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Point of View

The Concepts of Mild Depression

R. P. SNAITH

The term 'depression' is now used to cover a wider range of emotional disturbances than was the case when psychiatrists confined their attention to patients referred to psychiatric hospitals. There is considerable confusion about the variety of meanings and the loose terminology leads to claims and counter-claims about aetiology and treatment. The current classificatory systems and the variety of rating scales do not clarify issues concerning appropriate management. The guidelines for a clearer definition of a biogenic form of the concept of depression, which is likely to respond to antidepressant drug therapy, would be of considerable value to psychiatrists, non-psychiatric physicians and others who try to treat or help people in states of disordered emotion. Such guidelines are proposed.

Depression is one of the great themes of psychiatry; in addition to psychiatrists, a considerable number of people attempt to treat, counsel or otherwise help other people who are said to be suffering from depression; yet the concept of the state is obscure. There is little confusion about the recognition of a severe state, sometimes called a psychosis, but *milder* degrees of the condition lack definition. Sometimes the term depressive neurosis is used but Klerman *et al* (1979) have pointed out that a variety of concepts are associated with this term: stress precipitation, maladaptive personality patterns, unconscious conflicts, 'non-psychotic' symptoms; hence the term is so vague as to be useless if not frankly misleading. Kendell (1969, 1976) has argued, from a number of sources of evidence that the only reliable distinguishing feature between depressive psychosis and depressive neurosis is that of the severity of the disorder.

Some historical considerations

The term 'depression' was occasionally used by the early students of mental disorder, and by the end of the nineteenth century attempts were made by some psychiatrists to define states of depression; for instance one early British teacher (Bevan Lewis, 1899) wrote: "In simple pathological depression . . . the patient exhibits a growing indifference to his former pursuits and pleasures: the ordinary duties of life and business become irksome and devoid of interest: especially do all forms of mental exertion cause ennui and disaster . . . and the environment fails to call up pleasurable associations—a dreariness and gloom pervade the outside world, since it is interpreted in terms of the predominant feeling . . .". However, so far as institutional psychiatry was concerned the concept of 'Melancholia' was dominant and the history of this has been recorded by Lewis (1934) who recognised the term as: "Suffering many mutations, at one time the tenacious guardian of outworn schemes or errant theories; presently misused, cavilled at, disposessed, it has endured into our own times, a part of medical terminology no less than of common speech". The word 'depression' was not widely used until the second decade of this century and Alexander Walk (personal communication) wrote: "The word 'depression' only appears once in the Indexes of our Journal before 1909; this is a review of Clouston's Annual Report from Morningside for 1890, where he wrote that states of depression are becoming as common as exaltation as causes of admission to the asylum". ['our Journal' is *The Journal of Mental Science*, forerunner of *The British Journal of Psychiatry*.] It was Adolf Meyer (1905) who started the widespread adoption of the term and, curiously, this was in order to try to eliminate the confusion surrounding the use of the word melancholia: "If, instead of melancholia, we apply the term depression to the whole class, it would designate in an unassuming way exactly what was meant by the common use of the word melancholia and nobody would doubt that, for medical purposes, the term would have to be amplified so as to denote the kind of depression. In the large group of depressions we would naturally distinguish our cases according to etiology, the symptom-complex the course of the disease and the results". Alas, Meyer's hopes have remained unfulfilled in the subsequent eight decades. In fact the confusion worsened and Ascher (1952) commented: "There appears to be a good deal of confusion in the literature, as well as in practice, about depressive illness which is a left-over from the era of descriptive psychiatry. Concepts of psychogenesis, endogeny, reactivity, neurosis, psychosis and

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others have been introduced to clarify the issue . . . without producing the desired result".

If we now leave the domain of institutional psychiatry and consider the manifold states of human misery which are all sometimes called 'depression', we are in an even more confusing area. Here are the states of grief at loss, frustration of failed aspiration, the gloom of despair, the accidie of disillusion, the demoralisation of long suffering and the cynical outlook of the pessimist. Recently, in the wake of a new psychotherapeutic endeavour, cognitive therapy, there has been an interpretation of 'depression' as a lifelong habit of self-depreciation. Also in this confused field, is to be found the mild state of the biogenic disorder, also called 'depression' but so lacking in definition that it is widely overlooked. This is the state for which Kräupl Taylor (1966) regretted the absence of a term, a 'hypomelancholia' by analogy with hypomania: "Unfortunately this term is not in common use; instead such vague and theoretically misleading expressions as 'mild depressive reaction' or 'neurotic depression' are employed".

