DISCUSSION

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of

PRIMARY AND SECONDARY AFFECTIVE DISORDERS. A CLASSIFICATION OF DESCRIPTION, RESEARCH AND MANAGEMENT OF MOOD DISORDERS

by

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Depression has been called the most common psychiatric disorder today. Whether or not this is justified, it is a fact that close to two million people in the U.S. are treated yearly for depression. That is about one percent of the total population. Certainly, we never had so many depressed patients under treatment at one time. Is the incidence of depression growing? Or is this simply a phenomenon of better case finding, because doctors have been taught to recognize more depressions, and depressed patients come forth more readily, since more effective treatments are now available? Be that as it may, if most physicians are better equipped today to recognize depressions or other affective disorders, they are still far from having achieved a methodology for making accurate, valid and consistent differential diagnoses. Researchers are painfully aware of the impossibility of obtaining homogeneous samples of depressed patients, to study the incidence of observable symptoms of depression in the behavioral, experiential and autonomic fields, or to investigate its non-observable physical and psychodynamic substrates. Clinicians are frustrated by the low predictability of therapeutic results, again because the depressed patients they are treating constitute an almost random collection of persons who have certain symptoms in common, but seem to differ widely as to the basic pathological entities they represent.

Dr. Robins, who for a long time has been in the forefront of sober and solid research in the hotly contested field of affective disorders, now tackles the old differential diagnostic puzzle in this area with admirable decisiveness and sensible pragmatism. He presents us with a no-nonsense approach to this

problem which has become a redoubtable conversation piece whenever several psychiatrists want to engage in an argument.

The term "primary depression" is proposed by Dr. Robinsto cover those patients for whom the history reveals either no previous psychiatric disorder or a clearly manic or depressive illness; "secondary depression" is the term proposed when the history shows that a psychiatric disorder of another type has occurred in the past. One could hardly wish for a clearer operational definition. Gone are the old bones of contention, reactive vs. endogenous, neurotic vs. psychotic, involutional melancholia vs. manic-depressive disorder, as Dr. Robinspoints out. Some of us conservative psychiatristsmay react with an acute sense of loss at this sudden disappearance of several important pieces from our conceptual checkerboard; those of a more activist bent may say "good riddance!" Where does all this leave us?

To establish diagnostic validity with psychiatric patients, Dr. Robinshas previously described five phases. They are:

1. Precise clinical description;
2. Laboratory studies;
3. Exclusion of other syndromes;
4. Follow-up studies;
5. Family studies.

He has now aamended this table when it is to be applied to affective disorders by simply replacing the second phase of laboratory studies with a precise clinical description of pre-existing psychiatric disorders - obviously, because laboratory studies which

can be of diagnostic help in the differentiation of affective disorders, are still a pipe-dream. Under the circumstances, a chronological step seems to him the next best thing to fill the need for a systematic approach to affective orders at the present time. The application of the criteria for classification into primary and secondary depression would almost certainly distinguish very successfully between depressions with good and with poor prognosis.

These five operating rules brought back recollections of the structural-analytic method of psychiatric diagnosis which was developed by my old teacher, Birnbaum, and which, I think, is still unmatched for conceptual precision and conciseness as its survey of factors which determine psychopathology. Birnbaum also proposed five steps; however, there were not operating rules, but rather the basic factors of a conceptual framework. His five basic factors were:

1. Pathogenic
2. Pathoplastic
3. Precipitating
4. Predisposing
5. Preformative

As an illustration, the pathogenic factors of a depression might be the hypothesized disturbance of their biogenic-amine balance in the CNS, the pathoplastic factors the personality make-up, which determines the choice of specific symptoms, the precipitating factors the traumatic life stresses which determine the point in time at

which the depression manifests itself, the predisposing factors the hereditary potential and the preformative factors might be found in the cultural environment which plays and important, though less specific, role than the pathoplastic factors in the shaping of symptoms.

It should be noted, however, that there was neither in Birnbaum's time nor is there today, much reliable information available on the pathogenic factors, i.e. the real causes of the functional psychoses, including the affective disorders. Because of this, Dr. Robinshas chosen to eliminate all reference to etiological factors in his new classification of affective disorders. Throughout much of the last century, as psychiatry was gradually giving structure to its scheme of psychiatric diagnosis, an intellectual battle raged between those who insisted that the only legitimate basis of psychiatric classification was etiology and that without adequate knowledge of etiological factors, no psychiatric classification should even be attempted, and those who were convinced that a realistic compromise had to be made and psychopathological symptomatology had to be accepted as a basis for psychiatric diagnosis. A chronological factor - the consideration of the outcome of the illness - was then introduced by Kraepelin as a new and important development, and Dr. Robinshas added to this the family history and, more significantly, the patient's own past medical and psychiatric history.

The ever-recurring questions whether a traumatic life stress had occurred and if so, whether it was causally related to

a depression, we have, somewhat arbitrarily but effectively, solved for our hospital, where the diagnostic rule is now that a depressed patient should be called reactive only if a convincingly traumatic life stress, which is temporarily related to the onset of the depression, is revealed <u>within the first five minutes</u> of the diagnostic interview. Any depressive illness for which no clearly traumatic cause is discernable in this manner and which is not related to another co-existing psychiatric condition, is diagnosed as manic-depressive disorder or, at the involutional age, as involutional melancholia, regardless whether it is a recurrent or the first depression in a patient's life. Our underlying assumption is, of course, that the depression is endogenous unless proven otherwise.

Dr. Robins wants to get away from the controversial dichotomy endogenous-reactive altogether, also from Kendell's continuum endogenous to reactive and from Weitbrecht's nice alloy "endo-reactive". But Robins' unambiguous rule of procedure calling for a classification of depressions as primary or secondary, according to the presence of absence of a previously "diagnosable" psychiatric disorder, seems to me to present difficulties because <u>power of sampling</u> has been sacrificed to <u>precision</u>. With the ubiquitous, almost endemic, distribution of psychiatric disorders ~~(Midtown Study; Digby Study)~~ producing varied symptoms, but often little precise diagnosability in Robins's strict scientific sense and resulting in conditions referred to loosely as emotional maladjustment, inadequacy, instability, insecurity, personality

disorder (other than anti-social) etc., a large number of depressions might have to be classified as undiagnosed when Robins' stringent criteria are applied. This would possibly replace the qualitative problem of inhomogeneous samples with another, equally stimying, quantitative one of insufficient sample size

In conclusion, I would think that our first need today is one of tidying up existing practices of diagnosing depressive conditions. Hopes of achieving this through new methods of statistical stratification of naturally occurring samples of depressed patients have not been fulfilled. Objective external criteria for selecting samples (e.g. biochemical, neurophysiological or psychophysiological tests) do not exist. The only other way of assuring better diagnosis and higher homogeneity of depressed patients' samples would be to upgrade our training and sophistication in psychopathology and in the art and science of making a proper psychiatric diagnosis. Speaking realistically, this is, in the existing -RATHER ANTIDIAGNOSTIC- psychiatric climate on this continent, a practical impossibility. Thus, all other possible methods of tidying up and refining the diagnosis and classification of depressed patients having failed, I personally would welcome the introduction of Dr. Robins' radical, simple and effective method of distinguishing between primary and secondary depressions.