THE MISLABELING OF DEPRESSED PATIENTS IN NEW YORK STATE HOSPITALS*


American psychiatrists tend to diagnose depressive disorders far less readily than do their English colleagues. This contrast is true when psychiatrists making routine diagnoses in New York are compared with those making routine diagnoses in London public mental hospitals (Cooper et al., 1969; Gurland et al., 1969); and even holds true when American and English psychiatrists view the same videotaped interview with a patient (Kendell et al., 1969).

This contrast in the diagnostic predilection of English and American psychiatrists is found for nearly all kinds of patients even when they are grouped according to their psychopathology (Gurland et al., 1970). Indeed, there are several kinds of patients a majority of whom are diagnosed as a depressive disorder by English psychiatrists but as schizophrenic by American psychiatrists. One such kind of patient is characterized by a predominance of depressive symptoms.

On the face of it, a group of patients who show mainly depression might be expected to receive a label of depressive disorder rather than one of schizophrenia. Thus, this paper will present further data on patients with

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*The work reported here was supported by NIMH Public Health Service Grant MH 09191, Project for the Cross-National Study of the Diagnosis of the Mental Disorders in the United States and United Kingdom, Joseph Zubin, principal investigator. We gratefully acknowledge the help of Miss Pamela Roberts, A.A., Mrs. Jane Gourlay, M.A., Mrs. Judith Kuriyansky, Ed.M., and Jeffrey Klein, B.A., in data collection. We appreciate also the cooperation of the Directors and staff of those state hospitals in New York and area mental hospitals in London at which patients were examined by this project and the assistance of the statistical office of the New York State Department of Mental Hygiene.

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predominant depression in order to examine the appropriateness, usefulness, and consequences of the American style of diagnosis in this group of patients.

Sample Selection and Methods of Study

The data we will present here have been provided mostly by the project called "The Cross-National Study of the Diagnosis of the Mental Disorders," which is under the directorship of Dr. Joseph Zubin. Detailed descriptions of the study methods, sample selection, and main findings have been reported elsewhere (Cooper et al., 1969; Gurian et al., 1969; Gurian et al., 1970). Here we will give only a brief description as relevant to the current topic.

The project studied consecutive admissions to state mental hospitals in New York and area mental hospitals in London. The samples of New York and London patients came from three series. The first series, in the age group 35–59, consisted of 145 patients from a single hospital in New York and 145 from a single hospital in London. The second series, in the age group 20–34, consisted of 105 patients from each of the same hospitals. The third series, covering the age range 20–59, consisted of 192 patients drawn, in proportion to their rates of admission, from nine state hospitals in New York, and of 174 patients similarly drawn from nine public mental hospitals in London. Aside from age, the sole criterion for inclusion in the study was that the patient be a current admission to the hospital (not a transfer or a return from leave).

Each patient was administered a mental state interview by a project psychiatrist within 48 hours of admission. The interview was structured and consisted of approximately 700 items covering a wide range of psychiatric symptoms and behaviors. Probes were provided and ratings defined, but some room was left for clinical judgment in rephrasing probes and assessing responses. The universe of items was provided partly by British (Wing et al., 1967) and partly by American (Spitzer et al., 1964) sources. A structured history interview was also administered. A project diagnosis according to the 8th Edition of the ICD was made. The official hospital diagnoses on all patients were collected after they had been passed through the usual administrative channels. There was no interchange of information between the project and hospital staff at any stage during the course of the study.

In order to characterize the psychopathology of patients, we made use of scores on a number of dimensions of pathology. The items rated as positive in each of various sections of the standard mental state interview were added up so as to give each patient a series of scores for dimensions such as depression, hypomania, and paranoid delusions. Of special importance here is the score on depressive mood. Items contributing to this factor reflect a series of symptoms including the patient's reports of sadness, frequent crying, loss of appetite, and feelings of hopelessness.
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The Isolation of a Group of Morbid Depressives

We isolated a group of patients within our series whom we have called "morbid depressives" and who were defined in the following terms. At the time of admission to the hospital, or for the month prior to admission, they reported a sufficient number of symptoms of depression to yield a score above the mean for the combined New York and London samples on this scale, but showed no symptoms which could contradict the diagnosis of an affective disorder according to DSM-II or standard textbooks (Noyes and Kolb, 1963; Arieti, 1966) in the United States.

