions of impotency. Coined in the mid-19th century, and replacing melancholy, the term 'depression' came from usage that was 'popular in middle nineteenth century cardiovascular medicine to refer to a reduction in function' (Berrios, 1995, p. 386). Under this name, depression was characterised as 'reflected loss, inhibition, reduction, and decline' (Berrios, 1995, p. 386). In *The Dictionary of Philosophy and Psychology* (Baldwin, 1901), Joseph Jastrow defined depression as '[a] condition characterized by a sinking of spirits, lack of courage or initiative, and tendency to gloomy thoughts' (1901, p. 270). Here the word 'sinking' conjures the distinct image of deflation. The sense of impotence is brought to the fore when Jastrow distinguishes depression from dejection: 'depression refers more definitely to the lowered vitality of physical and mental life, dejection to the despondency of the mental mood' (Jastrow, 1901, p. 270).

Foucault made the observation on melancholy's impotence with reference to the 17th century. While it is not the case that melancholy became, as it were, what was defined as depression in the various DSMs (American Psychiatric Association, 1987, 1994, 2000, 2013), this characteristic of impotence is a point to labour upon. The kinship of melancholy and depression over the last several

centuries might be more usefully portrayed as reflecting their similar reliance on the idea of impotence.

While there is contention regarding the proposition that melancholy is the historical antecedent of depression, there is good justification for considering the cultural understanding attributed to the emblematic features of the two; namely, the notion of impotence. However, it is important to note that to consider these concepts together is not to stake a claim of continuity between them. For instance, the suggestion of a relationship between the concepts is rigorously analysed by Radden (2003), who differentiated between melancholy and depression on the basis of descriptive versus causal accounts, concluding that they are distinct. This view explicitly questions the attribution of melancholia as an historical precursor to contemporary depression. Acknowledging the significance of this distinction, I suggest it can be argued that it is the emphasis on *impotence* that enables a relationship between the two to be perceived.

What then happens when the 2013 *DSM-5* category of Depressive Disorders includes DMDD, a disorder that includes diagnostic criteria such as that

> [s]evere recurrent temper outbursts manifested verbally (e.g. verbal rages) and/or behaviourally (e.g. physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
>
> (American Psychiatric Association, 2013, p. 156)

Changes such as this stand opposed to an image of impotency that has arguably dominated our discourses of depression over several centuries. This suggests that what we may be experiencing (or possibly about to more frequently experience) is a different object of depression, one that could mean leaving Melancholia.

Leaving melancholia

The idea that depression is impotent and lacking vigour or energy is challenged by DMDD. Likewise, DMDD challenges our conception of distinctions between depression in childhood and adulthood, curiously bringing these together through the vehicle of temper outbursts. Certainly, we might be wise to consider the proposal that we are now 'leaving Melancholia' and, with it, the sense of overwhelming immobility. While temper outbursts might be considered emblematic of a certain kind of 'immobility' that frustrates adults, this is not the same kind of immobility depicted in *Melancholia I*.

Yet, although DMDD stands out among the Depressive Disorders, it is not the case that 'anger' has been wholly absent from contemporary conceptualisations

of depression. For instance, the previous edition of the DSM, *DSM-IV-TR* (American Psychiatric Association, 2000), stated that for 'prepubertal children' 'Major Depressive Episodes occur more frequently in conjunction with other mental disorders (especially Disruptive Behavior Disorders, Attention-Deficit Disorders, and Anxiety Disorders) than in isolation' (American Psychiatric Association, 2000, p. 354). In adolescents, the association between depression and other disorders is expanded to include the group of disruptive behaviour disorders as well as 'Anxiety Disorders, Substance-Related Disorders, and Eating Disorders' (American Psychiatric Association, 2000, p. 354).

It is also relevant to note that in relation to adults, the description for major depressive episode has criteria for the specifier 'Psychotic Features' that includes either delusions or hallucinations (American Psychiatric Association, 2000), and these may point towards violence to others. The Specifier is differentiated into either 'Mood-Congruent Psychotic Features' or 'Mood-Incongruent Psychotic Features', with the latter defined as 'content [that] does not involve typical depressive themes of personal inadequacy, guilt disease, death, nihilism, or deserved punishment' but that does include 'persecutory delusions, thought insertion, thought broadcasting, and delusions of control' (American Psychiatric Association, 2000, p. 413). Inclusion of persecutory delusions does render the possibility that, within a diagnosis of major depressive episode, there is scope for potency. That said, this has been a less emphasised characteristic of depression.

