The classification of depression: are we still confused?

James Cole, Peter McGuffin and Anne E. Farmer

Summary

Recent developments in the classification of major depressive disorder are reviewed in light of the predictions made by Kendell in the 1970s. Particularly, the institution of operational diagnoses along with the contentious issues of subdividing major depressive disorder and its characterisation on a dimensional as opposed to a categorical scale.

A history of confusion

In 1976, Robert Kendell published a seminal article in the Journal outlining the many problems (the ‘contemporary confusion’) relating to the classification of depression. Some of these, he argued, also had implications for the classification of mental illness as a whole. Farmer & McGuffin revisited and updated the issues in 1998 against the background of the Diagnostic and Statistical Manual 4th Edition (DSM–IV) and the then impending publication of the International Classification of Diseases 10th Edition (ICD–10). Now, 30 years after Kendell’s original paper and as we enter the run up to DSM–V and ICD–11, another update is timely.

In the mid-1970s the problems outlined by Kendell included how to validate diagnosis in the absence of any known pathological mechanism, how to subdivide depressive disorders and how to resolve uncertainty over the use of categories or dimensions. In particular, Kendell noted that the introduction of research operational criteria to define psychiatric disorders could have an impact on improving the reliability and the international standardisation of diagnosis – an issue of major importance at the time. He hoped that improving diagnostic reliability between researchers would be the first step in ensuring the validity of diagnosis, recognising that this could not be fully achieved until the aetio-pathology of depression is elucidated. What Kendell did not foresee in 1976 was the profound effect operational definitions would have on national medicine, classification is organised around systems (respiratory, renal, etc.) and aetiologies (vascular, neoplastic, infectious, etc). They necessarily focus on more positive, concrete phenomena, inevitably leaving some pathological experiences or observations unaccounted for.

Kendell proposed that a bipolar/unipolar subdivision of affective disorder had a persuasive research base and further supporting
The operational approach to defining depression is categorical in that it defines cases or non-cases of disorder. However, when originally proposed by Hempel, he accepted that the individual items of psychopathology that make up each definition were dimensional, where experience ranged in severity from mild, self-limiting and present in the general population to severe, persistent and pathological.15 Hempel suggested that for each criterion the rater had to ask ‘does the respondent exhibit this amount of (symptom) X?’ In terms of criteria for depression, this translates as ‘has the individual experienced at least 2 weeks of unremitting low mood?’ This imposes a severity threshold on a continuous variable: in this case, mood. Thus, recognition that symptoms of mental health are continuously distributed across individuals within the general population as well as in those with disorders has been implicit since operational definitions were first proposed. However, depression is a ubiquitous syndrome that is associated with various mental disorders (schizophrenia, substance misuse, eating disorders, anxiety) along with physical disorders such as Parkinson’s disease, myocardial infarction, stroke and obesity. Not all of these different manifestations of depression respond well to antidepressant medication, suggesting that they may be aetiologically distinct. Depression also ranges in severity and symptom profile from the severe psychotic type of disorder found in bipolar illness to mild neurotic depressive symptoms associated with some personality disorders. Recent taxonomic studies exploring whether there is a discontinuity between clinical depression and subthreshold depressive symptoms have been inconclusive.16

In fact, the ICD–10 classification of depression incorporates a quasi-dimensional approach, inasmuch as there are mild, moderate and severe forms which some authorities suggest have implications for treatment. For example, the UK National Institute for Health and Clinical Excellence (NICE) guidelines indicate that the preferred first line of treatment for mild depression should be psychological therapy and that drug treatment should be reserved for those with moderate or severe forms of illness.17 Arguing for dimensions v. categories becomes somewhat spurious since both approaches are necessary.17 Certainly, there is a clinical requirement to define cases of a particular disorder, since this determines management and prognosis as well as facilitating service planning. However, defining psychopathology dimensionally probably has greater utility for basic science research especially neuropsychology and genetics. The dimensional structures of the psychopathology of unipolar depression18 as well as their bipolar counterparts (L. Forty, personal communication, 2007), have already been established using multivariate statistical approaches. Thus, there is an accepted dimensional structure for depression that can provide the continuous measures required in certain spheres of research. This indicates that DSM–V and ICD–11 probably need to incorporate both categories and dimensions; not one or the other.17

Conclusions

So what has changed over the past 30 years? Is there still confusion over the classification of depression? The answer to the first question is that the main taxonomies have not been altered drastically. An operationalised approach to diagnosis is still predominant in the main nosologies, although this may be challenged in the next revision of the DSM. The subdivision of unipolar and bipolar depression is well established by the research evidence and the melancholic definition of depression is also receiving a
resurgence in research interest. However, new aetiological clues about shared and specific risk factors for depression, mania and schizophrenia are emerging from genetic and neuroimaging research and this may increasingly challenge traditional classifications. It is possible that we could see wholesale shifts in classificatory groups, as has happened in other branches of medicine (e.g. peptic ulcer being reclassified from inflammatory to infectious diseases).

Similarly, after much debate comparing dimensional v. categorical approaches to diagnosis, it is now evident that both have their specific applications and both are necessary to psychiatry. It seems highly likely at the time of writing that DSM–V will be cast in both dimensional and categorical formats.

Are we still confused? Since it remains the case that we still have little understanding of the precise aetiology of depression, the answer to this question is surely ‘yes’. Our current nosologies remain as ‘working hypotheses’ and have no greater validity than the definitions of depression that existed when Kendell wrote in 1976. Consequently, the ‘true’ classification of depression remains as elusive as it was 30 years ago, though this is by no means reason to give up hope for the future.

References