Definitions of terms

In the Present State Examination manual Wing and his colleagues (1974) have provided the most succinct definitions of psychopathological terms and, in order to clarify the issues of terminology the definitions of those terms relating to depressive states are set out here.

Depressed Mood
Depressed mood may be expressed in a number of ways — sadness, misery, low spirits, inability to enjoy anything, dejection. . . . The extent to which the subject has cried during the past month is one criterion of severity although it is not sufficient in itself (the deepest depression may be frozen misery which is beyond tears). Another criterion of severity is lack of variability; moderate forms of depression tend to come and go more than severe forms.

The authors state that depressive apathy and other forms of unpleasant affect e.g. nervous tension or anxiety should not be included in the concept of Depressed Mood.

Recent Loss of Interest
There is a definite recent diminution in the subject's interests, either some interests have been dropped, or the intensity of the interest has decreased. Everyone has interests of some sort but the extent of the diminution must be measured in the context of the range and depth of the subject's usual activities. Take into account everyday taking an interest in clothes, food and appearance, keeping up to date with news, etc. . . .

Self-Depreciation
The subject feels inferior to others, even — in the most intensive form of the symptom — worthless. . . . Ideas of self-depreciation are an exaggerated form of self-knowledge about part of the subject's own character, which gives a false picture because it is not balanced by the recognition that most human beings have similar faults. Self-depreciation implies a raising of the standard applied to the subject without an equivalent raising of the standard applied to others, or taking into account balancing merits . . .

Hopelessness
The subject's view of the future is bleak and without comfort. Two degrees of intensity are distinguished by whether the subject has given up attempting to cope, because he can see no point in trying because the future is hopeless. . . .

Observed Depression
Rate a sad, mournful look with tears in the eyes and gloomy monotonous voice. . . .

In addition to these items there are definitions for *Neglect Due to Brooding*, *Subjective Anergia*, *Slowness and Underactivity*, *Inefficient Thinking*, *Poor Concentration*, *Suicidal Plans or Acts*, *Morning Depression*, *Social Withdrawal*, *Guilt* and other related symptoms. The manual must be consulted for full definitions. It is evident that authors of the PSE have provided a valuable service by these definitions but even so it may be noticed that the definition of *Depressed Mood* is less precise than the other symptoms and covers, in fact, a range of concepts.

The nosological systems

Two widely used systems are the International Classification of Diseases, at present in its ninth revision (ICD-9: World Health Organization, 1978) and the third revision of the Diagnostic And Statistical Manual (DSM-III: American Psychiatric Assocation, 1980).

The ICD-9

Preview of the proposals for revision leading to ICD-10 indicate that the term 'depressive neurosis' will be abolished and depressive states will no longer be defined partly in terms of their supposed aetiology. However no substantial revision of the following comments is required). The glossary to the Mental Disorders Section of this system provides a convenient guide (p. 58) to the categories in which depression is a major or significant feature. There are 10 three-digit and 19 four-digit categories. In

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order to understand the guidance provided for classification the significant parts of the definitions are listed:

295.7 *Schizoaffective Type*
A psychosis in which pronounced manic or depressive features are intermingled with schizophrenic features . . .

296.1 *Manic-Depressive Psychosis—Depressed Type*
An affective psychosis in which there is widespread mood of gloom and wretchedness with some degree of anxiety . . .

298.0 *Other Non-Organic Psychosis—Depressed Type*
A depressive psychosis which can be similar to 296.1 but is apparently provoked by saddening stress such as bereavement or severe disappointment or frustration . . .

300.4 *Neurotic Depression*
A neurotic disorder characterized by disproportionate depression which has usually recognisably ensued on a distressing experience; it does not include among its features delusions or hallucinations and there is *often* preoccupation with psychic trauma which preceded the illness e.g. loss of a cherished person or possession. Anxiety is also *frequently* present; mixed states of anxiety and depression should be included here . . . [My italics]

301.1 *Affective Personality Disorder*
. . . is characterized by lifelong predominance of pronounced mood which may be persistently depressive . . .

308.0 *Acute Reaction to Stress Predominant Disturbance of Emotions*
Panic states, excitability, fear, depression and anxiety . . .

