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The Relationship Between the Depressive Illnesses

By G. A. FOULDS

Categories and Dimensions

In discussion of the wider issue of the characteristics of, and the relationship between, the classes 'psychosis' and 'neurosis', Maxwell (1972) wrote: '. . . the majority of all patients tend to have a basic core of symptoms, neurotic in type, which lend themselves to a dimensional description, but one whose prominence decreases somewhat as we pass from neurotic through affective psychotics to schizophrenics. In addition there are the psychotic type symptoms, which are rare and haphazard in occurrence. These are virtually absent in neurotics: they are most common in schizophrenics, but still not sufficiently numerous or patterned to support a clear-cut typology or to lend themselves to a dimensional description.'

In any sample of the general population, even neurotic type symptoms will be very far from normally distributed. Furthermore, one of the differentia between symptoms and personality traits would be lost if we were to think in terms of neurotic symptoms being normally distributed. All members of the general population are characterized in more or less degree by any particular personality trait; not all members of the general population are characterized by neurotic symptoms. It is awkward to have to think in terms of a dimensional description of neurotic symptoms only when one has got safely—or, more likely, very precariously—within the psychiatric universe, and to have to eschew such thinking when outside it. It seems inadvisable, therefore, to think in terms of a dimensional description of any form of personal, or psychiatric, illness. The reference group should be the general population, and this forces us into the use of categories.

When membership in a category is being determined by means of an inventory, a single affirmed item should be sufficient to place such a respondent in the category. Since, however, subjects may misread or misinterpret a few items, the size of any score represents the degree of likelihood of any such misinterpretations. It does not indicate severity of illness. One must, therefore, select a reasonable cut-off point with a view to minimizing error. Such a cut-off point should be the same for all clusters of items of equal length, regardless of distribution or of capacity to differentiate between criterion groups. The question one is trying to answer is: 'Does this subject have *any* state, *any* symptom, *any* delusion?'

Degree of distress experienced must contribute not to that, but to the degree of certainty that X has that symptom. Is this a reasonable assumption? X says he is unbearably distressed by feeling so low in spirits that he has sat for ages doing absolutely nothing. Y says he is a bit distressed by feeling so low in spirits that he has sat for ages doing absolutely nothing. Are we justified in concluding that X is more likely 'really' to have that symptom? Probably we are. Are we justified in concluding that X is more likely 'really' to be depressed? Almost certainly we are, and is not this what we are after? On the other hand, we would have no confidence that X with four delusions was more deluded than Y with three delusions; but a dimensional approach would require an affirmative answer.

If categories were to be forced upon us, the speculation of Kiloh *et al.* (1972) that 'endogenous depression has the quality of a categorical illness, whilst neurotic depression is an expression of a dimension of personality' (even apart from the switch from the 'illness' to the 'personality' universe) would be unacceptable. More acceptable would be the debate as to whether depressive symptoms (would that the disputants kept to that one universe!) are unimodally or bimodally distributed. Even if the point that the reference group should be the general population were rejected, Eysenck's (1970) claim that two dimensions are needed adequately to distinguish between neurotic

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and psychotic depression would be still more unacceptable, since symptoms of psychotic depression are very far from normally distributed even in a psychiatric population.

If we are to be concerned with categories rather than with dimensions, the important questions become: 'How many useful categories of depression are there?' If there are at least two, 'What is the relationship between them?'

Differentiation and Description

In a study by Garside *et al.* (1971), out of 15 items which distinguished between neurotic and psychotic depression only two were positive for neurotic depression. This result is very similar to that obtained by Foulds (1965). Garside's two items were 'precipitating events' and 'somatization'. The first is not a symptom, but a putative cause of a symptom. Neither is specific to neurotic depression. No one would make a diagnosis of neurotic depression on the basis of precipitating events and somatization. No characteristic has been unearthed without which one would *not* make a diagnosis of neurotic depression; but it is with just such characteristics that one must concern oneself if one's problem is the relationship between neurotic and psychotic depression. These characteristics must lie within the universe of symptoms and signs, and not in events or conditions antecedent to, or consequent upon, the development of such symptoms and signs. The category must first be identified by means of the necessary and sufficient conditions for placing any person in that category. Only then can one seek to discover characteristics which are descriptive of, but inessential to, membership of that category. Kiloh *et al.* (1972) have confused diagnostic differentiae with descriptive characteristics (Foulds, 1962). There is no dimension of personality in the absence of which one would refrain from making a diagnosis of neurotic depression.