Patients were therefore only placed in the group of morbid depressives if they showed scores above the mean on the scale of depressive mood and no other symptoms except possibly anxiety, retardation, loss of interest, hypomania, depersonalization, and loss of insight. We excluded patients who were given a project diagnosis of alcoholism, drug addiction, or organic disorder, or who had symptoms which are mentioned in textbooks or in DSM-II as suggesting schizophrenia, such as delusions of control, blunting of affect, incomprehensibility, hallucinations, paranoid delusions, or delusions of grandeur. Despite the extreme strictness of the criteria for selecting the morbid depressives, they proved to constitute between 10 and 20 percent of the consecutive admissions we examined in New York state hospitals.

For purposes of comparison, we isolated a second group of patients who were not depressed and who had symptoms highly suggestive of schizophrenia. Patients included in this group were those who had scores below the mean on the scales of depression and hypomania, but high ratings on the scales measuring blunting of affect, incomprehensibility, or delusions of control. Patients diagnosed by the project as alcoholic, drug-addicted, or organically disordered were also excluded from this group. For convenience, we refer to this group with symptoms suggestive of schizophrenia as "nondepressed psychotics." They constituted about the same proportion of admissions as did the morbid depressives. Table 1 contrasts the criteria for the isolation of the two groups of patients described above.

Results

We compared the morbid depressives and the nondepressed psychotics on variables other than psychopathology in order to highlight additional features which might further indicate whether the former group would be best assigned to the depressive disorders. The examination of one feature, namely a favorable outcome, seemed particularly relevant to this issue.

We measured outcome by the one-year outcome index of Burdock and Hardesty (1961), a function of the number of days that the patient spent out
### Table 1
Criteria for two kinds of patients

<table>
<thead>
<tr>
<th></th>
<th>Morbid depressives</th>
<th>Nondepressed psychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed Mood</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Hypomania</td>
<td>±</td>
<td>-</td>
</tr>
<tr>
<td>Project diagnosis of alcoholism, drug addiction, or organic disorder</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Anxiety, retardation, loss of interest, depersonalization, loss of insight</td>
<td>±</td>
<td>±</td>
</tr>
<tr>
<td>Hallucinations, paranoid delusions, delusions of grandeur</td>
<td>-</td>
<td>±</td>
</tr>
</tbody>
</table>
| Delusions of control, blunting of affect, incomprehensibility | - | *±*

* = scores must be above the mean
− = scores must be below the mean
± = scores can be either above or below the mean

*At least one of the three scores must be above the mean.

of hospital during the year after his admission, and of the number of releases and readmissions during the course of that year. For convenience, we considered only what we arbitrarily defined as good or poor outcome. The frequency distribution of scores on the outcome index showed a dip at an index of 0.75, and we therefore took this figure as the boundary between good and bad outcome. A patient with good outcome was one with an outcome index exceeding 0.75, that is, one who was discharged within three months after admission and was not readmitted during the course of one year. The necessary data were obtained from the statistical office of the New York State Department of Mental Hygiene at Albany, and also by a direct search of the patients’ case notes. Table 2 shows that the majority of the morbid depressives had a good early outcome in contrast to the nondepressed psychotics, where the majority had a poor early outcome.***

***Each separate chi square value incorporates Yates’ correction for continuity. The pooled chi square value, also with one degree of freedom, is determined using Cochran’s procedure (1954).
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Table 2
Psychopathology by Early Outcome in Three Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Morbid Depressives</th>
<th>Non-depressed Psychotics</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Good</td>
<td>N</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
<td>75.0%</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>66.7%</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>66.7%</td>
<td>15</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 15.52****

*= p < .05   ** = p < .01   *** = p < .001

The morbid depressives were thus distinguished by the predominance of depression in their clinical picture, the absence of clinical signs conflicting with the diagnosis of a depressive disorder, and a favorable early outcome in a majority of cases. We might therefore have expected that at least a majority of the morbid depressive group would be given a diagnosis of depressive disorder by the hospital clinicians if we included under this rubric a wide range of depressive disorders, namely manic-depressive psychosis, depressed type; reactive-depressive psychosis; involitional melancholia; and depressive neurosis. As is shown in Table 3 this was, in fact, the case for the morbid depressives in the London hospitals. However, the striking paradox is that in the majority of cases the morbid depressives were called schizophrenic by the New York hospitals, although there was no tendency for the morbid depressives to be put in any one specific subcategory of schizophrenia by the New York hospital psychiatrists.

