Prognostic effects of biographical data and differences between neurotic depressive, endogenous depressive and healthy subjects

K.-E. Bühler a, S. Geyer b, H. Haltenhof c, H. Bardeleben d

a Medical School Julius-Maximilians-University, Würzburg (D)

b Medical Sociology, Department of General Medicine, Medical School, Hannover (D)

c Department of Social Psychiatry and Psychotherapy, Medical School, Hannover (D)

d Institute of Sociology, University of Augsburg (D)

Summary


Biographical data are not significantly influenced by depressive mood and depressive cognition. For endogenous depressives there is no significant predictive effect of biographical variables on duration and outcome of therapy. However, neurotic depressives show a significant predictive effect of neuroticism and of aim-relatedness on changes of mood. There is no significant difference in the duration of inpatient treatment for neurotic and endogenous depressives. Neurotic and endogenous depressives do not differ in mean SDS-score at the beginning of inpatient treatment. Neurotic depressives show less improvement in depression but both types of depression show a significant improvement during inpatient therapy. The depressive groups show significantly higher scores on the scale “neuroticism” and significantly lower scores on the scale “aim-relatedness and unspecific motivation”, whereas the healthy controls show significantly lower or rather higher scores on those variables. Neurotic depressive subjects show significantly higher scores on “aim-relatedness and unspecific motivation” as well as a significantly higher “mean subjective stress index” whereas endogenous depressive subjects show significantly lower scores on both scales.

Keywords: depression; typology; personality; biography; life events

Introduction

Since the advent of DSM-III the diagnosis of affective disorders is a descriptive one without...
aetiological implications. The disadvantage of such a global classification is the wanting of intrinsic guidelines for a differential therapy with respect to psychotherapy versus pharmacotherapy. To improve this shortcoming, we suggest a tentative stipulation of a subtype of major depression which has a psychological aetiology. The features of this subtype relate to personality, biography and life events.

Personality variables show strong associations with vulnerability for depressive disorders. Hirschfeld et al. (1983) found recovered depressives more introverted, submissive and passive with increased interpersonal dependency compared to the normal population. According to Angst and Clayton (1986) unipolar depressives scored high in aggression and autonomic lability. Elevated levels of autonomic lability or of neuroticism were also found by Maier et al. (1992), Rorsman et al. (1993), Kendler et al. (1993), Clayton et al. (1994), Lauer et al. (1997), Surtees and Wainwright (1996), and Boyce et al. (1991). In addition to this personality trait, Maier et al. (1992) found elevated levels of rigidity and lowered levels of extraversion and frustration tolerance. Lauer et al. (1997) confirmed the elevated scores on rigidity. Also reported were – besides rigidity – lack of confidence (Surtees and Wainwright, 1996), affective personality traits, asthenia, subjective asthenic symptoms, a tendency to be easily strained and to ruminate (Rorsman et al., 1993), high interpersonal sensitivity (Boyce et al., 1991), lower emotional strength, resiliency, interpersonal dependency and increased thoughtfulness.

An important question is the differentiation by means of life events between different depressive disorders, i.e. between the so-called endogenous or rather psychotic subtypes on the one hand and reactive, neurotic and adjustment disorders on the other hand.

Investigations concerning this issue show contradictory results (Brown and Harris, 1989; Copeland, 1980; Costa e Silva, 1989; Katschnig, 1986; Sandermann, 1993). Some authors found no difference between endogenous or rather psychotic depressive disorders and reactive or neurotic depressive disorders (Benjaminsen, 1981; Brown and Harris, 1978; Brown et al., 1979; Forrest et al., 1965; Leff et al., 1970; Nanko and Demura, 1993; Paykel et al., 1969; Perris, 1984b; Thomson and Hendrie, 1972). But there are also investigations which show a difference in life events between endogenous and reactive or rather neurotic depressive disorders. Matussek and Neuner (1990) found less life events before the onset of endogenous depressive disorders compared with cases of neurotic depression. Similar results were presented by Wittchen and von Zerren (1988), Frank et al. (1994) and Brown et al. (1994). The temporal relation between a severe life event and the consecutive depressive period was more pronounced in neurotic than in endogenous disorders.

