Classification of Depression

Robert L. Spitzer, M.D., and Jean Endicott, Ph.D.

Robert L. Spitzer, M.D.
Director, Evaluation Section, Biometrics Research, New York State Department of Mental Hygiene, New York State Psychiatric Institute; Associate Professor of Clinical Psychiatry, Department of Psychiatry, College of Physicians and Surgeons, Columbia University.

Jean Endicott, Ph.D.
Co-Director, Evaluation Section, Biometrics Research, New York State Department of Mental Hygiene, New York State Psychiatric Institute; Research Associate, Department of Psychiatry, College of Physicians and Surgeons, Columbia University.
The term depression is used in several different ways. As a symptom, depression refers to a painful subjective mood and is often described with such terms as "down in the dumps," "sad," "low," "blue," or "discouraged." Often patients will not use these clear synonyms for depressed mood but will instead complain of such feelings as "emptiness" or "not caring about anything." The term depression is also used to describe the behavioral signs from which an observer can infer the likelihood of depressed mood. Such signs include lack of animation in voice and body movement, downcast faces, tearfulness, and slowed speech and gait.

Depression is also used as a name of a syndrome which includes a dysphoric mood and associated symptoms. The dysphoric mood most often is an intense subjective feeling of depressed mood. However, the depressed mood may be mixed with, or predominantly a mood of, irritability or anxiety. The most common associated symptoms are: (1) poor appetite or weight loss, or more rarely, increased appetite or weight gain; (2) sleep difficulty, or more rarely, sleeping too much; (3) loss of energy, fatigability or tiredness; (4) generalized slowing down of bodily movements (psychomotor retardation), or more rarely, psychomotor agitation; (5) loss of interest in usual activities, such as work, family, friends, hobbies or sex; (6) feelings of self-reproach or excessive and inappropriate guilt either of which may reach delusional proportions; (7) complaints of diminished ability to think or concentrate, such as slowed thinking or mixed-up thoughts (which may be subjectively experienced by the subject and not observable, or when severe, can be directly observed); and (8) recurrent thoughts of death or suicide, including thoughts of wishing to be dead, with or without true suicidal intent.

The associated symptoms listed above are common in many other psychiatric conditions, but when three or more of these symptoms are present it is quite likely that careful inquiry will reveal a dysphoric mood even if it is not a prominent complaint in and of itself. The combination of
dysphoric mood and several of these symptoms strongly suggests the depressive syndrome.

Depressed mood, and even the depressive syndrome, may be considered a normal reaction in certain circumstances, such as following the death of a loved one, a business failure, or any life event which lowers one’s self-evaluation or removes important sources of gratification. Depression is pathological when there is no discernable life event to account for the reaction, or when the depressed mood or associated symptoms are so persistent or incapacitating as to exceed the expected reaction given the entire context of the situation in which it occurs.

The term depression is also used as a diagnostic term to indicate a group of conditions in which depressed mood or the depressive syndrome is the central disturbance, in contrast to other psychiatric conditions, which may or may not be accompanied by depressive symptoms.

Although the medical profession has always recognized states of depression, a satisfactory classification of the depressive disorders is still lacking. At the present time, there are many competing classification schemes which emphasize different distinctions between patients with depressive symptoms. Unfortunately most classification schemes, such as the Diagnostic and Statistical Manual (DSM-II) of the American Psychiatric Association, attempt to place patients in mutually exclusive categories, thereby failing to do justice to the complexity of the varied clinical phenomena seen in depressed patients.

The classification that is presented here (see Table 1) is a simplification of the classification in the DSM-II. It is based largely on differentiating disorders on the basis of phenomenology and course. In contrast, the DSM-II classification often makes distinctions based on presumed etiology, such as life events in the diagnosis of Psychotic Depressive Reaction and age of onset in the diagnosis of Involutional Melancholia. These etiological assumptions have, in our judgment, not yet been adequately shown to reflect fundamental differences among depressed patients. In addition, the DSM-II classification implies that stressful life events are never a significant factor
in the recurrent psychotic depressive disorders. This assertion is contradicted by clinical experience and only confuses the differential diagnostic problem.