309.0 *Adjustment Reaction: Brief Depressive Reaction*
States of depression, not specifiable as manic-depressive, psychotic or neurotic, generally transient, in which depressive symptoms are usually closely related in time and content to some stressful event.

309.1 *Adjustment Reaction: Prolonged Depressive Reaction*
States of depression, not specifiable as manic-depressive . . . generally long lasting; usually developing in association with prolonged exposure to a stressful situation.

311 *Depressive Disorder Not Elsewhere Classified*
States of depression, usually of moderate but occasionally of marked intensity, which have no specifically manic-depressive or other psychotic depressive features and which do not appear to be associated with stressful events or other features specified under neurotic depression".

313.1 *Disturbance of Emotions Specific to Childhood And Adolescence; With Misery And Unhappiness*
. . . the main symptoms include misery and unhappiness . . .

Surveying these definitions it is clear that the word 'depression' is introduced into most of them without further qualification or definition; the two exceptions are the manic-depressive psychosis where the mood is described as one of "widespread gloom and wretchedness" and the emotional disorder of childhood characterised by "misery and unhappiness". For the rest it seems that the user is free to include any concept of the term depression that he wishes. The definition of Neurotic Depression is particularly vague and there are so many generalisations that the only certain statement is that symptoms of delusions or hallucinations preclude the diagnosis.

The DSM-III

(This paper was written before the proposals for revision were seen by the author. Inspection of the draft for DSM-III-R indicates that major revision of the following comments is not necessary). In this system the terms neurosis and psychosis have been abolished and diagnostic categories are independent of supposed aetiology. Depressive disorders are defined in the terms of the prevailing symptoms, their intensity and their duration. These are classified under the major category of Affective Disorders into Major Affective Disorders, Other Specific Affective Disorders and Atypical Affective Disorders. (The authors are apologetic about the use of the German word *Affekt* instead of the English word Mood but state that tradition has made this inevitable). Apart from the Affective Disorders there is only one other category in which the word 'depression' is used and that is *309.00 Adjustment Disorder With Depressed Mood.*

296.2 *Major Depressive Episode*
For this category to be correct the subject must experience one of two alternative symptoms and experience four other symptoms from a list of eight. The first two symptoms are: 'dysphoric mood' and 'loss of interest in all or almost all usual activities and pastimes (anhedonia). Dysphoric mood is defined by a choice of epithets: depressed, sad, blue, hopeless, low, down in the dumps and (surprisingly) irritable. The list of eight symptoms, of which four must have been present nearly every day for at least 2 weeks (in children under 6, at least three of the first four) are: a) poor appetite or significant weight loss or increased appetite and significant weight gain; b) insomnia or hypersomnia: c) psychomotor agitation or retardation; d) loss of interest or pleasure in usual activities or decrease in sexual drive; e) loss of energy, fatigue; f) feelings of worthlessness, self-reproach or excessive inappropriate guilt; g) diminished ability to think or concentrate; h) recurrent thoughts of death, suicidal ideation or attempt.

The category can be further classified as 'With Psychotic Features' when either mood congruent or mood incongruent psychotic features are present or

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as 'Melancholia' if some of the symptoms are of more severe degree and there is evidence of diurnal variation of mood. It should be noticed that anhedonia appears in both sections of the definition so making it unlikely that the category could be correctly applied in the absence of that symptom.

Two other categories of affective disorder depend upon symptoms of lesser severity than Major Depressive Episode and chronicity. These are:

301.13 *Cyclothymic Disorder.*
During the past two years numerous periods during which some symptoms characteristic of both the depressive and the manic syndromes were present but not of sufficient severity and duration to meet the criteria for a Major Depressive or Manic Episode. . . .

The disorder must not be simply a partial remission of bipolar disorder.

300.40 *Dysthymic Disorder*
It is recognised that this may be termed depressive neurosis in other classificatory systems. The disorder must have been present for two years; it usually commences at a young age; chronic physical illness or psychosocial stresses, personality disorder or an affective disorder which does not fully remit are predisposing factors; the symptomatic criteria are the same two mandatory alternatives as in Major Depressive Disorder and then three of a list of 13 accessory symptoms must be present.

296.82 *Atypical Depression*
This is a residual category for individuals with depressive symptoms who cannot be diagnosed as Major or Other Specific (Cyclothymic or Dysthymic) or Adjustment Disorder.