Table 3
Hospital Diagnoses Given to Morbid Depressives in New York and London

<table>
<thead>
<tr>
<th>Hospital Diagnosis</th>
<th>Series 1</th>
<th>Series 2</th>
<th>Series 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>37.5%</td>
<td>73.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>50.0%</td>
<td>15.4%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Other</td>
<td>12.5%</td>
<td>11.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>N</td>
<td>24</td>
<td>52</td>
<td>12</td>
</tr>
<tr>
<td>Chi Square</td>
<td>10.85**</td>
<td>15.00***</td>
<td></td>
</tr>
</tbody>
</table>

*= p < .01   ** = p < .01   *** = p < .001
In accounting for this paradox, we first considered whether the New York hospital psychiatrists were overlooking the depressive symptoms displayed by these patients. This did not appear to be the case. There is ample evidence that the New York psychiatrists behaved toward the majority of morbid depressives as if they were depressed, and toward the majority of nondepressed psychotics as if they were not depressed.

In the first place, as shown by Table 4, the hospital staff gave a diagnosis of a depressive disorder significantly more often to the morbibly depressed patients than to the nondepressed psychotics. In two out of the three series, the morbid depressives were diagnosed as depression more frequently than were the nondepressed psychotics. In series 2, none of the patients in these two contrasted groups was diagnosed as depression.

Table 4
Psychopathology By Hospital Diagnosis of Depression in Three Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Morbid Depressives</th>
<th>Non-depressed Psychotics</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Depression</td>
<td>N</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
<td>37.5%</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>12</td>
<td>0%</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>19.0%</td>
<td>15</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 7.63**

* = p < .05  ** = p < .01

Furthermore, as shown by Table 5, the hospital psychiatrists prescribed antidepressive therapy (either in the form of drugs or EST) within a month of the patient’s admission significantly more often to the patients with morbid depression than to the nondepressed psychotics regardless of the label they placed on them.

Even in series 2, where none of these patients was diagnosed as a depressive disorder by the hospital psychiatrists, slightly more of the morbid depressives were treated early for depression than were the nondepressed psychotics. (The total frequencies in this table, and in others in which treatment is considered, are not equal to the numbers given in other tables because there were some patients for whom treatment data were unavailable.) Even those patients in the morbid depressive category who were not diagnosed as having a depressive disorder by the hospital staff were nonetheless more likely to
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Table 5
Psychopathology By Early Treatment
of Depression in Three Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Morbid Depressives</th>
<th>Non-depressed Psychotics</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Treated Early</td>
<td>N</td>
</tr>
<tr>
<td>1</td>
<td>24</td>
<td>33.3% 3</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>36.4%</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>21</td>
<td>57.1%</td>
<td>15</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 14.95***

* = p < .05  ** = p < .01  *** = p < .001

receive early antidepressive therapy than the nondepressed psychotics (see Table 6).

The group of patients in New York State hospitals called morbid depressives thus have depression as their cardinal symptom, have no symptoms that militate against a diagnosis of depressive disorder, and tend, more often than a group of patients called nondepressed psychotics, to be given antidepressive therapy, to be called a depressive disorder by the hospital psychiatrists, and to have a favorable early outcome. Nonetheless, a labeling paradox is found in that the majority of the morbid depressives are given a diagnosis of schizophrenia by the hospital doctors.

Table 6
Psychopathology By Early Treatment of Depression
For Patients Not Diagnosed Depressed By the Hospitals
in Three Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Morbid Depressives</th>
<th>Non-depressed Psychotics</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Treated</td>
<td>N</td>
</tr>
<tr>
<td>1</td>
<td>15</td>
<td>20.0%</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>36.4%</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>47.1%</td>
<td>15</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 8.01**

** = p < .01
The Recent History of the Diagnosis of Depression in the U.S.

A reasonable explanation of the paradox noted above might be that there is a strong bias on the part of American psychiatrists against diagnosing depressive disorders and in favor of diagnosing schizophrenia, and that this bias can be understood in terms of the training and recent traditions of American psychiatry. Eugen Bleuler (1951) taught that in most cases the diagnosis of manic-depressive psychosis can only be made after excluding schizophrenia and since this is a widely held view, the diminishing popularity of the diagnosis of the depressive disorders can perhaps best be understood by considering the expanding concept of schizophrenia.