Bühler et al. (1999) found an influence of personality variables on life events. The number of life events, their mean subjective stress (i.e. the subjective stress divided by the number of life events), neuroticism and aim-relatedness (a dimension of the Biographical Questionnaire for Alcoholics; BIOQUEST-AL by Bühler and Bardeleben, 1996) are on a direct path of the LISREL-model strongly influenced by biographical data. That means the more negatively the primary socialisation is reported, the more life events, the higher their subjective stress (assessed by scale), the more neuroticism and the less aim-relatedness were communicated and vice versa. Neuroticism in the LISREL-model influences in a positive way strongly and aim-relatedness influences negatively in a medium way the number of life events and their subjective stress. That means the higher the neuroticism and the lower the aim-relatedness were reported, the more life events and the higher subjective stress were communicated and vice versa.

Hypotheses

In extension of our previous findings the aim of this study was to investigate the influence of biographical variables, personality variables and life events on short-term prognosis, i.e. the outcome of inpatient treatment. Further on the study examines the difference between neurotic depressive, endogenous depressive and healthy subjects concerning biographical variables, i.e. biographical scaled scores, personality variables and life events.

The following hypotheses were stated:

1. Depressivity does significantly change the reporting of biographic data.
2. Biographical scaled scores and life-event variables allow a prognosis of duration of treatment, of changes in SDS and AMS scores, and of clinical short-term prognosis.
3. Subtypes of depressive disorders differ in mean score of Self-Rating Depression Scale (SDS; Zung, 1965) and Adjective Mood Scale (AMS; von Zerren, 1986) in the course of inpatient treatment.
4. Neurotic depressive, endogenous depressive and healthy subjects differ in biographical scaled scores, personality variables and life-event variables.
Method

Sample: The patient group consists of a random sample of depressive subjects diagnosed both as major depression by SKID (1990; DSM-III-R, 1989; code: 296.2x, 296.3x) and according to ICD-9 as neurotic (n. D.; n = 50 Ss; ICD-9 code: 300.4) or as endogenous depression (e. D.; n = 50 Ss; ICD-9 code: 296.1). For German insurance companies psychiatric patients were diagnosed according to ICD-9. The diagnostic procedure according to ICD-9 is based more on clinical intuition and less on operational criteria. For this investigation clinical intuition is no disadvantage because the psychological aetiology is based on stipulation and the investigation has to prove if such a stipulation is useful. Stipulation is the first step of scientific elucidation. All diagnostic procedures in this investigation were carried out by the same person, the first author. Therefore the diagnosis is reliable concerning the stipulated criteria.

The neurotic and endogenous depressives were matched according to age (mean: 50.77 years), sex (female: n = 25 Ss; male: n = 25 Ss) and education (elementary school: 25 Ss; high school: 13 Ss, and university: 12 Ss). The 50 nonpsychiatric and non-depressive controls (SDS score: 26; AMS score: 7) were matched according to age, sex, and education too. The sample of the nonpsychiatric and nondepressive controls is based on the sociodemographic features given by the depressive samples.

The treatment was antidepressive drug therapy combined with an unspecific psychotherapeutic approach for both patient groups.

Questionnaires: The self-reporting questionnaires were used for the patient groups at the beginning of inpatient and – to assess the influence of depressivity on the reporting of biographic data – at the end of inpatient treatment. The interval between both tests was in the mean 40 days.

The “Biographic Questionnaire for Alcoholics” (BIOQUEST-AL, Bühler and Bardeleben, 1994, 1996) is constructed for a clinical population and consists of one biographic scale and two personality scales. Thus it is both a biographic and a personality questionnaire. Originally designed for alcoholics the BIOQUEST-AL shows sufficient reliability for depressive subjects too (Crohnbachs alpha: scale 1: .85; scale 2: .86; scale 3: .84). Since the BIOQUEST-AL scales have an impact on life events in depressives (Bühler et al., 1999) and life events have an impact on depressive disorders, this questionnaire was used in our study.

