THE NOSOLOGICAL STATUS OF DEPRESSION

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1 – Early aetiological conceptions :

Although the nineteenth century has seen a scientific revolution, the state of knowledge in psychiatric circles remained at the pre-scientific stage for a long period of time. It was not until Kraepelin, the founder of modern psychiatry, published his lehrbuch der psychiatrie in 1896 that a renewed interest was shown to the study of the aetiology and nosology of psychiatric disorders in general, and depressive ones in particular.

Kreapelin subdivided mental illnesses into three major categories : dementia praecox, manic-depressive psychosis, and paraphrenia. By introducing this classification, kraepelin had established a nosological system that gave psychiatry its much needed scientific basis and respect in the medical community.

In his subsequent publications, Kraepelin elaborated his views on both the nosology and the genesis of depressive disorders :

"Manic depressive insanity... includes on the one hand the whole domain of so-called periodic and circular insanity, on the other hand simple mania, the greater part of the morbid states termed melancholia and also a not inconsiderable case of amentia... all the above-mentioned states only represent manifestations of a single morbid process." (1902).

Kraepelin believed that manic-depressive psychosis and indeed all mental illnesses are due to organic causes, although he later conceded that external factors (exogenous) may exert a substantial influence on the prognosis as well as the genesis of certain disorders. In addition to maintaining an organogenesis conception of depressive illness, Kraepelin developed and adopted a classification model whose rigidity and lack of clarity impeded the understanding of the mechanisms underlying most diagnostic entities.

Although kraepelin's approach won a widespread popularity for its clinical objectivity and nosological innovations, it was also criticised for its lack of flexibility. Theoreticians and clinicians dissatisfied with Kraepelin's system questioned both the underlying theoretical conception and the clinical considerations on which it rests. For kraepelin did not only maintain his organogenesis conception of mental

illness in spite of contrary evidence, he also relied exclusively on the prognosis to define his 'disease entity'.

While European investigators such as Lange (1928) restricted themselves to making cosmetic changes in Kraepelin's original model, a new school of thought (in America) headed by Adolf Meyer offered a radical view of mental illness in general and of depressive illness in particular. Meyer contested Kraepelin's concept of 'desease entity' and proposed that psychiatric disorders should be viewed as 'reaction types' displayed by an individual to adapt to environmental changes and constraints. Meyer's theory of 'psychobiology', in contrast to the cartesian dualism of mind and body adopted by traditional psychiatry, strongly emphasised the unity of both the psychological and biological structures :

"The apparent disorder of individual organs is merely an incident in a development which we could not understand correctly except by comparing it with the normal and efficient reaction of the individual as a whole, and for that we must use terms of psychology not of mysterious events, but actions and reactions of which we know they do things, a truly dynamic psychology. There we find the irrepressible instincts and habits at work, and finally the characteristic mental reaction type constituting the obviously pathological aberrations... by dropping some unnecessary shells and traditions, we can see a psychopathology develop without absurd contrast between mental and psysical..." (Meyer, 1908).

Meyer's concept of psychobiological unit was enthusiastically embraced and used to approach both the aetiology and nosology of depressive disorders. Those who espoused Meyer's views stressed the importance of personal and social factors in the genesis of depression, thus depression ceased to be a correlate of brain pathology. The Meyerians also rejected the endogenous-reactive (exogenous) dichotomy advocated by Kraepelin and his followers, instead they proposed that depression should be viewed as a single illness differing not in nature but in severity and chronicity. The Meyerian framework was undoubtedly reflecting the growing influence that psychoanalysis was beginning to have on psychiatric thought since its formulation by Freud.

2 – The nosological debate.

Kraepelin's and Meyer's divergent views regarding both the nature and classification of depressive disorders gave rise to a long but fruitless debate centred exclusively around the nosological issue, relatively neglecting important questions about the aetiology and treatment of depression. According to kendell (1976), the reason for this state of affairs is that :

"They (depressions) provide a convenient arena for several disputes about the nature and classification of mental illness as a whole : whether mental illnesses are diseases or reaction types, whether they are independent entities or arbitrary concepts ; whether they should be classified on the basis of their sympomatology, their aetiology or their pathogenesis; and whether they should be portrayed by a typology or by dimensions." (p.15).

Whatever the reason fot this controversial debate, there is no doubt that the nosological status of depression was at the heart of the dispute. While some have

argued for the existence of distinct categories of depressive illenesses (e.g., Gillespie, 1929), others, however, maintained that all depressive illness was the same, and the differences observed in symptomatology were merely quantitative (e.g., Lewis, 1934). Although some areas of agreement have since emerged (cf. Kendell, 1975, 1976), nevertheless the literature on classification of depressive disorders is still confusing. Table 1 illustrates this point.

