Original Contribution Kitasato Med J 2011;41:1-9

The subtype classifications and characteristics of chronic depression

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Background: Chronic depression has many features and atypical types and is one of the most important problems in psychiatric clinical medicine because it is often a depressive state that is prolonged despite the availability of appropriate treatment.
Objective: We examined the features of chronic depression and identified new atypical subtypes.
Subjects: A total of 36 patients, 26 women and 10 men, who visited the Department of Psychiatry, Kitasato East University Hospital, from September to October 2004, were included in this study. From these, we selected patients who were over 20 years old, had experienced continuous depression, and had recurring bouts of depression continuously for at least 2 years.
Method: We used a combination of assessment measures and a self-rating questionnaire.
Results: Our investigations led to the diagnosis of the three major types of depression within the larger depression category: borderline personality disorders accompanied by a depressive state, middle-aged and elderly dysthymia, and an adolescent-peculiar depressive state.
Conclusion: Psychoses can now be classified in many ways. In this study, we have reconsidered cures for the three major types of depression.

Key words: chronic depression, refractory depression, depressive neurosis, major depressive disorders, borderline personality disorder

Introduction

Every now and then, we hear it said in the media that, "Depression is the mind catching cold." This saying must have come from the understanding that depression will improve quickly if it is detected early and treated with therapies such as antidepressants. Typical depression used to be called endogenous depression, but the term major depressive episode has been frequently used in recent diagnostic criteria. Some degree of remission can certainly be expected if a patient receives appropriate immediate treatment and maintenance therapy for his or her first episode of major depression, but it is believed that even with treatment and therapy, the condition would persist in 25% to 30% of the patients.

On the other hand, there are quite a few cases that present with dysphoria, which differs from typical depression. There has been an increasing number of cases with unstable personalities that present with severe depression, as a reaction to ordinary events that do not seem particularly significant to others, which sometimes leads to self-inflicted injuries. It is not easy to induce remission of dysphoria in such cases, and the dysphoria frequently continues for years. Dysphoria had been given names such as neurotic depression and depressive personality, but there is no agreement on how to treat these psychoses in a clinical setting, as they are suspected of having a variety of clinical presentations and etiologies.

The objective of this study is to determine if there is a more specific therapy by clarifying the subtype classifications of patients with persistent dysphoria and their characteristics.

Subjects

The subjects in this study were patients who received treatment at the outpatient clinic of the Department of Psychiatry of Kitasato University Hospital between

Received 17 January 2005, accepted 8 February 2005
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September and October 31, 2004, who met the following conditions: (1) At least 20 years old; (2) Had a continuous feeling of depression or a period of at least 2 years during which the patient had constant repeated feelings of depression, even if the patient had a period during which he or she felt normal, it did not last for more than 2 to 3 weeks (established in accordance with the diagnostic criteria in the International Classification of Diseases [ICD]-10[1] for dysthymia); (3) Was not diagnosed with an organic disorder including symptomatic disorder, emotional and behavioral disorder caused by psychotropic substances, schizophrenia, schizophrenic disorder, delusional disorder, or mental retardation according to the ICD-10; (4) Written consent was obtained after being given oral and written explanations about the purpose of the study.

Methods

The physician in charge assessed the presence of personality disorder for relevant cases that fell into the period specified. The cases were assessed for personality disorders set out in the ICD-10, such as affective instability or compulsive, histrionic, avoidant, or dependent personality disorders. Furthermore, as a self-recording questionnaire, a 60-item General Health Questionnaire (GHQ60)[2] (to evaluate the severity and profile of the symptoms of neurosis), Self-rating Depression Scale[3] and Social Support Questionnaire (SSQ)[4] (to evaluate the level and quality of social support) were given. The study was explained to the subjects orally and in writing, and written consent was obtained.