The questionnaire consists of 38 items forming three scales: unipolar scale 1, named “Neuroticism” or “Emotional Instability”, is characterised by depressivity, rumination, liability of mood, emotional disturbances, despair, hopelessness, anxiety concerning the future, resignation, anxiety concerning failure and insufficiency, low self-esteem, impression of uselessness, and isolation. Bipolar scale 2, named “Unfavorable versus Favorable Primary Socialisation”, is characterised by either rejection of the inharmonious (parental) home, severe type of upbringing, socialisation and education, little support by parents or by educators on the one hand or by trustworthiness of parents or educators and harmonious (parental) home on the other hand. Unipolar scale 3, named “Aim-relatedness and Unspecific Motivation”, is characterised by conventional achievement motivation, unspecific motivation, purposiveness, resolution, orientation to the future, planning of life, social contact, cooperation, self-esteem, ego-strength, and ego syntonia.

The BIOQUEST-AL scales reflect three fundamental dimensions which are important for clinical populations or samples. These fundamental dimensions relate to personality (i.e. neuroticism), to biography (i.e. primary socialisation), and to motivation. To avoid redundant variables, no further neuroticism scales were added.

The “Inventory of Life Changing Events” (ILE; Siegrist and Dittmann, 1983) combines an event list with respondent-based ratings covering the last two years. The interviewer reads through the list of 32 potentially stressful events, e.g. divorce, death events, accidents, illnesses, and two open categories to the patient. The number of life events (NLE) is an overall indicator for stress during the period in question. For every reported event 10 descriptive dimensions have to be completed by the respondent, namely predictability, controllability, situative vulnerability, subjective importance of an event, disruption of daily routines, active coping behaviour, two items of social support, “psychological costs” of event coping, previous experience with an event, and the degree of event-related distress present at the time of interview.

A “Mean Subjective Stress Index” (MSI) is computed by adding up the scores on a five-point scale over all descriptive dimensions and all events weighed by the number of life events.

The Self Rating Depression Scale (SDS, Zung, 1965) consists of 20 items which are rated according to frequency of occurrence on four-point scales. The item values are summed up and higher scores indicate higher degrees of depressivity.

The Adjective Mood Scale (AMS, von Zerssen, 1986) includes 28 polar items describing either positively or negatively mood states as reported.
by the majority of medical and, in particular, psychiatric patients. The Severity of Impairment Score (SIS, Schepank, 1995) which consists of three five-point scales (somatic, psychic, and social) was rated by doctors at the beginning and at the end of inpatient treatment. Further on the following sociodemographic variables were taken into account as background variables: age, sex, marital status (married, widowed, divorced, single), education (primary school, high school, college and university), and occupation (working, housewife, in education, pensioner, without occupation). All computations were performed by procedures of SPSS (1991).

Results

Influence of depressivity on the reporting of biographical data

To assess the memory bias of depressivity for biographical data the mean scores of BIOQUEST-AL scales, number of life events, MSI and chronic problems (CP) as well as the correlations of the six variables before and after inpatient treatment of depressive subjects were compared. There were no significant differences in scale 2 of BIOQUEST-AL (primary socialisation), of the number of life events, of the MSI and of the global score of chronic problems, whereas the differences of mean scores in scale 1 (neuroticism) and scale 3 (aim-relatedness) of BIOQUEST-AL were statistically significant (see table 1).

The scores of scale 2 ($r = 0.50; p < 0.001$) and 3 ($r = 0.37; p < 0.01$) of BIOQUEST-AL, the number of life events ($r = 0.83; p < 0.001$) and the global score of chronic problems ($r = 0.78; p < 0.001$) before and after inpatient treatment correlated significantly in a positive way whereas there were no significant correlations for scale 1 of BIOQUEST-AL and the MSI. Summing up, there was no significant memory bias of depressivity for biographical data (scale 2 of BIOQUEST-AL, NLE, MSI, and CP).

Prognostic effects of biographical data

To assess the prognostic effect of biographical data, a multiple regression was computed (procedure “Regression” of SPSS, 1991) with biographical data (BIOQUEST-AL: scale 1, 2, and 3; ILE: NLE and MSI) as independent variables and the duration of inpatient treatment (DT) and changes in measures of SDS, AMS, and SIS as dependent variables. For the endogenous depressives no significant predictive effect of biographical variables on duration and on outcome of therapy was found. The neurotic depressives show a significant predictive effect of the first and third scale of BIOQUEST-AL (see table 2) on the difference of AMS scores before and after inpatient treatment. The $t$ value of the first scale of BIOQUEST-AL is $-5.355$ (significant $+ 0.003$) and of the third scale of BIOQUEST-AL $-2.346$ (significant $+ 0.032$). This means: the higher the neuroticism and the higher the aim-relatedness of the subjects, the less the improvement of mood assessed by AMS.