A means by which to conceptualise these changes might be to think in terms of 'control' and 'lack of control' (Toohey, 2004). As Toohey (2004) argued with reference to changes to 'depression' and 'melancholia' between Greek and modern representations, 'We witness in this evolutionary shift a movement from activity to passivity, from body to mind (and interiority), from complicity to estrangement, from public to private, from mark to sign, and paradoxically and above all, from lack of control to control' (2004, p. 56). In this view, depression and melancholy, as we have recently known it (along with immobility), demanded a sense of 'control' (perhaps this is a cue for the issue of control and temper outbursts). In much earlier representations dating from 400 BCE, this sense of control is far from evident; what we see is a 'lack of control' that is caused by none other than *agitation*.

A depression of children and young people that speaks of DMDD might thus be better understood as one that eschews popularised images of Melancholia, and instead embraces lack of control, where one is caught in the maelstrom of agitation. A legendary example of this form of agitation is the figure of Orestes who, interestingly, has been interpreted to represent not only a 'melancholy' but also an 'energetic madness'. In the following section, I focus on an adult portrayal of melancholy and agitation in order to consider the varying ways melancholia and depression have been historically construed. As I will show,

this enables me to examine how the politics of truth is very much implicated in the production of diagnostic criteria that now connect a child's temper outbursts to depressive disorders, the most diagnosed of mental disorders in the world (see Giles, Chapter 12, this volume).

Meeting Orestes

Orestes is claimed to be an archetypal figure of melancholy. Take, for instance, Lawlor's assertion in *From Melancholia to Prozac: A History of Depression*: 'It has been argued that depression has existed since classical times, and the character of Orestes, in Aeschylus' tragic trilogy, the *Oresteia*, is proof' (2012, pp. 24–25). Here we can consider depression and melancholia might be thought of as forms of 'madness'. By murdering his mother (matricide), Orestes plunges into a 'melancholic madness', a story famously told in *The Eumenides* by Aeschylus (458 BCE) and later in *Orestes* by Euripides (408 BCE). Also described as myth (Ingham, 2007), the story of Orestes has variations in this melancholic madness as well as in the politics of its discourse – variations that remind us of the changes to how an anger verging on madness can come to be portrayed as depression (or, in *DSM-5*, as DMDD).

The presence of depression in Orestes is considered to be portrayed in an Apulian vase of the 4th century BCE:

> Orestes, as depicted on a fourth-century BC red-figure Apulian vase (now in the Louvre), is undergoing a rite of religious purification in order to rid him of the murder of his mother, Clytaemnestra, who had been party to the murder of his father, Agamemnon. Oreste's depression is manifested in his posture, the downcast eyes and drooping body, drained of all energy.
>
> (Lawlor, 2012, pp. 24–25)

Images of the Apulian red-figure bell-krater can be accessed on the website for The Louvre, Paris (http://www.louvre.fr/en/oeuvre-notices/apulian-red-figure-bell-krater).

A rather different depiction of Orestes can be found in the Greek play *Orestes* by Euripides, a play in which we see frenzy and anger. Take, for example, the description by Electra, the sister of Orestes, who states, 'my poor Orestes fell sick of a cruel wasting disease; upon his couch he lies prostrated, and it is his mother's blood that goads him into frenzied fits' (Euripides, 408 BCE). This 'cruel wasting' changes abruptly:

> 'Tis now the sixth day since the body of his murdered mother was committed to the cleansing fire; since then no food has passed his lips, nor hath he washed his skin; but wrapped in his cloak he weeps in his lucid moments,

> whenever the fever leaves him; other whiles he bounds headlong from his couch, as a colt when it is loosed from the yoke.
>
> (Euripides, 408 BCE)

'Bounding from his couch', a movement so vigorous it is compared to 'a colt loosed from the yoke' is vastly different from the reclining figure depicted on the Apulian bell-krater. It is an image more reminiscent of the painting by Adolphe William Bouguereau, *Orestes Pursued by the Furies* (1862) (see Figure 10.2).