The depressive disorders can be divided into those that tend to be episodic (Major Depressive Illness, Schizo-affective Disorder, and Minor Depressive Illness) and those that reflect life long personality traits (Cyclothymic Personality and Depressive Personality). Admittedly, the distinction is often arbitrary since some episodes of depression can last for many years, there is some fluctuation of level of severity of symptoms within those individuals who have life long signs of depression. In addition, individuals with depression as a personality characteristic can in addition have discrete episodes of severe depression.

Major Depressive Illness. This category is for episodes of illness in which the depressive syndrome is present and symptoms suggesting schizophrenia are absent (see Schizo-affective Disorder below). The course and clinical phenomena vary tremendously. Some episodes are of sudden onset and related to obvious life stress, whereas others are not. The patient may be minimally disturbed in his social functioning or incapacitated. Some of these patients may have no other psychiatric symptoms other than the simple depressive syndrome, whereas others may be floridly psychotic with paranoid, nihilistic or somatic delusions and/or hallucinations. The delusions and hallucinations, if present, tend to be consistent with the mood, for example, delusions of guilt or unworthiness, or hallucinations in which the patient is being reviled for his sins.

Within the Major Depressive Illness category, patients can be further subdivided into those who have had episodes of both mania and depression (bipolar), and those who have only had episodes of depression. The latter are divided into those who have had two or more episodes all of depression (unipolar recurrent) and those who have only had one episode. The bipolar and unipolar groups are called Manic Depressive Illness (bipolar and depressive type), in DSM-II.
The first episode of a Major Depressive Illness is categorized as either Psychotic Depressive Reaction, Neurotic Depression, or Involutional Melancholia in DSM-II.

Several features relevant to treatment are often noted in further subclassifying an episode of Major Depressive Illness. (1) An episode whose onset appears to be clearly related to stress, can be designated as "situational depressions." Such episodes tend to be of short duration. (2) Episodes of Major Depressive Illness which are not preceded chronologically by any other diagnosable psychiatric disorder, such as Phobic or Obsessive-Compulsive Disorder or Alcoholism, are termed "primary" whereas episodes which develop following another psychiatric disorder are termed "secondary." This distinction is of particular importance when both illnesses are present at the same time because it is likely that when the depressive episode is over, the patient will still have the preceeding psychiatric illness. (3) Another important distinction which has obvious relevance for management is whether or not the patient is psychotic (in the sense of having delusions or hallucinations) or whether the patient is incapacitated and unable to function in his usual roles.

There are several clinical features which are often referred to as "endogenous phenomena" which have been shown to predict good response to somatic therapy, such as ECT or psycho-pharmacological agents. These include: lack of reactivity (once depressed, doesn't feel better when something good happens), distinct quality to depressed mood (depressed mood is perceived as distinctly different from the kind of feeling one would have following the death of a loved one), mood regularly worse in the morning (diurnal mood variation), pervasive loss of interest or pleasure in usual activities, feelings of self-reproach or guilt which is excessive or inappropriate, early morning awakening or middle insomnia, psychomotor retardation or agitation, poor appetite and weight loss. The more of these features, particularly the first three, which are present, the greater the likelihood of response to somatic therapy. (5) Finally, patients with a Major
Depressive Illness who manifest significant signs of agitation (pacing, handwringing, pulling at clothes or hair) or retardation (slowed up, increased latency of speech) are referred to as having either an "agitated" or "retarded" depression. Agitated depressions seem to respond better to phenothiazines than to more usual anti-depressant medication.