This study was carried out with the approval of Hospital Ethics Committee B of the Faculty of Medicine of Kitasato University. Moreover, in addition to the findings from this study, the case records were added to the present study in consideration of the characteristics as follows. Consideration has been given wherever possible in recording the cases so that personal information is not apparent in parts that are not associated with the main objective of the study.

Background for the selection of subjects and Methods

Definition of chronic depression

The term chronic depression is used when depression lasts for an extended period of time, but cases where the depression has persisted even with appropriate therapy and those where the depression has persisted without any therapy should essentially be differentiated. On the other hand, according to the concept of endogenous depression that was used in the past, it was believed that a typical case would naturally achieve remission in 6 to 9 months without therapy. This fact also relates to how the term acute depression is normally not used even though there is the term chronic depression. Therefore, the concept that depression can be perceived across the board as chronic depression if it has continued for an extended period of time, regardless of whether or not it has been treated, can also be established. Cases were selected in this study following this concept, regardless of past therapy or appropriateness.

Duration of depression

The duration of depression is generally defined as over 2 years for chronic depression. This duration is also used in DSM-IV. Scott[5] reviewed reports in the literature from 1921 to 1974 and defined the duration to be over 2 years in 15% to 20% of the cases. Angst[6] also defined the duration to be over 1 year for 24.5% of cases of unipolar depression and over 2 years for 17% of cases of depression. Since diagnostic criteria change, there is a problem that the subjects in the studies are not uniform, but cases where depression persists for more than 2 years may be close to 20%.

Test results and case descriptions

In the past, the classification of depression changed constantly, and it is still being revised due to changes in the clinical picture of depression that involve new epidemiological data, the accumulation of biological evidence such as responsiveness to drug therapy, genetic predisposition, and social changes. The problems related to diagnosis that provided the setting for this study are as follows.

The term neurotic depression was frequently used to refer to the state of chronic melancholia in the past. An entry concerning neurotic depression in the ICD-9 states: "A neurotic disorder that follows a normally difficult/painful experience that is characterized by a condition of depression which is disproportionate to that experience. Its characteristics do not include delusion, but preoccupation with trauma (for instance, the loss of someone or something precious) that precedes the illness is frequently seen."

However, the DSM-III[7] released by the American Psychiatric Association in 1981 established a diagnostic criteria for all psychiatric illnesses that could be called operational, which established that all states of depression that have continued for more than 2 years and that were not severe enough to meet the diagnostic criteria of major

depression were to be defined as dysthymic disorders, and that it is nearest conventional neurotic depression. The symptoms of depression are emphasized in these diagnostic criteria, and there is no consideration given at all to the causes of the illness such as experience, personality or the life history of the patient.

Although there is an advantage to making a diagnosis with the symptoms alone, as there will be less inconsistency of a diagnosis by the persons making the diagnosis, information relating to the patient's life history that should be referred to will not be obtained. This is one of the reasons why the diagnostic criteria that came after DSM-III are criticized for eliminating personalized therapies for patients, even though they are useful for solving the problem of inconsistent diagnoses by the persons making the diagnoses. Classifications by Akiskal[8] based on triggers such as age of onset have subsequently influenced the development of the DSM, and the classification of chronic (melancholia) is still developing.

There is an underlying view in this study that an effective classification that leads to therapy cannot be made based on the DSM, which basically classifies the conditions using the symptoms alone. However, it is a fact that it becomes difficult to see the characteristics of the group as a whole by just examining a small number of cases. With that, the authors have classified the cases that met the comprehensive criteria by a certain standard, presented the findings of the symptoms of a number of cases in each group along with the data from the self-recording questionnaires, and then attempted to obtain information that was clinically pertinent.

Results

Case background

There were 36 cases, 26 women and 10 men. Age during the study period was an average of 47.1 years (standard deviation [SD] 14.9). Looking at age by sex indicates that, with women at 49.0 years (SD 16.0) and men at 42.2 years (SD 10.7), it was not significant.