This 19th-century painting depicts an Orestes with energy, attempting to escape the merciless anger of the furies. Bourguereau, responding to critics of the painting, commented on energy, stating 'I soon found that the horrible, the frenzied, the heroic does not pay' (Harrison, 1991, p. 111). This depiction of Orestes shows frenzy and, in so doing, is an energetic depiction of Orestes' experience of melancholia.

Figure 10.2 Adolphe William Bouguereau, *Orestes Pursued by the Furies* (1862)
Source: Chrysler Museum of Art, Norfolk, Virginia, USA.

The melancholic madness of Orestes

Understanding the figure of Orestes represented in the Apulian red-figure bell-krater demands knowledge of his story, a point underscored by Toohey (2004) in *Melancholy, Love and Time: Boundaries of the Self in Ancient Literature*. In his analysis of Orestes' 'madness' (which I draw on closely in the remainder of this chapter), Toohey (2004) maintains, 'If we did not know that it was Orestes and had not noticed that he had a sword in his hand, then we would say that the male seated in the center of the representation . . . was bored' (p. 15).

That said, while this representation of Orestes could be assumed to be similar to that of Dürer's (1514) *Melancholia* (also appearing with lassitude), closer inspection shows a figure containing energy, which is, in Toohey's (2004) words, 'agitation':

> Orestes' face and much of his posture exhibit a patina of motor retardation. But there are clear signs of mental activity – of agitation. There is the sword in his right hand: that Orestes intends it for some form of violent use is apparent by the apprehensive index finger on his right hand. That the sword points in the general direction of the Furies suggests that it is intended for use against them, rather than as a symbol of his act of matricide (Podlecki, 1989; Shapiro, 1994; Sommerstein, 1989), as a symbol of suicidal thoughts . . . or simply as a means for slitting the piglet's throat. (p. 17)

While this analysis appears to examine melancholia and depression as 'constructs', Toohey does not consider either as purely constructed. He views depression as 'a persistent cultural entity that not unexpectedly, certain eras find difficult to accommodate conceptually' (2004: p. 39). While Toohey's book is critiqued for its methodological and historical content (Whitmarsh, 2005), it does provide a useful analysis of the figure of Orestes and the varying representations of his 'melancholia', variations that strike a chord with DMDD and depressive disorders.

Greek interpretation of melancholia drew on 'the humoral theory of black bile, (μέλαωα χολή) from which the word melancholy proceeds. μέλαωα χολή or melaina chole was translated into Latin as atra bilis and into English as black bile' (Lawlor, 2012, p. 27). Thus, from a medical standpoint that used humoural theory, 'the individual in whom black bile predominates comes increasingly to be seen as "melancholic" ' (Toohey, 2004, p. 28). Such is the medical means through which the madness of Orestes was understood.

Toohey (2004) offered an analysis that critiques the straightforward attribution of 'melancholia', noting the similar complexity of melancholia represented

in the Apulian red-figure bell-krater by the Eumenides Painter of the 4th century BCE and that depicted by Aeschylus in *The Eumenides* (458 BCE). This melancholia, however, is differently portrayed in Euripides' *Orestes* (408 BCE). Recalling the excerpt from Euripides' *Orestes* cited above, it is clear that Orestes moves between 'waste' and energy; a vacillation that might prompt some (including Toohey, 2004) to retrospectively propose a diagnosis of bipolar disorder. This, however, is a contested notion, not only because 'retrospective diagnosis' of historical figures is problematic, but 'manic depression, as construed by post-nineteenth-century definitions, bears no relation to the classical forms of mania, in which mania (insanity and delirium) might emerge from melancholia if the melancholia became particularly severe' (Lawlor, 2012, pp. 26–27). Here, again, we see not only a stark difference of opinion, but also an indication of the complexity of representation of the melancholic.