Schizo-affective Disorder. This category is for patients who have an episode of illness where the depressive syndrome is present but who in addition, have symptoms which by themselves would suggest schizophrenia. Such symptoms include bizarre or fantastic delusions not clearly related to either lowered or elevated self-esteem, evidence of impairment in the organization of speech which makes it difficult to understand at times other than when manic and excited (thought disorder), and frequent or peculiar hallucinations not clearly related to the disturbance in mood. In DSM-II this condition is called Schizo-affective Schizophrenia but recent research evidence suggests that the condition may be more related to affective illness than schizophrenia, hence the term Schizo-affective Disorder, rather than Schizo-affective Schizophrenia. As in DSM-II, Schizo-affective Disorder is subdivided into two types, depending upon whether the depressive or manic syndrome is present. Patients with Schizo-affective disorder seem to respond better to phenothiazines than to anti-depressant medication.

Minor Depressive Illness. This category is for patients who have an episode of illness characterized by intense depressed mood and none or only a few of the symptoms of the depressive syndrome, and who show no signs suggesting a psychosis. The corresponding category in DSM-II is Neurotic Depression.

Life long Disorders. Cyclothymic Personality is characterized by a life long pattern of alternating periods of depressed and elated mood which are not readily attributable to external circumstances. In between the depressed and elated periods the patient may have a normal mood
but more commonly the mood swings from one to the other. This condition is rare and is thought to be associated with the development of bipolar depressive illness.

The more common lifelong depressive disorder is that of Depressive Personality. There is no term for this condition in DSM-II but it would include many individuals diagnosed as Hysterical or Inadequate Personality. These individuals typically deal with stressful situations or disappointments of any kind, with more intense and persistent depressive affect than is ordinarily expected. Such individuals may, in addition, have episodes of Major Depressive Illness. Individuals with Depressive Personality are thought to be more likely to develop an episode of Major Depressive Illness in which endogenous features are minimal (often referred to as "reactive-depressions"). Similarly, there is some research evidence that individuals who develop a unipolar Major Depressive Illness with many endogenous features are not as likely as other depressed patients to have had a Depressive Personality.

Conclusion. Some of the confusion in the psychiatric literature and in treatment recommendations made for depressed patients has developed because of the lack of a generally agreed upon method for classifying the depressive disorders. In an effort to clarify some of the nosological issues related to biological, genetic and life experience variables, the Clinical Research Branch of the National Institutes of Mental Health has initiated a collaborative project on the psychobiology of the depressive disorders which will involve investigators in a large number of centers throughout the country. Hopefully, the results of this work will result in a classification system for the depressive disorders that is more useful to both clinicians and research investigators than are current classification systems.
References


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* Useful distinctions for Major Depressive Illness
  (1) whether or not associated with stress
  (2) primary or secondary
  (3) psychotic or not
  (4) presence or absence of endogenous features
  (5) agitated or retarded
Questions

Approximately three weeks prior to seeing her physician a 26 year old graduate student flunked an important examination. Over the next few weeks she became increasingly tense, anxious, and depressed. She had difficulty concentrating and falling asleep. Her appetite was poor. She started to reproach herself for having been a failure at school and also for trivial sexual indiscretions with her boyfriend of many years ago. Because of increasing insomnia and lethargy she consulted her physician. She expressed a conviction that she had contacted a disease from her boyfriend that was effecting her mind and nervous system. A similar episode occurred six years previously which lasted three months. There is a family history of suicide and mania.

The most likely diagnosis is:
1. Minor Depressive Illness
2. Schizo-affective Disorder
3. Paranoid Schizophrenia
* 4. Major Depressive Illness

Important features of this episode are (check all that apply):
* 1. presence of stress prior to episode
* 2. many endogenous features
* 3. evidence of impaired reality testing
* 4. recurrent episodes

The most appropriate treatment would be:
1. Psychotherapy alone
* 2. Tricyclics
3. ECT
4. Phenothiazines

There is a good possibility that (check all that apply):
* 1. She will have future episodes of depression.
* 2. She will develop a chronic illness resembling schizophrenia.
* 3. She will have a good response to somatic therapy.
* 4. Future episodes may be manic.