The Hierarchy of Classes of Personal Illness

If, then, one is concerned with categories rather than with dimensions, Maxwell (1972) can be interpreted to mean either that *most* schizophrenics have some neurotic symptoms, *more* affective psychotics have some neurotic symptoms, and *all* neurotics have some neurotic symptoms; or, alternatively, that one can be *more certain* that all neurotics have some neurotic symptoms than one can that all affective psychotics have some neurotic symptoms, and *still more certain* that all neurotics have some neurotic symptoms than one can that all schizophrenics have some neurotic symptoms.

The first interpretation would constitute partial support for the hierarchy proposed earlier (Foulds, 1965)—all disintegrated psychotics have some of the symptoms of partially integrated psychotics and of neurotics; all partially integrated psychotics have some of the symptoms of neurotics; all neurotics have some of the symptoms of neurotics. Whether the second interpretation supported the hierarchy would depend upon the degree of certainty regarded as acceptable.

For the sake of the argument, let us suppose that the necessary and sufficient condition for making a diagnosis of psychotic depression—in the absence of symptoms or signs of disintegrated psychosis—be the presence of intropunitive delusions, and that the necessary and sufficient condition for making a diagnosis of neurotic depression—in the absence of symptoms and signs of psychosis—be the presence of a state (or prolonged mood) of depression. It would follow that all those who manifested intropunitive delusions would also manifest a state of depression; but not all those who manifested a state of depression would manifest intropunitive delusions.

Foulds and Caine (1959), in fact, had found that items to do with depressive affect, criticism of one's own functioning (being slower, less able to concentrate, etc.) and complaints of poor general health were affirmed frequently, but failed to differentiate between neurotic and psychotic depressives. These items were, therefore, descriptive of both groups of depressives; but they were not differentiae. Only delusions of guilt differentiated between the groups. There were no sub-scales or indices on which neurotic depressives significantly exceeded psychotic depressives. These results would, therefore, be in accord with the opinion of Kiloh *et al.* (1972) that 'neurotic depression is a diagnosis

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made by exclusion of the features of endogenous depression', and of Foulds (1965); but the latter would add that psychotic depression is a diagnosis made only after excluding the features of disintegrated psychosis.

In the illustration which follows attention will be confined to an 8-item inventory of intropunitive delusions and an 8-item inventory of state of depression. In the case of the delusions, any one of three degrees of certainty with which the belief is held could be affirmed; in the case of state of depression, any one of three degrees of distress could be experienced. Scores, therefore, ranged from 0 to 24 on each inventory. It was decided that a score of 5 or more gave reasonable confidence that the subject 'really' did experience, or 'really' did intend to convey that he experienced, some delusional belief or some mood of depression.

Thirty patients of mixed diagnoses performed as follows:

	SD 4−	SD 5+
ID 5+	1	10
ID 4−	7	12

ID = Intropunitive Delusions; SD = State of Depression

The theory demands that the north-west quadrant be void. In fact, only one patient (clinically diagnosed as a psychopath, the only one in the group) fell into that quadrant.

Of the 30 patients, 3 had been diagnosed clinically as Manic-Depressive, depressive phase, 1 as Manic-Depressive, phase uncertain, and 4 as Neurotic Depressive. They performed as follows:

	SD 4−	SD 5+
ID 5+		2 MDd
ID 4−	1 MD?	4 ND
		1 MDd

The patient who scored low on both indices scored high on State of Anxiety.

These tentative results lend some support to the view that the relationship between intropunitive delusions and a state of depression is an inclusive one, such that all those with intropunitive delusions experience a state of depression, but not all those with a state of depression experience intropunitive delusions. This finding, together with those of Foulds and Caine (1959), Foulds (1965), Garside *et al.* (1971) and Kiloh *et al.* (1972), all point to the likelihood of an inclusive relationship between psychotic and neurotic depression, such that all those with 'psychotic depressive' symptoms have 'neurotic depressive' symptoms, whereas not all those with 'neurotic depressive' symptoms have 'psychotic depressive' symptoms.

Summary

It is argued that we are forced into the use of categorical classification for all forms of psychiatric illness when we use symptom indices, owing to the markedly skewed distributions of such indices in the general population.

Re-examination of such published data, together with some new data, suggests that the relationship between neurotic and psychotic depression may well be an inclusive one, such that all those with psychotic depressive symptoms have 'neurotic depressive' symptoms, but not all those with 'neurotic depressive' symptoms have 'psychotic depressive' symptoms.

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