The domain of schizophrenia mapped out by Kraepelin was enlarged by Eugen Bleuler’s psychological definition and the later work of the psychodynamic school. Borderline states were added by Langfeldt, Kasanin and others, and were given names reminiscent of schizophrenia, such as the schizophreniaform or acute schizo-affective psychoses. Adolf Meyer emphasized that the schizophrenic reaction could have a good outcome and that therapeutic nihilism was not justified.

Early, subtle, unclear, and disguised states of schizophrenia attracted attention and culminated in the delineation of the pseudoneurotic schizophrenic by Hoch and Polatin (1949). A ten year follow-up of pseudoneurotic schizophrenics revealed that only 10 percent had developed chronic schizophrenia in the long run (Hoch et al., 1962). The concept of schizophrenia in the United States had become very different from that in Europe. Outright abuses of the concept of schizophrenia have also occurred, sometimes making it synonymous with craziness, or failure to respond to psychotherapy. Malzberg (1959) followed the trends in the diagnosis of first admissions to New York state hospitals and showed a steady decrease in the diagnosis of manic-depressive disorders from 1932 to 1950, with a corresponding increase in the diagnosis of schizophrenia over the same years.

Some Consequences of this Trend

The bias introduced for traditional reasons has led to such an overemphasis on schizophrenia that the major psychopathological distinctions between affective disorder and schizophrenia have broken down in American diagnoses. We have reported elsewhere (Gurland et al., 1970) that the association between the patient’s psychopathology and the hospital diagnosis he received was far weaker in New York than in London. A circular process has been initiated in which the standards of diagnosis in the United States have become less rational and thus less useful, leading to a disregard of diagnosis.

As evidence of this disregard for diagnosis we show in Table 7 that in the group of morbid depressives the relationship between the hospital’s diagnosis
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Table 7
Hospital Diagnosis By Early Treatment of Depression for Morbid Depressives in Two Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Depression</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Treated</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>55.6%</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 3.61

and the administration of antidepressive or EST therapy was weak and not statistically significant. (In this and the next table, the second series is omitted because not a single morbid depressive from that series received a hospital diagnosis of a depressive disorder.)

Even though the hospital psychiatrists paid little attention to their diagnoses in prescribing treatment, we might wonder whether they were influenced in their management of the patient by whatever prognostic implications they attached to their diagnoses. However, Table 8 shows that there was no relationship at all between diagnosis and early outcome within the group of morbid depressives; that is, within this relatively favorable outcome group, the outcome was the same whatever the patient was called.

The New York hospital psychiatrists appear to have turned to a consideration of symptomatology rather than to diagnosis as a guide to their treatment. It is more the patient's psychopathology than his diagnosis which leads to the different treatment given by New York hospital psychiatrists to the morbid depressive group, as opposed to the nondepressed psychotics. Thus, at

Table 8
Hospital Diagnosis By Early Outcome for Morbid Depressives in Two Series of New York Patients

<table>
<thead>
<tr>
<th>Series</th>
<th>Depression</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>% Good</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>77.8%</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

Pooled Chi Square = 0.09
least for the morbid depressives in New York state hospitals, the diagnosis given to a patient by the hospital psychiatrist is of little consequence to that patient.