Table 1 : Proposed classifications of depression (adapted from kendell, 1976).

	A. Simple typologies
One category	Lewis (1934)
	Depressive illness
Two categories	Roth (1965)
	Endogenous depression
	Neurotic depression
	Van Praag (1965)
	Vital depression
	Personal depression
Three categories	Overall (1966)
	Anxious-tense depression
	Hostile depression
	Retarded depression
Four categories	Paykell (1971)
	Psychotic depression
	Anxious depression
	Hostile depression
	Young depressives with personality disorder
	B. Dimensional systems
One dimension	Kendell (1968)
	Psychotic-neurotic
Two dimensions	Eysenck (1970)
	Psychoticism and Neuroticism

In this second part of the present paper, a brief review of the arguments that animated the debate on the nosological status of depression is made, and attempts at evaluating some newly proposed classifications are also made. And finally, the question of whether depressive disorders should be portrayed by a typology or dimensions is asked and a tentative answer is proposed.

2.1 – The unitary conception

The unitary conception of depressive disorders was proposed by Meyer following his sharp criticism of Kraepelin's nosological and aetiological formulations. But it was Lewis (1934) who actively defended and finally established this nosological scheme in modern clinical psychiatry. Clinicians and researchers who subscribe to the unitary view of depressive disorders, argue for their homogeniety, although

they recognize that substantial differences may exist in phenomenology, severity, and chronicity of some depressive states. The monists, as they are now known, regard depression as a single illness that occurs in various degrees of severity and chronicity. They argue that the endogenous (psychotic) reactive (neurotic) dichotomy advocated by Kraepelin and later reiterated by Gillespie (1929) and many others, is neither supported by aetiological studies nor justified by treatment purposes.

While the separatists, those who favour the dichotomy, were actively searching for evidence to substantiate their claim, the monists limited themselves to refuting such evidence. Repeated clinical observations and follow-up studies were soon to reveal that psychotic and neurotic depressive patients exhibit differences not only in clinical symptomatology but also in premorbid personality.

Lewis (1938) was unconvinced by the arguments presented in favour of the discontinuity. He pointed out that the diagnostic categories of psychotic and neurotic depressions :

"....are nothing more than attempts to distinguish between acute and chronic, mild and severe; and where two categories only are presented, the one manic-depressive – gives the characteristics of acute, severe depression, the other of chronic mild depression".

Lewis's unitary approach to the classification of depressive disorders remained unpopular in psychiatric quarters for many years. His views on the nosology and nature of deprissive illnesses were not shared by his continental colleagues, although they were eventually espoused and promoted by Henri Ey (1954), a leading French psychiatrist.

2.2 – The endogenous – reactive distinction.

Two fundamentally different views of the nature of depression exerted a great influence on discussions about the relationship between endogenous and reactive depressions that started some fifty years ago between the Kraepelinians and the Meyerians. Those loyal to the Kraepelinian tradition adopted a dualistic approach and therefore argued strongly in favour of the distinction between endogenous (psychotic) and reactive (neurotic) forms of depression. In an important paper intitled "The Clinical Differentiation of Types of Depression" Gillespie (1929) reiterated and elaborated on Kraepelin's dichotomy. After a careful study of a group of clinically depressed patients, Gillespie concluded that reactive and autonomous or endogenous depressions are two distinct types of depressive illness. Gillespie's decision to view endogenous and reactive forms as two distinct disease entities was based on symptomatic data. The results of his study showed that patient diagnosed as reactive depressives were characterised by mood fluctuations and reactivity to environmental changes. Those diagnosed as endogenous depressives, however, displayed a different type of symptomatology whose major characteristic is non-responsiveness to external or environmental influences.

Although Gillespie's notion, that endogenous and reactive depressions can be separated on the basis of reactivity to the environment, may be (theoretically) sound, when applied it failed to descriminate adequately betwen the two clinical

conditions. Despite lack of evidence supporting this symptomatic approach, clinicians and researchers continued to use Gillespies's "reactivity" as their major diagnostic criterion.

Until some twenty years ago the decision to classify depressive illnesses into endogenous or reactive was based either on clinicial symptomatology or on treatment response. However, the refinement of psychometric techniques and the application of sophisticated statistical methods in recent years has offered a sound scientific basis for such nosological classification. Indeed, researchers on both sides of the Atlantic have enthusiastically applied multivariate analystic techniques to all sorts of data (including epidemiological data) to test the classification model inherited from kraepelin and Gillespie. Although some of their attempts may have been hindered by obvious methodological constraints, their results have not been inconclusive.