Significantly though, melancholia was much more than 'wastage', with agitation playing a key part in this malaise. The point is that when we meet Orestes, we begin to see not only the presence of agitation (as opposed to Melancholia's impotence and lack), but how this agitation is variously taken up and portrayed. For example, referring to his comparison of Orestes in Euripides' play with that of the figure depicted on the Apulian red-figure bell-krater, we see connections with agitation, but startling differences between exteriority and interiority:

> What links both figures is that they are prey to an extreme agitation and an awful fear (even terror) that plays havoc in their lives. But the agitation and fear of Euripides' Orestes and his violent melancholia is driven from without – from the gods and the Furies. The fearful agitation of the Eumenides Painter's Orestes is driven from within – the Furies cannot have caused this, because they share the same facial expression.
>
> (Toohey, 2004, p. 23)

Euripedes' 408 BCE play did not engage with a focus on the affect of impotency. By contrast, this was represented in the Apulian red-figure bell-krater.

Differing representations of Orestes, such as the Apulian vase where an affect without energy is shown, are suggestive of the ways discourses of madness not only shift and change, but even more elementally, reveal how context impacts representation of experience. Certainly, Toohey's (2004) analysis (to which I have referred extensively) picked up differences between classical Greek medical and popular usages, arguing that while medical usage connects to a wasted, impotent figure reclining on the Apulian red-figure bell-krater, '[n]on medical usage . . . associates the term with violence and anger' (p. 27) and thus takes up the 'Euripidean (violent and angry) Orestes' (p. 27). For Toohey (2004) then, the different portrayals reveal much about how melancholy was engaged, with

'Euripides *Orestes* provides a sobering illustration of the inability or unwillingness of the literary tradition to represent melancholia in truly complex manner' (p. 20). Here we see quite simply the workings of discourse in the production of knowledge about melancholia.

Interestingly, following Toohey's (2004) line of argument, it becomes clear from his analysis that more attention was paid to exteriority than on interiority. Before proceeding to Toohey's conclusion, it is worth pausing to consider the 'neuro-interiority' that is clearly marked out in the *DSM-5*. For instance, the new manual is structured to follow a 'neurodevelopmental life span approach' (Halter et al., 2013, p. 33). At the same time, DMDD, formerly labelled 'temper tantrum dysregulation', has been criticised as 'a symptom of other disorders' (Welch, Klassen, Borisova, & Clothier, 2013, p. 168). As we see an emphasis on 'neuro-interiority', we can also see how internalising and externalising disorders, what might be considered to be separate can be brought together under the diagnosis of DMDD. For instance, DMDD is reported to be 'highly comorbid with internalizing (depression and anxiety) and externalizing disorders (attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder)' (Axelson, 2013, p. 137)

Reflecting on his analysis, Toohey (2004) concluded that the differing representations of Orestes reveal difficulties with how melancholia was discursively engaged, arguing that while it was 'present' and 'periodically acknowledged, but its time had not come' (p. 42). As he outlined:

> This simple, though astounding, fact has been little understood. *The discursive tradition, then, with which depressive melancholy had to contend was one taken up with the outer, the surface, the mark, and the body as it was perceived in society*. The passivity of depressive melancholia – for this period a mere epiphenomenon of mania – had little to offer such tradition.
>
> (p. 42, emphasis added)

Following the argument set out by Toohey (2004), the story of Orestes presents a tantalising account of differences in the way melancholia is conceived, as well as the differences between popular and medicalised accounts. The former account is closer to Euripedian 'anger' and 'colt free from the yoke', while the latter depicts the more benign, yet subtly agitated figure on the Apulian bell-krater. The two variations radically demonstrate different ways through which melancholia can be conceived, with both signalling agitation, albeit in strikingly different forms. In this sense, we could propose that the DMDD of *DSM-5* is an eerie 'resurfacing' of a very old interpretation that fills melancholia with agitation, and as such is not so strange after all. There is, however, another angle to consider: the question of the politics of truth.