However, a tempting speculation presents itself, of great relevance to the welfare of patients. Suppose we assume that as a consequence of bias in diagnosis the depressive disorders have been greatly underestimated in the American hospital populations. Is it not then likely that this would lead to neglect of the needs of depressed patients in the hospital? Our data indicate that this may be so. For instance, we can point to the smaller numbers of morbid depressives who received treatment appropriate for depression in the New York sample than in the London sample (see Table 9).*

Table 9
Treatment of Depression Within a Year of Admission for Morbid Depressives From Series I in New York and London

<table>
<thead>
<tr>
<th></th>
<th>New York</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>% Treated</td>
<td>N</td>
</tr>
<tr>
<td>24</td>
<td>50.0%</td>
<td>51</td>
</tr>
</tbody>
</table>

Chi Square = 8.14**

** = p < .01

Consequences for Research

There are equally important consequences for psychiatric research of the tendency to underdiagnose depressive disorders. Many state hospitals throughout this country bear within their colossal structures a cell in which research workers from such disciplines as psychology, physiology and biochemistry are located. Insofar as they wish to base their work on patients within certain diagnostic groups, they are usually dependent on the hospital psychiatrists to provide those diagnoses. The problems arising in research as a result of the heterogeneous behaviors included under the diagnosis of schizophrenia are well known. To some extent this is inevitable but the inclusion of

*These data are for the first series only because treatment data from the second and third London series are not yet available. The proportions are for those treated for depression within a year of admission (rather than within a month as in the previous tables) because the data from London were in this form only.
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morbid depressives in schizophrenia would appear to be a gratuitous complication.

Furthermore, studies that seek to find objective discriminators of affective disorder and schizophrenia will be hampered by the partial and erroneous inclusion of the former in the latter. Fortunately, those workers concentrating on the affective disorders will nor be so much troubled by the converse problem, the inclusion in the affective disorders of patients with symptoms highly suggestive of schizophrenia. Only a single one of all the nondepressed psychotics in our three series received a diagnosis of depression. Furthermore, in our previous work we have shown that patients with ambiguous or mixed symptomatology are hardly ever called an affective disorder by the New York hospital staff (Gurland et al., 1970).

Conclusions

We fear that much of this presentation will be regarded as critical in tone. We will therefore close on a positive note. We have shown that there are more patients with a depressive disorder in New York hospitals than is generally recognized from reported statistics. New York hospital psychiatrists have turned to psychopathology rather than diagnosis in treating these patients and show themselves to be sensitive to such patients' depressive symptoms. It seems well within the grasp of the hospital psychiatrists to give a distinctive label embodying the term depression to those patients whose predominant symptom is depression and who present no obvious and reliable features of schizophrenia. Such a label would be more consistent with the treatment the psychiatrist gives than are the diagnoses he now makes, and would also be a more useful predictor of early outcome. There are labels within the international classification of disease, and its American version, DSM-II, which would answer this purpose well.

The appropriate labeling, in one form or another, of patients such as the morbid depressives would seem likely to lead to the recognition of the higher frequency of morbid depressives in state hospitals, to a greater awareness of the need for antidepressive therapy, to more rational planning of hospital services, and to more fruitful collaboration between clinicians and research workers.

References


DISCUSSION OF
DR. GURLAND'S PAPER

JEROME D. FRANK
The Johns Hopkins University School of Medicine

This study is characterized by the painstaking, thorough, and lucid presentation and analysis of data that we have come to expect from Dr. Gurland and his colleagues.

Before turning to a discussion of the main finding, I should like to call attention to a subsidiary one which may be of some interest but which the paper did not discuss. This is the relationship of age to diagnosis. In both the United States and the United Kingdom, for patients with the morbid depressive syndrome (i.e., having above the mean number of symptoms of depression and no symptoms which could contradict this diagnosis) patients under 34 are less often diagnosed depressed and more often diagnosed as neither schizophrenic nor depressed. Furthermore, the "other" category is used about three times as often for the younger than the older patients in both countries. Perhaps this reflects the less stable and more confusing manifestations of psychoses in younger people, or perhaps the greater incidence of behavioral problems which might lead to a diagnosis of character disorder. The paper does not give the age breakdown for the largest series, that is, number three. It would be interesting to see whether the same finding holds true for it.

The major finding is indeed startling, and is seen most clearly with the morbid depressive patients who are under 34. In the United States, of 12 such patients, who, it will be remembered, had more than the mean number of signs of depression and no signs incompatible with this diagnosis, not one was diagnosed as depressed and two-thirds were diagnosed as schizophrenic, as compared with 47 percent depressed and 14 percent schizophrenic in the London series. Since other analyses showed that the American psychiatrists were no less sensitive to the symptoms of depression than the British ones, one must concur with the conclusion that American psychiatrists are biased
in favor of diagnosing schizophrenia and against diagnosing depression as compared to their London colleagues.