In what is now known as the Newcastle school, Roth and his colleagues devoted most of their time to investigating the endogenous reactive or neurotic issue. In their major study, Carney, Roth, and Garside (1965) subjected a set of data, obtained from a sample of 129 clinically depressed patients diagnosed as endogenous or neurotic, to multiple regression analysis and found evidence supporting the endogenous-neurotic dichotomy. The results of their study clearly showed that the distribution of sympton scores was bimodal, although subsequent attempts to replicate their results have apparently failed, (kendell, 1968; Post, 1972).

A series of factor analytic studies (Killoh and Garside, 1963; Rosenthal and Klerman, 1966; Hamilton and White, 1958; Rosenthal and Gudeman, 1967; Mendels and Cochrane, 1970; Carney, Roth, and Garside, 1965; Hordern, 1965) reviewed by Mendels and Cochrane (1970) have also reported evidence supporting the distinction between the endogenous and neurotic types of depression. Their review showed that the following symptoms or items loaded positively on the endogenous factor: (a) depth of depression, (b) retardation, (c) loss of interest in life, (d) non-responsiveness to environmental changes, (e) visceral symptoms, (f) absence of precipitating stress, (g) weight loss, and (h) insomnia. It is evident that the clinical picture suggested by the symptoms listed above is that of endogenous depression.

In sum, most factor analytic studies found evidence for the existence of a boundary between "endogenous" and "neurotic" depressions. The studies also appeared to have clearly described and positively identified a specific endogenous state. However, as Costello (1970) and Kendell (1976) noted, relatively a few studies produced factors corresponding to the ill-defined "neurotic" type of depression. In short, agreement has been reached on the endogenous-neurotic distinction and the existence of an endogenous type of depression. But the definition and classification of "neurotic" depression is open to debate.

2.3 – The unipolar-bipolar classification

The unipolar-bipolar classification was originally proposed by Leonhard (1959) to reduce the ambiguities and semantic confusion generated by Kraepelin's concept of manic-depressive psychosis. The diagnosis label of bipolar depression is essentially given to patients who have experienced both manic and depressive episodes

(alternating mania and depression), and that of unipolar is given to patients who have had successive episodes of either mania or depression (recurrent mania or recurrent depression). Unlike the previous classifications, which are based either on aetiological considerations (endogenous/psychogenic) or on clinical symptomatology (e.g., reactivity to environmental changes and constraints), the unipolar-bipolar classification is made on the basis of anamnetic data. In one of the studies supporting the unipolar-bipolar distinction, Perris (1976) found significant personality and epidimeological differences. The results of this study showed that bipolar depressive patients tend to display a "syntonic personality pattern", an extrovert type of personality; in contrast, the unipolars were found to be characterised by an "asthenic personality pattern", an introvert and anxious type of personality. Perris also found that bipolar depression starts ten years earlier than the unipolar one.

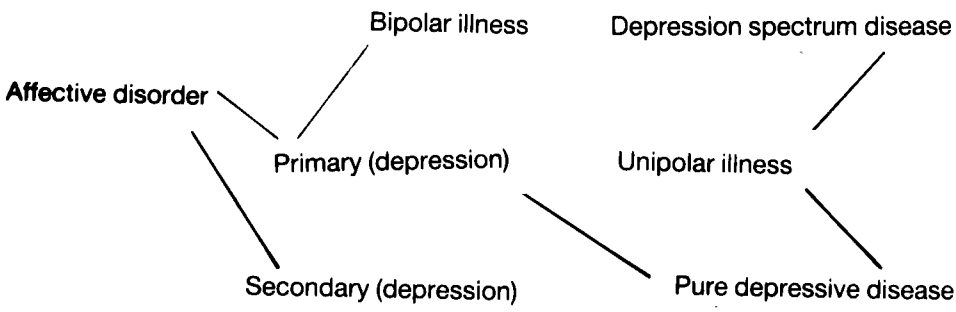
Another important finding reported by Angst (1966), in support of the unipolar-bipolar classification, concerns the incidence and frequency of affective disorders amongst relatives of unipolar and bipolar depressive patients. The results of his study revealed that the risk of developing unipolar depression is higher amongst close relatives of bipolar patients than those of unipolar depressive patients. More recent studies, however, failed to replicate this finding (Reich, Clayton, and Vinokur, 1969; Helzer and Vinokur, 1974). Instead, the studies showed that relatives of bipolar patients are more likely to develop unipolar illness than bipolar illness.

Although significant differences were found in premorbid personality and familial history, more evidence regarding both clinical symptomatology and pharmacological response should be provided if the unipolar and bipolar depressions are to be regarded as separate clinical entities and Leonhard's classification be useful and acceptable.