Classification of cases and results

The 36 cases were first divided into 2 groups based on the presence (group A) or absence of complication by a personality disorder. Next, cases not complicated by a personality disorder were divided into 2 groups depending on whether or not the period of onset of the depressive state could be determined within a range of 2 months (undeterminable, group B; determinable, group C) and respective characteristics were studied. Sex, age, results of the self-administered questionnaire, etc. for each group are shown in Table 1.

There was no significant difference between the 3 groups regarding sex (x^2 test, P = 0.163), but group A was mostly female, group B was about 50%/50% and group C was mostly female. Average age was 38.0 years in group A: for groups B (44.6 years) and C (56.2 years), the age was higher (Kruskal-Wallis test, P = 0.007). The difference between group A and C was significant (Scheffe's multiple comparison, P = 0.006).

Average SDS scores, which serve as an index of the severity of the depressive state, for groups A, B, and C were 56.7, 51.5, and 45.0, respectively. A difference was noted between groups (one-way ANOVA, P = 0.017). And the difference between groups A and C was significant (Scheffe's multiple comparison, P = 0.018). Average GHQ scores, which serve as an index of the extent of neurotic symptoms, for groups A, B, and C were 42.4, 34.5, and 21.5, respectively. A difference was noted between the groups (one-way ANOVA, P = 0.009), and the difference between groups A and C was significant (Scheffe's multiple comparison, P = 0.011).

The SSQ assesses whether there are individuals who can provide support in one's surroundings by dividing them into 10 types of figures. Based on the questionnaire,

Table 1. Characteristics of each type

Classification	A	B	C	
Personality disorder	Having	Not having	Not having	All groups
Timing of onset	Possible	Possible	Possible	
Subjects (women/men)	11 (10/1)	11 (6/5)	14 (10/4)	36 (26/10)
Investigated age (years)	38.0 (9.5)	44.6 (17.0)	56.2 (11.9)	47.1 (14.9)
SDS score	56.7 (12.3)	51.5 (6.9)	45.0 (9.1)	50.6 (10.6)
GHQ score	42.4 (18.2)	34.5 (14.1)	21.5 (15.6)	31.8 (17.9)
SSQ score	5.3 (3.2)	7.8 (2.4)	6 (4.3)	6.4 (3.5)

assessment of the extent (SSQ score) to which individuals are aware of people who can provide support at 0-10 points indicated that scores were lowest for group A, although there was no significant difference between the 3 groups (Kruskal-Wallis test, P = 0.241). The complicating personality disorder in group A was affective lability in 9 cases, avoidance in 2 cases, and dependence in 2 cases (there were cases complicated by 2 or more personality disorders).

Other characteristics of each group

Characteristics that could not be fully assessed from the questionnaire are herein described. There tended to be many cases complicated by conditions such as bulimia and panic disorder in group A. Social adjustment was generally poor. Many patients had experienced separation from a parent in early childhood. Cases in group B had noticeably poor social adjustment such as being unable to hold a job or frequently changing jobs if they were employed.

Many of the cases in group C experienced onset after middle age, and many had a satisfactory social adjustment before the manifestation of a depressive state. Neurotic symptoms were not obvious. Cases in group C had a period in the past in which they were clearly diagnosed with major depression. Cases can be largely divided into 2 groups: cases where the depressive phase is considered to be prolonged (group C2), and cases where individuals with absolutely no problems in terms of social adjustment exhibited a depressive state after experiencing one of their life's most unpleasant events and where, as seen by others, the depressive state did not abate even during periods when the individual believed that problems relating to the event were resolved (group C1).

Presentation

As previously stated, assessment of mental disorders relying only upon scales and results of self-administered questionnaires result in a limited assessment. There are also views that assessment of cases is highly individualized and lacking a scientific basis, although it provides information that supplements assessment scales and results of self-administered questionnaires and is described in briefly subsequently.

Group A: Patients with a personality disorder or multiple disorders

(Case 1) Female in her early 20s, office worker

There were no remarkable illnesses in the family and no personal medical history. The patient lived with both parents and her older sister, although when she was 16, her parents divorced, after which she lived with her mother and sister. She began living alone upon graduating from junior college.