I believe the major reason for this is the difference in the preferred conceptualization of schizophrenia in the United States and Great Britain. In the United States, initially under the leadership of Adolf Meyer, and later, powerfully reinforced by that of Sullivan and Frieda Fromm-Reichmann, we have favored a view of schizophrenia as resulting from faulty habit patterns developed in pathogenic family constellations and therefore best treated by offering patients a new human relationship that might counteract these unfortunate influences. This has implied that psychotherapy is the preferred treatment, and that if the therapy were good enough, the prognosis could be hopeful. On the other hand, English psychiatric thinking, dominated by the Kraepelinian tradition and reinforced by Mayer-Gross, has viewed schizophrenia as an organic disease which, often taking the form of dementia praecox with an ominous prognosis, is not especially amenable to psychotherapy. One must add that psychotherapy, primarily as a result of the psychoanalytic influence, has always enjoyed the highest prestige of all forms of psychiatric treatment in the United States, which is not true in Britain.

The depressed patient is a poor candidate for psychotherapy. He interacts sparsely with others, is dull and unproductive, sees the world in an impoverished and stereotyped way, and really wants to be left alone. Furthermore, on the one hand his illness is self-limited and his improvement can clearly be facilitated by antidepressants and electroshock therapy and, on the other, he is apt to relapse from time to time with or without psychotherapy. The few reports in the literature of psychotherapy with depressed patients stress what a difficult, long, drawn-out, and dubious undertaking it is.

Young schizophrenics, on the other hand, are considered in the United States to be ideal candidates for psychotherapy—at least, psychotherapy with them is always a rewarding and challenging experience for the therapist. They have a rich inner life, are very sensitive to nuances in interpersonal behavior, and the therapeutic relationship is a lively and eventful one with constant shifts and challenges. The literature is full of fascinating accounts of long-term therapy of schizophrenics, which every young psychiatrist hopes to emulate. To be sure, the effects of intensive, long-term psychotherapy on schizophrenics remain problematical, especially in view of the recent studies of May and his colleagues (1). However, let me hasten to add, they do recognize the importance of what they call psychotherapeutic management of such patients—i.e., they do not dismiss the role of psychological factors in exacerbating or reducing schizophrenic manifestations. But, even if the patient does not get better, the therapist has had an interesting time and, in view of the stresses that long-term treatment of schizophrenics puts him under, he can feel that he is earning his fee.
A more troublesome question raised by this study is whether diagnosis is useful with this group of patients. Although diagnosis has several functions, its ultimate purpose is to guide treatment. In the United States the findings of this study are equivocal in this respect. More of the group of morbid depressives diagnosed depressed received antidepressant medication early than those diagnosed "other," but the differences are not statistically significant. Whether the patient with morbid depressive symptoms is, or is not, diagnosed as depressed seems to make no difference with respect to the frequency of early improvement (i.e., discharge from the hospital within three months and remaining out of it for a year). Compared to the London sample, fewer of the patients in the United States received antidepressant treatment. Since the London outcome figures are not given, one cannot determine whether the administration of appropriate treatment really affects outcome. Judging from the high rate of good outcome in the American series (65 to 78 per cent), the London figures could not be much higher. This suggests that, in fact, the form of treatment does not make too much difference with this group. Although antidepressant treatment and electroshock therapy are probably the treatments of choice, the spontaneous remission rate is high and some patients with depressive symptoms respond well to phenothiazines. Taken together, these may obscure the possible advantages of appropriate antidepressant treatment.

I fully concur with the authors that more cross-cultural consistency would be achieved by classifying psychiatric patients in terms of syndromes rather than disease entities. This would clearly benefit research because research data cannot cumulate unless researchers agree on the labels they apply to the phenomena they are studying. Although it might not affect therapy with this particular group of patients, the value of using target complaints rather than clinical entities in guiding pharmacological treatment of psychotics has been amply demonstrated. One obstacle to the use of syndromes rather than clinical entities in the past may have been the greater labor involved, but this today is obviated by the computer.

We must all be grateful to Dr. Gurland and his colleagues for undertaking the laborious, painstaking task of cleaning out the Augean stables of psychiatric diagnosis. It is good to know that they are making tangible headway.

Reference