2.4 – The primary-secondary classification

The primary-secondary classification may be said to be a refinement of that of Leonhard. Unlike the previous one, it makes a useful distinction between those depressive illnesses preceded by psychiatric disorders and personality disturbances (secondary depression) and those depressions wich are not preceded by any known psychatric or personality disorder (primary depressions). Table 2 illustrates this classification.

Table 2 The primary-secondary classification (adapted from Kendell, 1976).



As can be seen in table 2, the primary-secondary nosological model disregards All those depressions contamined by or associated with physical illnesses and major personality disorders. Having separated primary and secondary affective disorders, Robins and his colleagues (1972) then subdivided the former ones into bipolar (consisting of both depression and mania) and unipolar depressions (consisting of depressive illnesses only). By further considering the unipolar type, the authors made a very useful distinction between what they called "depression spectrum disease" and "pure depressive disease".

The distinction between these two sub-types is supported by anamnetic studies. Winokur (1974) found that patients of the "depression spectrum disease" category experience their first depressive episode before the age of 40, those of "pure depressive desease" category develop a depressive illness before the age of forty.

An important feature of this classification model is its clarity and flexibility. More importantly, the model allows precise operational definitions and as such it provides a useful nosological framework for both clinicians and researchers of depression.

2.5 – The dimensional classification

In his initial study on "The classification of depressive illnesses" Kendell (1968) employed a series of multivariate analytic techniques in an attempt to differentiate between the psychotic and neurotic forms of depression. The data obtained from 1,080 patients diagnosed as psychotic, involutional, or neurotic depressives, was subjected first to discriminant function analysis then to factor analysis. The results showed that, although there was a tendency for psychotic depressives to obtain hign scores and neurotic depressives to obtain low scores, the distribution of symptom scores was unimodal. Accordingly Kendell concluded :

"Discriminant function analysis provides no suport either for the hypothesis that neurotic and psychotic depressions are qualitatively distinct or for the hypothesis that involutional melancholia is an independent entity" (p.31).

Following his first unsuccessful attempt to demonstrate bimodality between psychotic and neurotic depressions, Kendell subjected his clinical ratings to factor analysis. Once again he failed to produce any evidence for the psychotic-neurotic dichotomy. In his final attempt to solve the issue, kendell employed, in the same study, Eysenck's criterion analysis method to a set of his data. Here again the analysis showed no clear cut boundaries between the two types of depression.

In spite of repeated failures to separate the psychotic and neurotic depressions, kendell maintained that "a valid boundary" between the two types can be demonstrated if only the diagnostic techniques were refined and their reliability enhanced. However, when a subsequent study by kendell and Gourlay (1970) yielded similar results to the previous one, kendell (1976) abandoned his arguments for a dichotomy and adopted a continuum view of depressive illness. Kendell's model offers a sort of compromise (Fowles & Gersh, 1980) in that it relatively satisfies both the separatists and non-separatists :

" *Regarding depressive illness as a psychotic/neurotic continuum is a convenient way of acknowledging the apparent lack of any valid boundary between type A*

(psychotic) and type B (neurotic) illness, yet at the same time acknowledges that the differences – in symptomatology, premorbid personality, treatment response and lifetime course – between the two extremes are too extensive to be regarded as differences in severity and chronicity". (p.19, 1976).

But as kendell later conceded, a two dimensional with one dimension expressing psychoticism and the other representing neuroticism (Eysenck, 1970), may even "do more justice" to the diversity and complexity of depressive symptomatology than one-dimensional model.

3 – Concluding remarks

Research on the nature and classification of depressive disorders has been the battle-ground for Kraepelinians and Meyerians since the early days of modern psychiatry. This selective review of the relevant literature showed that the disputes between researchers and clinicians of rival schools were more about how depressive disorders should be classified than on how they should be approached or treated. While some based their classification on aetiological considerations, others used clinical symptomatology as their main nosological criterion. These differences in both theoretical orientation and empirical consideration promoted a long debate wihich confused and at times obscured the nosological status of depression. But despite the early confusion, agreement has been reached that depressive disorders should be classified on the basis of symptoms and history. Agreement has also emerged on the existence of an endogenous type of depression.

With regard to the issue of whether depressive disorders should be portrayed by a typology or dimensions, there seems to be an emerging consensus that the former classification system should be adopted despite its obvious limitations (cf. Kendell, 1976). Part of the reason is that the typological system fits better with most systems adopted in other allied medical and scientific disciplines than the dimensional one. In addition to its familarity, the typological or categoriacal classification is easy to understand and use. And as such it facilitates communication between researchers and clinicians of different theoretical persuasions.

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