The DSM-III provides fairly well defined criteria for categorisation but unfortunately a heterogeneous group of individuals may be included under each of the categories.

A further problem with the category Major Depressive Episode is that many physically sick individuals could be included simply on account of their physical illness and without the necessity to postulate a presence of a mental disorder; thus depressed mood, loss of appetite or weight, insomnia, loss of energy, loss of sexual drive and recurrent thoughts of death may all occur in serious physical illness. This failing, widely overlooked, is examined by Kathol and Petty (1981). The inconsistencies arising from different definitions of depression have been studied by Sashidharan (1985).

Individual Diagnostic Systems
Research findings and the possibility of extrapolation of meaning to other contexts is seriously hampered by the variety and imprecision of diagnostic systems and also by the adoption system individual to a particular research group. Space allows only one example of such an individual system which is, however, selected on account of the fundamental questions and conclusions about the nature of depression arrived at by the leader of the research team, Professor George Brown and his associates. The criteria for 'case' and 'borderline case' of depression are based on the Present State Examination symptoms (Finlay Jones *et al*, 1980). For a case Depressed Mood is mandatory and then any four of a list of ten symptoms: Hopelessness, Suicidal Ideas or Actions, Weight Loss, Early Waking, Delayed Sleep, Poor Concentration, Neglect Due to Brooding, Loss of Interest, Self-Depreciation, and Anergia. Symptoms must have been present for 2 weeks but there are no clear criteria of severity. Given the difficulties, already noted, in the PSE definition of Depressed Mood it is therefore clear that these criteria constitute a very wide trawl into which large numbers of sick, poor or unhappy people may be caught up. It is perhaps not surprising that Brown and his colleagues find this state they define as 'depression' to be related to social and personal disadvantage and also to have a high prevalence.

Rating scales

Many research studies have based the definition of a 'case' of depression on a certain score having been attained on one or other of the large number of depression rating scales. The different construction of these scales, and their individual characteristics of item array, cause serious difficulties in comparing one study using one scale with another using a different scale. The procedure of arriving at a definition of a case by adding up numbers derived from severity grade score of a number of symptoms has a certain attraction until it is realised that one case may be very different from another. As an instance of this, Cooper & Fairburn (1986) found that a group of bulimic and a group of depressed patients had similar scores on the Montgomery-Åsberg Depression Rating Scale but different symptoms, or scale items, contributed strongly to the overall score in the two groups.

The widely used Hamilton Depression Scale (Hamilton, 1967) consists of 17 items: depressed mood, feelings of guilt, suicidal ideation, work and activities, insight, retardation, agitation, insomnia (early, middle and late), psychic anxiety, somatic anxiety, gastrointestinal symptoms, general somatic symptoms, genital symptoms (loss of libido or menstrual disturbances), hypochondriases and loss

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of weight. The last six of these items are symptoms of somatic disturbance and account for 31% of the possible total score; if the insomnia items, which so often rate highly in physical illness are included, then 42% of the total is accounted for. The Depression Inventory (Beck *et al*, 1961) is another widely used 'depression' scale and again contains a high proportion of symptoms relating to somatic disturbance. Stewart *et al* (1965) pointed out that such symptoms are common in medically ill patients and advised that such assessment scales for depression should be avoided but their advice has largely been unheeded. An improvement on previous scales is the Montgomery-Åsberg Depression Rating Scale (Montgomery & Åsberg, 1979): this scale is oriented toward psychic symptoms and are: apparent sadness, observed sadness, inability to feel, difficulty in concentration, inner tension, pessimistic thoughts, suicidal thoughts, lassitude, reduced sleep, and reduced appetite. However even here 30% of the total score is accounted for by the last three items and all three commonly occur in all illnesses and states of distress, not just depression.

The range of self-assessment scales are popular as screening instruments for the presence of mood disorder. They are open to the same fallacies. For instance Kutner *et al* (1985) studying depression and anxiety in dialysis patients found that scales containing disease related items yielded exaggerated scores. The depression scale they used was the Self-Rating Depression Scale (Zung, 1965); this contains 20 statements, five of which are: 'I have trouble sleeping at night', 'I eat as much as I used to', 'I notice I am losing weight', 'I have trouble with constipation', 'My heart beats faster than usual'. Other items which may well be rated highly by people who suffer from physical sickness or are under some other adversity are: 'I feel that others would be better off if I were dead', 'My life is pretty full', 'I feel I am useful and needed', 'I feel hopeful about the future', 'I enjoy looking at, talking to and being with attractive women/men'. Altogether over half of the items of this widely used depression scale are composed of feelings or symptoms which do not necessarily indicate the presence of a mental illness.