The patient was, as far as she can remember, already aware of the discord between her parents, and her father frequently did not return home. As a kindergartner, her mother had told her that her father not returning home was "because your father is staying at some other woman's house." During her elementary-school years, her grades were average, but she often complained of feeling ill, and she was absent about 30 days a year. When she did attend school, she often spent the day in the school nurse's office. Her absences decreased during her middle- and high-school years, but she often lamented about not being happy regardless of what she did and being unable to make friends. Even after entering junior college, she complained of being depressed by the littlest of things and was seen by a psychiatrist and underwent treatment. During her junior-college years, she exhibited a terrible attitude when talk of the break up with her boyfriend was mentioned. She cut her wrists several times with a kitchen knife.

After graduating from junior college, she was employed by a company and started living by herself in an apartment. She continued to work, but she continually complained of feeling depressed and feeling empty. At one time, she was able to make the same and opposite-sex friends, but she quickly became extremely dependent upon them, even so much as becoming a burden to them. Thus, when the other person acted to distance himself or herself from the patient, her feelings of depression worsened, and she repeatedly cut her wrists and overdosed on the medicine prescribed to her by her psychiatrist.

About 4 years have passed since treatment by a psychiatrist was begun. An antidepressant, fluvoxamine was prescribed when the patient was in a severely depressive state, and a mood stabilizer, sodium valproate was prescribed when the patient was highly impulsive such as when she cut her wrists. However, the depressive state persists, and the patient exhibits severe depression to the extent that it is sometimes accompanied by suicidal thoughts.

Group B: Patients with no complications of a personality disorder and in which the period of onset was difficult to determine

(Case 2) Male in his early 20s, office worker

Regarding the family medical history, the father did exhibit a depressive state, although there is no detailed information on it. There were no remarkable illnesses in

the personal medical history. The patient still lives with both his parents and younger brother. There were no particular problems in kindergarten and elementary school, although upon entering high school, the patient sometimes complained of not wanting to go to school for no apparent reason. He missed school for no apparent reason on 10 days of his second and third year of high school; although after graduation, he proceeded to a 4-year university. During his first and second year of university, he appeared healthy to others because of his enthusiasm in student social activities, although the patient himself reflects upon this time as being preoccupied with trying to rid himself of depressing feelings.

During his third year of university, while busy with graduation research, the patient's feelings of depression grew more severe, and he saw a psychiatrist. While receiving drug therapy and psychotherapy, the patient somehow managed to graduate from university and to begin working; although he consistently complained of being depressed, of tiring easily, and of not enjoying his work. He continued to complain of dissatisfaction with his company, saying that there was no work suited to him and that the company was not thinking about him personally.

Group C1: Patients with no complications of a personality disorder and in whom the period of onset could be determined (cases with no periods when they were diagnosed as having a major depressive disorder)

(Case 3) Female in her early 50s, education-related professional

There were no remarkable illnesses in the family or in her medical history. The patient married at 23 yesrs old, but her husband died of lung cancer when she was 48. The eldest daughter (30 years old) and second daughter (28 years old) both left home after getting married, and the patient currently lives alone.

After graduating from university, the patient started work related to teaching. Other than taking time off of work, before and after giving birth, there were no particular problems in the patient's life. Immediately after the death of her husband, the patient complained of feelings of depression even though she returned to work. About one year prior to being seen by a psychiatrist, problems arose with a close female friend at work concerning a male colleague. The patient felt betrayed by the close friend she had trusted until then. As of that time, slumps in her mood continued, and although insomnia and loss of appetite were sometimes noted, the patient did not take any time off work. After being seen by a psychiatrist, the patient's course was followed up with psychotherapy and antidepressant therapy. One year after being treated, her female friend left work due to circumstances not particularly related to the incident, and the male colleague was transferred. However, the patient's feelings of depression have changed little. Even though 3 years have passed since the manifestation of her depressive state, she says, "The problem I was initially concerned about no longer exists, but I don't feel any better." She is continuing to see her psychiatrist.

