

Psychopharmacology and the Classification of Functional Psychoses

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Four-Dimensional Classification: Conceptual Development

Affective Psychoses

Melancholia and Depressions

Empiricistic and Pragmatic Classifications

Kurt Schneider has been considered by some as "the last classicist in psychiatry" (Kisker, 1968). Nevertheless, his classification of "depression" was not unanimously accepted. It remained restricted to the German speaking countries until the late 1970s. Instead, in English speaking countries attention was focused on the rapidly growing British school under the leadership of Aubrey Lewis who in his classic article restated Kraepelin's unitary view. Lewis' (1934) publication was based on a clinical survey of depressive states which provided him with data to conclude that "melancholia" was not a group of disorders but one disease.

For some time Lewis' thesis has dominated British psychiatry. However, during the late 1950s--almost a quarter of a century after the publication of the original paper--the controversy, whether all depressions are the same endogenous disease or constitute different disorders distributed on a continuum, erupted again (Ban, 1981). The resulting research led to some of the empiricistic classifications based on a wide range of descriptive data collected from depressed patients and submitted to multivariate statistical techniques, e.g., factor analysis, cluster analysis, or multiple discriminant analysis. By employing this approach Kiloh and Garside (1963) identified a bipolar factor splitting observations into positive and negative loadings. Endogenous depression (age over 30, depression worse in morning, weight loss 7 lbs. or more) and neurotic depression (responsive to environmental change, self-pity, initial insomnia) were differentiated. Similarly, Kendell (1968) identified at the fourth order of analysis, a bipolar factor contrasting psychotic depression and neurotic depression. By employing principal component analysis, he found that the three leading symptoms of neurotic depression were anxiety, tension, and brief duration of illness. Within the same frame reference Hamilton and White (1959) discerned that depressed patients with retardation is made up of different population from depressed patients with agitation. Grinker et al. (1961) separated four types of depression: retarded, anxious, hypochondriacal and angry. Overall et al. (1966) distinguished three classes of depression: retarded, anxious, and hostile. Paykel (1972) described four categories of depression: psychotic, anxious, hostile and "depression in the young with personality disorder." Klein (1974a,b) proposed three groups of depression: endogenomorphic, chronic dysphoric, and reactive. Raskin and Crook (1976) identified four classes of depression: agitated, neurotic, endogenous, and "depression with poor premorbid personality" (Table X).

Simultaneously with classifications of depression based primarily on cross-sectional psychopathological data, numerous other classifications have been proposed. On entirely pragmatic grounds Kielholz (1972) differentiated among three different groups of depressions: somatogenic, endogenous and psychogenic. Robins and Guze (1972) differentiated between

two groups of depression: primary and secondary. Primary depression refers to a combination of signs and symptoms that involve psychomotor and vegetative dysfunctions, dysphoria, hopelessness, worthlessness, guilt, and suicidal preoccupations occurring de novo as a primary disorder of mood. Secondary depression refers to similar signs and symptoms usually with feelings of sadness, inadequacy and hopelessness that occur during the course of a preexisting non-affective psychiatric disorder or is associated with medical illness. Implied in secondary affective disorder is an antecedent disease. Because of this, secondary depressions may show considerable heterogeneity (Andreasen and Winokur, 1979). This contrasts with primary depression which forms a relatively homogenous group. Even primary depression however, has some heterogeneous features in regard to the course of the disease and the prevailing psychopathologic symptoms (Perris, 1974). When compared with patients suffering from primary depression, patients with secondary depression tend to have a lifelong coping style characterized by depression, make more but less serious suicide attempts, and complain more of hostility, anxiety, somatization and difficulties in falling asleep (Andreasen and Winokur, 1979).

Table X

Authors	Year	Groups
Hamilton and White	1959	Agitated Retarded
Grinker et al.	1961	Type A (Retarded) Type B (Anxious) Type C (Hypochondriacal) Type D (Angry)
Kiloh and Garside	1963	Endogenous Neurotic
Overall et al.	1966	Retarded Anxious Hostile
Kendell	1968	Psychotic Neurotic
Kielhoz	1972	Somatogenic Endogenous Psychogenic
Paykel	1972	Psychotic Anxious Hostile Depression in the young with Personality Disorder
Robins and Guze	1972	Primary Secondary
Andreasen and Winokur	1972	Pure Spectrum Disease Nonfamiliar or Sporadic
Klein	1974	Endogenomorphic Chronic Dysphoric

Raskin and Crook	1976	Reactive Agitated Neurotic Endogenous Depression with Poor Premorbid Personality
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Classifications of depression.