Conclusion: The politics of truth

Foucault engaged with the story of Orestes in two significant places in his work: in *The History of Madness* (2006) and in his 1983 lectures 'Discourse and Truth: The Problematization of Parrhesia' (published as *Fearless Speech*; Foucault, 2001). In the former, Foucault drew on Racine's *Andromache* (1667) in his analysis of the 'literary experience of madness in the Renaissance' (p. 580), and for the latter, he worked with Euripides' *Orestes* (408 BCE) in his analysis of Greek parrhesia (Foucault, 2001). Both engagements with the story of Orestes offer a means to contemplate what we might call the politics of melancholy, a politics that has occurred with the creation and insertion of DMDD into a chapter 'Depressive Disorders' in *DSM-5*.

As Foucault explained in *Fearless Speech* (2001), 'Euripides' *Orestes* – a play written, or at least performed, in 408 BC, just a few years before Euripides' death, and at a moment of political crisis in Athens when there were numerous debates about the democratic regime' (Foucault, 2001, p. 57). The critical importance of this political moment, to the play (and for Foucault, to his interpretation of parrhesia) is evident in Foucault's extensive description of this political moment:

> And now we can see the precise historical and political context for this scene. The year of the play's production is 408 B.C., a time when the competition between Athens and Sparta in the Peloponnesian war was still very sharp. The two cities have been fighting now for twenty-three long years, with short intermittent periods of truce. Athens in 408 B.C., following several bitter and ruinous defeats in 413, had recovered some of its naval power. But on land the situation was not good, and Athens was vulnerable to Spartan invasion. Nonetheless, Sparta made several offers of Peace to Athens so that the issue of continuing the war or making peace was vehemently discussed. In Athens the democratic party was in favor of war for economic reasons which are quite clear; for the party was generally supported by merchants, shop-keepers, businessmen, and those who were interested in the imperialistic expansion of Athens. The conservative aristocratic party was in favor of peace since they gained their support from the landowners and others who wanted a peaceful co-existence with Sparta, as well as an Athenian constitution which was closer, in some respects, to the Spartan constitution. The leader of the democratic party was Cleophon – who was not native to Athens, but a foreigner who registered as a citizen.
>
> (Foucault, 2001, p. 70)

Orestes is also depicted in Racine's *Andromache* (1667), which Foucault discussed as an exemplar of the shift from a renaissance madness which might

contain reason to one where madness is understood as unreason (Foucault, 2006):

> The gesture that banished madness into the dull, uniform world of exclusion is neither the sign of a pause in the evolution of medicine nor an indicator of a halt in the progress of humanitarian ideas. Its exact meaning comes from the simple fact that in the classical world madness was no longer the sign of another world, and became instead a paradoxical manifestation of non-being. In the final analysis, confinement was not overly concerned with suppressing madness or removing from the social order a figure which could not find its place there, and its essence could not really be described as the exorcism of any danger. It only manifested what madness is, in its essence: the unveiling of non-being. (p. 249)

Here Foucault's reference is to the classical world, roughly the 17th and 18th centuries and the period of the great confinement, where madness, as unreason, could be banished, or more exactly, excluded. Orestes, then, in Racine's *Andromache*, signals the fundamental shift in madness to non-being and, importantly for this analysis, the connections with politics.

As the above analysis reminds us, madness requires a politics and this very politics means that madness shifts and changes (see O'Dell & Brownlow, Chapter 16, this volume). A figure such as Orestes can be absolved by the casting vote of Athene (Aeschylus, 458 BCE), be cured by the divine Apollo (Euripides, 408 BCE), or can be expunged from society (Racine, 1667). In terms of the politics of our times, DMDD is, I venture to suggest, no different. This is a child mental disorder that has been created to meet the needs of a politics concerned with 'over diagnoses' and attendant issues of extremely high prescription rates. This is a disorder emerging from political concerns couched in politically aware ways, deploying terms such as 'false positives' (Leibenluft, 2011, cited in Gitlin and Miklowitz, 2014, p. 89). This can also be formulated in a manner evoking praise, such as 'the new diagnosis [DMDD] is viewed as an alternative to assigning a lifelong diagnosis of bipolar disorder, which often is accompanied by powerful drug treatment (Margulies, Weintraub, Basile, Grover, & Carlson, 2012)' (Halter et al., 2013, p. 34).