Group C2: Patients with no complications of a personality disorder and for whom the period of onset could be determined (patients with periods diagnosed as major depressive disorders)

(Case 4) Male in his late 40s, education-related professional

There were no remarkable illnesses in the personal or family medical history. After graduating from university, the patient worked in a technical profession and continued to exhibit no particular problems. Prior to graduation, the patient lived with both his parents; however, after starting to work, he lived alone. After getting married at 35 years old, he lived with his wife. A much-expected first child was born when the patient was 40, and he felt both joy and responsibility. In May about 2 years later, feelings of depression, feelings of worthlessness, loss of appetite, insomnia, etc. manifested with no particular impetus, so the patient saw a psychiatrist in September and was diagnosed with depression. At the time, her physician said, "You'll get better in 3 to 4 months if you take your medicine as directed and get some rest" (the diagnosis at the time was a major depressive episode, and the remark about the expected response to antidepressant therapy was confirmed by the treatment records of the time).

Treatment was begun, and feelings of depression quickly abated at first. Then, after about 2 months they were milder than they were prior to beginning the treatment. However, feelings of depression persisted, and they persisted for about 3 years despite occasionally abating. During that time, there were periods when the patient was given 3 types of antidepressants up to the maximum dosage, but the patient's symptoms remained relatively constant.

Considerations

Lingering major depression disorder

When depressive disorder cases are analyzed from the

point of view of chronic depressive disorder or a long-term depressive state, and there are not discussions concerning the causes of the disorder or the diagnosis itself, the cases tend to be diagnosed as major depression. Cases in which the depressive state is prolonged are classified in group C2. The evaluation measure and the self-administered questionnaire could not clearly differentiate between the cases of major depression that were diagnosed in a certain period and those which were not. However, taking a detailed look at the patients' medical histories, it is expected to easily hold onto this information; therefore, group C2 cases are in an independent subtype. Six of the 36 chronic depression disorder cases (19%) apply to group C2. Moreover, the cases that at least once had received proper antidepressant medication are also called treatment-resistant depression cases.

Treatment-resistant depression is usually defined by how the disorder is going to be treated and how long treatment will take, however, they are all dispersed definitions. According to the easiest (easily judged to be difficult to cure) diagnostic standard, treatment-resistant depression is the one that does not react to one type of tricyclic antidepressants. Also, there are the following definitions: "depressive state that lasts at least 6 months, and does not react to 2 kinds of antidepressants"; "does not react to 2 kinds of antidepressants, or does not react to 1 kind of antidepressant and to electroconvulsive treatment." These are some examples of definitions that combine the period of the depressive disorder to treatment methods and tend to make the standard stricter and more rigid. Considering, the period of a depressive state as a criteria, there are definitions that consider the minimum to be 2 years.[9]

Therefore, it is vital to recognize that the lingering of a depressive state of a major depressive disorder is part of a chronic depressive disorder. And when looking at a patient's medical history and it is discovered that the patient has not had the appropriate medical treatment, it is necessary to begin a proper antidepressant treatment.

Cases that combine personality disorder

Emotional instability was the personality disorder seen most often in group A patients. Moreover, avoidance and dependence were also manifested. However, because some of the cases considered as avoidance or dependence were diagnosed as emotional instability connected with a depressive state, emotional instability was the personality disorder most frequently pointed out.

Emotional instability (ICD-10) is described as "being accompanied with emotional unbalance," and its inferior classification, called the borderline type, is described as "having some characteristics of emotional disorder," "constant empty mood," "tendency to have very unstable relationships that can cause repeated emotional crises," "succession of suicide threats and acts of hurting oneself," and finally it is described as "it could happen without any kind of accelerator." In other diagnostic standards, emotional instability is called borderline personality disorder. Also, the DSM-IV10 (diagnostic criteria) of borderline personality disorder include other characteristics than those described in the ICD-10, e.g., "the disorder starts in the beginning of one's adulthood, and it becomes clear in various situations," "a continuous unstable self-image or sense of self," and "emotional instability due to over reaction of one's feelings."