The majority of depression rating scales contain a motley collection of symptoms, attitudes and feelings and will produce high prevalence rates and a large proportion of false positives if case detection relies upon them.

Discussion

In 1984 Mayou pointed again to the well-known fact that lack of agreement on definitions of disorders causes great difficulty in psychiatry. In no area is this more true than in the concept of depression and Andreason (1982) wrote: "Although affective disorders have been recognised for thousands of years, clinicians and researchers have still not reached agreement on the basic concepts of these disorders and the best methods of classifying them". Richmond & Barry (1985) surveyed the confused areas between mental illness and 'normal' states of distress, the large numbers of professional and other workers engaged in these grey areas and the potential enormous waste of resources and misapplication of treatments; they concluded: "Better definitions of clinical disorders must be developed *e.g. differentiating demoralisation from depression*. Psychiatry must clarify the areas where its expertise overlaps with other mental health disciplines (Lowy) and take the initiative in reallocating resources so that the paradox of increasing resources creating additional need can be overcome". [My italics]

Psychiatry is still overconcerned with providing classificatory systems but these too often end as mere pigeon holes into which patients can be placed with their appropriate diagnosis but frequently the diagnosis fails to lead to correct treatment or else treatments are applied blanket-fashion no matter what the diagnosis. In a leading work on depression (Weissman & Paykel, 1971), the authors wrote: "Attempts have been made to isolate within clinical depression two or more types, classified by such labels as neurotic, psychotic, reactive, endogenous. These are of considerable research interest. . . . However their practical application in guiding treatment is still limited".

At the time when psychiatrists confined their attention to patients admitted to mental hospitals there was rarely much difficulty about the diagnosis of the depressive phase of manic-depressive psychosis. This is a severe illness with fairly stereotyped symptomatology; the addition of information from the course of the disorder, the history of mania and familial history leads to fairly certain conclusions about the correct management and treatment. But the situation has now changed in three respects. a) Attention is now paid to the milder mood disorders occurring in the community and non-psychiatric hospital departments; b) workers other than psychiatrists are involved in the detection and treatment or care of people suffering from these mild mood disorders; c) finally, effective treatments, both psychological and pharmacological are now available, or rather such treatments can be effective when applied in the correct circumstances.

At the present time there is a vogue for community studies in the field of depression. Commonly, rating

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scales or diagnostic systems of one type or another are applied and a high prevalence of 'depression' is revealed. Researchers wonder at the fact that general practitioners, cancer physicians, neurologists and so on should be so inept at diagnosing this treatable condition but all that has happened is that a larger number of people have been declared to be in the company of the mentally ill or in need of some type of psychiatric or psychological treatment which is frequently not specified.

In future, research in this area must rest upon the need to provide more certain guidance on whether or not treatment is required and if so, what form that treatment should take. Now that effective antidepressant drugs are available the next essential task of psychiatry is to provide clear working guidelines of who might reasonably be expected to respond to such prescription, cutting short much misery and confusion and the frustration of other physicians and psychological therapists to help them.

How then may 'depression in this mild form be defined and assessed? One solution would be to stop using the term altogether and to describe states of mind in simple terms: grief at loss, poor self-esteem, demoralisation due to adversity and so on. The American DSM has made a start by reverting to the old term 'melancholia to describe the severe biogenic depressive illness; but what of the milder biogenic disorder, the state which has a high chance of improvement with antidepressant drug treatment, i.e. Kräupl Taylor's 'hypomelancholia'? In this paper I have put forward the reasons why current diagnostic systems are unsatisfactory and are frequently misleading. The wide range of current depression rating scales are also mostly misleading since they are composed of a motley of items on which any sick or unhappy person may score highly. Reliable laboratory tests are not available, possibly because attempts have been made to validate them on poorly defined clinical samples. In any case a laboratory test would have to be very easily conducted to be of real value to the large numbers of people who are involved in the management of 'depression'.