Reading Foucault's (2001) discussion, we can see how Euripides' *Orestes* picks up on the politics of the time: '[O]ne of the issues clearly present in Orestes' trial is the question that was then being debated by the democratic and conservative parties about whether Athens should continue the war with Sparta, or opt for peace' (Foucault, 2001, p. 71). The absolution of Orestes' murder of his mother connected with the political needs of the times. It did not, for instance, follow a course similar to that of Pierre Riviere's murder of his family, a case so closely analysed by Foucault (1978). Is it not the case that

the very discourse that produces DMDD is likewise none other than a politics of our time? This is to say that the decision to diagnose this state of mental disorder onto a child with tantrums rests upon the concerns of a select few (arguably not even the diagnosticians, but rather the writers of diagnostic texts).

It is surprising how little the debate on DMDD has been concerned with the placement in the 'Depressive Disorders' chapter in *DSM-5*. It would seem that the debate has come to rest on the diagnosis of 'tantrums' as disorders, and in so doing it has overlooked the conceptual shifts that occur when depression becomes disruptive. Perhaps adherence to the notion that child DMDD flows into an adult unipolar depression absolves DMDD from, as it were, 'disrupting' our understanding of depressive illness. While this may be a convincing argument for some, it does present considerable problems for conceiving the experience of children as distinct from adults. Will it be the case that tantrums come to mean the harbouring of depression?

In his discussion of melancholy and the 'melancholic experience' in the *History of Madness*, Foucault (2006) emphasised:

> The key point is that this process did not go from observation to the construction of explanatory images, but that on the contrary images fulfilled the initial role of synthesis, and their organizing force made possible a structure of perception where symptoms could finally take on their significant value, and be organized into the visible presence of the truth.
>
> (Foucault, 2006, p. 277)

This emphasis on the 'structure of perception' supports a line of reasoning that takes as its object how depression (or melancholy) is perceived. Thus images of objects of impotence (or their tantrums) enable an 'organizing force' that, to paraphrase Foucault (2006), structures our perceptions and consequently gives value and weight to the symptoms that tell the truth of depression. So images of impotence or of tantrums all add weight to how we conceive of, as well as perceive, disorders such as depression. This may partly help to answer why having disruption and tantrums in a chapter on depression hasn't been the key issue of debate with DMDD. Quite simply, we may just be adjusting our view to take in Orestes as well as Melancholia.

The philosopher Ian Hacking (2002) pointed out how ontology and 'new names' are interrelated: 'With new names, new objects come into being. Not quickly. Only with usage, only with layer after layer of usage' (p. 8). In the case of depression, while it is not a matter of 'new names', we should not be fooled. Rather, we need to consider the effects of a discourse that shifts and changes with layers of usage such that a new object (albeit with the same name, depression) comes into being.

Table 10.1 Educational practice highlights

1.	DMDD is a problematic inclusion in the manual of psychiatric disorders.
2.	The inclusion of DMDD as a form of depression has not yet been substantively critiqued.
3.	The inclusion of 'tantrums' is contested.
4.	There is a risk of stigmatisation for children in the school environment.

Summary

This chapter outlines the importance of critically reflecting on the diagnostic criteria for DMDD now included in *DSM-5*. In so doing, it mounts the argument that DMDD is a new and problematic inclusion to the 'Depressive Disorders' in an extremely influential manual of psychiatric disorders. Significantly, the inclusion of this new 'disruptive' and 'energetic' disorder as a form of 'depression' has yet to meet with substantive critique. DMDD criteria include 'tantrums', a point that has been hotly debated. For instance, as Wakefield (2013) pointed out, 'Children tend to outgrow these temper tantrum problems, so treatment and stigma may be applied unnecessarily to large numbers of children' (2013, p. 150). It is unknown how this new child disorder will impact, positively or negatively or even if it will afford the clarity that it is hoped to deliver. As Gitlin and Miklowitz (2014) concluded, 'whether this new category will advance diagnostic clarity and/or more appropriate treatment is unknown' (2014, p. 89). The chapter demonstrates how historically informed analysis can be drawn upon to reflect on how interpretations and representations of melancholia and depression are very much connected to the political, the discursive, and, in the 21st century, to the authors of one manual of mental disorders. For a simple summary of the implications for practice, see Table 10.1.

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