The characteristics of a feeling of depression in those cases are fluctuation of feelings and emotions, coexistence of feelings of emptiness, suicide attempts, and frequent acts of hurting oneself. Regarding the suicidal behavior, Black et al.[11] reports that 75% of the people diagnosed as borderline personality disorder exhibits suicidal behavior and 10% committed suicide. Therefore it is not appropriate to think lightly of "suicide threats." Meanwhile, in all of the (diagnostic criteria) "inappropriate irritability and outbreak of anger" was reported, and a depressive feeling is always in the background of these symptoms. However, it does not necessarily mean that the patient is in a continuous state of depression.

Corruble et al.[12] reports that out of the cases that fulfill the diagnosis criteria of major depression, 20% to 50% of the inpatients and 50% to 80% of the outpatients fulfilled the diagnosis criteria of personality disorder. Disorders of group B were seen most often, and 10% to 30% were borderline personality disorders. There is a report that analyzed patients a considering borderline personality disorder, 85% of the patients suffered from combined mood disorders, and 62% suffered major depression.[13]

Patients who do not have personality disorders and never been diagnosed as having a specific period of major depression

How such cases have been diagnosed

Cases that are included in groups B and C1 are not diagnosed as manic depression or major depression as they are cases in which a state of depression persists. Those cases are diagnosed as depressive neurosis in both the DSM-II and the ICD-9. Therefore, it was necessary to analyze the relationship between a patient's personality and the environment in which the patient lives. Also,

psychotherapy was thought to be the most suitable treatment. Subsequently, the National Institute of Mental Health in the United States started a joint research project on the psychotherapy of depression's. In order to develop it, a research diagnostic criteria[14] was planned, and according to that, there are 2 other categories of depression. The first is called intermittent depression, which lasts at least 2 years. It is characterized by times of normal feelings between depressive states, however, most of the time, the person is suffering from depression. The other category is when the person does not satisfy the standard of an established form of depression, but that the feeling of depression continues. This category is therefore called, "quasi" depression.

In 1980 the American Psychological Association issued a DSM-III that took the discussion about the causes of psychiatric disorders out of the diagnostic criteria, which facilitated the diagnostic criteria to be used. In these criteria, people afflicted by the symptoms of depression for more than 2 years, but do not meet the standard of major depression are all considered to be suffering from a dysthymic disorder. In other words, the focus of the diagnostic criteria shifted from the cause of depression to its effects. Therefore, cases of group B and C1 that were formerly considered to be depressive neurosis, according to the recent DSM-IV diagnostic criteria, have to be diagnosed as dysthymic disorders. Furthermore, DSM-IV divides dysthymic disorder into other subgroups: early occurrence, if the people that contracted a dysthymic disorder are under the age of 21; and late occurrence, a dysthymic disorder at the age of 21 or elder.

Cases of middle-aged people

Regarding the contracting mechanism of depressive neurosis in middle-aged people, Yoshimatsu[15] says that it comes to the surface triggered by conflict neurosis that is usually brought on by an experience of loss. Before contracting depression, people tend to have a dependence-like personality and/or a narcissistic personality. In other words, triggered by a real and an emotional loss experience the person's defense system collapses, and together with this depression feeling, conflict neurosis occurs which is thought to aggravate the various neuroses symptoms. Furukawa[16] reports that there was a case of late occurrence of dysthymic disorder that began in the fifth decade, during a period of 1 year this person was stressed by taking care of his or her grandmother, and it was triggered by the death of the pet dog. This person contracted major depression and stayed in a depressive state for more than 7 years.

