APA, williamspapers, DSM-III-R, box 1, DSM-III misc
major depressive DD

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Robert L. Spitzer, M.D.
Chairman
American Psychiatric Association Task Force
on Nomenclature and Statistics
722 W. 168th St.
New York, N.Y. 10032

Dear Bob;

Thanks for your letter of February 2 about the DSM-III criteria for depression. I am glad that Michael Feinberg and you have gotten together over the recent study which we reported in Lancet and which he will be presenting at the APA meeting in May. I am writing now to give you my personal thoughts on the issue and I am sure that what Michael communicates will be very congruent with my own comments.

The basic problem as I see it is that you have created a serious difficulty by intermingling two concepts which ought to be held totally separate. These are, the concepts of typology and severity. My emphatic view is that it is a serious mistake to have only one basic depressive typology or category. Based on our own clinical views, and supported by the emerging profile of laboratory markers, I believe that there should be two categories of depression. These should be endogenomorphic and non-endogenomorphic depression. For each you could then have severity ratings. Please note that I said non-endogenomorphic for the contrast group rather than neurotic or reactive. I think it is now very clear from the work of Leslie Kiloh, Donald Klein, Hagop Akiskal, and Peter Lewinson that the endogenomorphic (categorical) aspects of depression are quite orthogonal to the characterological or neurotic features.

Your basic entry criteria for "depression" approach the endogenomorphic variant but at the same time they are sufficiently different and sufficiently unspecific that they allow in a sizeable number of patients with non-endogenomorphic depressions. As I am sure you are aware, the St. Louis group are quite explicit on this point as far as their criteria (which are close predecessors of your own) are concerned (see Woodruff's book, pp. 6).

I don't know what your reasons can be for saying that the basic entry criteria for a major depressive disorder cannot be changed. I would hope that anything can be changed if there are good enough reasons.

For defining the endogenomorphic group I think that your present endogenous criteria are a good starting point. I also agree with your idea about the hierarchical value of depressive psychosis. At the same time I would suggest a few additional features for defining this category. They are: hypersomnia and weight gain for suspected bipolar subjects; positive family history of endogenomorphic depression (especially bipolar); a personal history of definite previous episodes and remissions (unipolar or bipolar); true pathological guilt (not simply demoralized self-reproach); dysphoric mood characterized as "empty" in addition to the other descriptors that you have listed.

For the definition of non-endogenomorphic depressions I think that a good starting point would be the criteria that Joe Schildkraut has been using for a long time and which he shared with me recently. I am sure that you will have seen them yourself also. His criteria focus on the subjective, psychological and cognitive aspects of depression but specifically omit the characteristic endogenomorphic features.

I would add the hierarchical stipulation that if the patient meets features of <u>both</u> non-endogenomorphic and endogemorphic depressions then the endogenomorphic label takes priority. The non-endogenomorphic features will then be noted because of their significance in affecting the response to treatment and the long term course of the individual patient (see Mendels and Cochrane, 1968; Akiskal et al, 1978).

Within each of the two major categories that I am suggesting you should then not have much difficulty in setting up criteria for severity. I would suggest that these be based on the usual clinical considerations: level of subjective distress; functional incapacity; suicidal pressure; psychotic features which are mood-congruent (and which should also include catatonia) and so on.

I am sincerely suggesting these changes to you with the greatest possible sense of urgency. I honestly believe that you will be buying yourself (and the rest of us) a lot of grief if you allow the unitary category of major depressive disorder to remain. I have no doubt that there <u>are</u> two distinct types of "depression" and that it is essential for clinicians to make the distinctions both for clinical practice and for research. Please give our suggestions your earnest consideration.

With best wishes.

Sincerely,

Bernard J. Carroll, M.D., Ph.D.
Director, Clinical Studies Unit
Associate Director
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BJC:rm

cc: Dr. M. Feinberg
Dr. D. Klein
Dr. J. Schildkraut