A solution to the problem of defining mild biogenic depression must rest upon the recognition of well defined clinical features which may relatively easily be established as being present or absent. For all the foregoing reasons these clinical symptoms must not include somatic symptoms which may occur in a wide variety of bodily illnesses, nor must a non-specific state such as insomnia and lack of energy be included. Symptoms indicative of severe mood disorder, such as suicidal preoccupation are unsuitable for they would lead to a high false negative rate. Referring again to the list of symptoms in the DSM definition of Major Depressive Disorder, what remains? There remain: depressed mood (dysphoria) loss of pleasure response (anhedonia), psychomotor retardation or agitation, feelings of worthlessness, self-reproach, inappropriate guilt, and diminished ability to think or concentrate. Two further symptoms from the list of 'depressive' symptoms in the PSE may be considered: hopelessness and neglect due to brooding, although both have implications of a severe disorder.

Kräupl Taylor described the essential hypomelancholic symptoms: "There is usually a decrease in mental and physical activity, in self-confidence and in the enjoyment of pleasure. The patient lacks energy and initiative in general". Another student of mild biogenic depressive disorders is Klein (1974); he recognised that stress sometimes was a factor in the precipitation of depressive states which were nonetheless to be considered biogenic in terms of having a high likelihood of response to antidepressant drugs, and so he coined the term 'endogenomorphic depression' and described the pathognomonic feature of this state: "A sharp, unreactive, pervasive impairment of the capacity to experience pleasure or to respond affectively to the anticipation of pleasure".

Which features then may be taken to be pathognomonic of the mild biogenic depressive state? Depressed mood is too diffuse a concept, too ill-defined as witness the number of epithets which may be provided to substitute for it. Feelings of worthlessness and guilt are too liable to have a basis in reality i.e. to be psychogenic; hopelessness may also be based upon the undeniable situation of the person and therefore unreliable as an indicant of biogenic depression. Psychomotor retardation is a reasonable proposition, a feeling of being slowed in thought and action; but in many patients prominent anxiety is present and agitation not retardation is the experience; moreover retardation is too liable to be a symptom of physical diseases, such as parkinsonism or arthritis, to be a reliable guide to the presence of biogenic depression in the setting of physical illness.

Of all the states anhedonia emerges as the central and reliable symptom of hypomelancholia. Anhedonia, the loss of ability to experience pleasure may also be fairly reliably ascertained by a few key questions: does the sight of flowers or a beautiful sunset lift the heart or the sound of one's favourite music make one want to sing with it? Can one anticipate with pleasure, look forward to a usually enjoyed event such as a weekend outing or a visit from a friend? Does one still pursue old hobbies or pastimes with real pleasure or does one simply do them for the sake of doing something or to put on

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appearances? And can one still enjoy a good joke with real mirth?

Some time ago we were asked by a physician to help him sort out, in his busy medical practice, which of his patients were just unhappy, demoralised or miserable for some other reason and which may be helped by the prescription of an antidepressant drug. As a result of this exercise we devised the Hospital Anxiety And Depression Scale (Zigmond & Snaith, 1983); this is fully described elsewhere but the essential feature is a subscale called 'depression' which comprises seven items: one is a 'dysphoria' item—I feel cheerful—and another a retardation item, but the essential basis is anhedonia and the other five items describe this experience in one form or another. The scale therefore measures anhedonic depression which we take to be the best indicant of hypomelancholia and we advised our colleagues to consider prescribing antidepressants if a high score appeared in this scale. Kendell (1982) advised that two or more criteria should be used when selecting subjects for biological research in mental illness and I also advocated the combined use of both a researcher administered and a self-assessment scale (Snaith, 1981).

The definition of the ubiquitous states that masquerade under the term 'depression' is of central importance and no real progress will be made in research and the development of clear guidelines to effective intervention until this is done. Considering the vastness of the sea of human unhappiness and the huge numbers of people attempting to fish souls out of it, this definition is perhaps the most urgent problem demanding solution by psychiatrists. In this essay I have developed the view, based upon examination of the work of others and on my own clinical experience, that anhedonia, if it is persistent and not adequately accounted for by the person's circumstances is at present the nearest guide to the biogenic depressive disorder. This suggestion needs to be put to the test of critical research.

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R. P. Snaith, MD (Lond.) FRCPsych, *Senior Lecturer in Psychiatry, University of Leeds and Honorary Consultant Psychiatrist, St James's University Hospital, Beckett Street, Leeds LS9 7TF*

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