In the present study, as in group C1, the matters that occurred before the contraction of depression in the life history of the patient are considered as well as most of the neuroses symptoms seen before the on set of depression. Those depression cases were caused by an external event, therefore it is necessary to make use of this information for treatment.

Cases of young people

The analyzed cases that are included in group B are not combined with personality disorder, and neurosis symptoms are not remarkable, but the social adaptation skills of young people tend to decline with advances age. If a simple diagnostic guideline is adopted, those cases are considered to be dysthymic disorders, however, they tend to have more neurotic symptoms than do those in middle aged. They also tend to have not only depression but also a loss of interest and pleasure.

Kasahara[17] once took cases of university students' apathy in the foreground and called the depressive state peculiar to adolescents, "students' apathy" or "*taikyaku* neurosis." The main symptoms are apathy common to depression, but it is different from fretful behaviors or repression typical in depression. External events in the patient's social history that precede depression are not prominent and physical symptoms are seldom seen. As there are not many neurotic symptoms, and there are not worries as seen when having neurotic conflicts, it is necessary to put this condition into a different classification from the former one. Schneider[18] in the book "Psychopathic Personality" gives 10 different types of personality disorders, one of which is depression.

That depressive people have continuous depressive feelings in every life experience and are hopeless and pessimistic is well known. In the DSM-IV, however, a distinction is made. There was not an official term for this diagnosis, however, a special category was made. In this category, depression and personality disorders are included as diagnostic tools for future research. Also it is reported that it manifests in early adulthood because that is when there is recognition of depression and an extensive style of behavior. There are many issues related to the differences between depression and dysthymic disorder. In a depressive personality disorder the recognition of the disorder and personal relationships are emphasized, however there are some physicians who think it is meaningless to differentiate between them.

It is thought that the symptoms of major depression extracted from group B are similar to those. Medication treatment in those cases is not effective. While neurotic symptoms are not shown, there is a possibility that

psychotherapy may not produce the desired results either.

Classification of chronic major depression

The subjects in the present study were examined regarding the following points of view: whether or not the depression was combined with a personality disorder or disorders, and to what extend it is possible to specify the period of contraction. Thus, it was possible to classify the patient's condition into one of three types. Also, it was clear that cases diagnosed as major depression were included in the third type. Therefore, if those cases are put in a special category, then they could be divided into 4 types. One of the types is in group C2, and there is a period in which it can be diagnosed as major depression. These cases are called refractory depression and treatment-resistant depression and have been extensively discussed recently, however, clinically speaking, they are sub-categories of major depression. Personality disorder, especially the depressive state with borderline personality disorder (group A) is almost always being recognized nowadays. However, it is not clear how to classify it clinically, as both diseases could be a cause of each other, and also it is still not clear if they should be explained by their cause and effect relationship instead. Also, it is still necessary to discuss if both diseases have mutual causes or if this combination happened by chance.[19]

Most patients, that group applies to cases that do not combine personality disorders to depression, and these for whom it was difficult to specify the period when their depression was contracted (group B), are patients who contracted depression in adolescence. Patients in group C1, for whom it was comparatively easy to specify when depression was contracted, are middle aged. Both of the groups were traditionally called depressive neuroses. The second group leaves an impression that the relationships among personality and environment and neurotic conflicts are easier to appear in those patients. For them, it is necessary to have both antidepressant treatment and psychotherapy. The first group, however, does not show neurotic conflicts and is considered to be peculiar to adolescents.

In recent years the mass media talk about "detachment or isolation." This condition might be similar to what has already been mentioned above. Moreover, during this period there are frequent episodes of general loss of balance or harmony, therefore, this condition requires careful observation. Recently, there is an inclination in the field of psychiatry towards using antidepressants to treat patients suffering from all kinds of depression. However, at least for the types discussed in this study, it is mandatory to reconsider the methods of treatment.

Acknowledgment

The authors thank all the staff members of the Psychiatric Department of Kitasato University School of Medicine who cooperated with this research.

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