The relation of neuroticism and improvement of mood seems trivial: the higher the neuroticism the more depressed the mood and the less improvement of mood is expectable. The interpretation of the relation of aim-relatedness to less improvement in mood is more complex. To understand the relation, it is necessary to know that subjects below the median for aim-relatedness show significantly higher scores on AMS, i.e. more depressed mood, than subjects above the median. The mean score of AMS for neurotic depressive subjects below the median for scale 3 of BIOQUEST-AL is 18.23 (AMS score) and of subjects above the median for scale 3 of BIOQUEST-AL is 16.79 (AMS score). The difference between both scores (above median 16.79 and below median 18.23) is statistically significant ($t$-test; $p < 0.05$). The range for improvement in mood is higher for

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Differences in mean scores before and after inpatient treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>t1</td>
<td>11.92</td>
</tr>
<tr>
<td>t2</td>
<td>6.42</td>
</tr>
<tr>
<td>sig. t-test</td>
<td>n.s. t-test</td>
</tr>
</tbody>
</table>

$t$-test, $p < 0.05$; n.s. = not significant; $t_1$ = begin of inpatient treatment; $t_2$ = end of inpatient treatment; BIOQ 1 = scale 1 of BIOQUEST-AL; BIOQ 2 = scale 2 of BIOQUEST-AL; BIOQ 3 = scale 3 of BIOQUEST-AL; NLE = number of life events; MSI = Mean Subjective Stress Index; CP = chronic problems.
subjects below than for those above the median of aim-relatedness and the subjects below the median of aim-relatedness improve more than those above the median. That is the reason why subjects with higher scores on aim-relatedness show less improvement in depressed mood than subjects with lower scores on aim-relatedness.

Differences between neurotic and endogenous depression

There is no significant difference in the duration of inpatient treatment for neurotic (41 days) and endogenous (39 days) depressive patients in t-test. Furthermore, these two groups do not differ in mean SDS score (53.35 vs 59.32; t-test; p <0.05; see table 3) at the beginning of inpatient treatment, but differ significantly at the end of inpatient treatment (45.10 vs 36.41; t-test; p <0.05; see table 3). Neurotic depressives show less improvement in therapy even if the difference in SDS score between the beginning (53.35), and the end of inpatient treatment (45.10) was statistically significant (t-test; p <0.05; see table 3).

The SDS score for endogenous depressives shows at the beginning of inpatient treatment 59.32 points and at the end of inpatient treatment 36.41 points. This difference is also statistically significant (t-test; p <0.05; see table 3).

Concerning the AMS neurotic and endogenous depressives differ neither significantly in mean AMS score (17.65 vs 20.01; t-test; p <0.05; see table 4) at the beginning of inpatient treatment nor at the end of inpatient treatment (14.61 vs 13.86; t-test; p <0.05; see table 4). Neurotic depressives show lower AMS scores at the beginning and higher AMS scores at the end of inpatient treatment than endogenous depressives and thus show less improvement in therapy (AMS score for neurotic depressives at the beginning 17.65 and the end of inpatient treatment 14.61; see table 4). The AMS score for neurotic depressives between beginning and end of inpatient treatment was statistically not significant (t-test; p <0.05; see table 4).

To assess the differences between the groups, a discriminance analysis was computed (procedure “discriminant” of SPSS, 1991). The canonical discriminant functions show a significant discrimination between the three groups (see table 5). According to diagram 1 the canonical discriminant function 1 discriminates between the two depressive groups and the healthy controls. Discriminant function 1 can be characterised (see table 6) mainly by the variable “neuroticism” of BIOQUEST-
The depressive groups show high scores on the scale “Neuroticism”, whereas the healthy controls show low scores on this variable. Discriminant function 2 discriminates between the depressive groups (see fig. 1) and can be characterised (see table 6) by the variables “Aim-relatedness and Unspecific Motivation” of BIOQUEST-AL and MSI of ILE. Neurotic depressive subjects show high scores on “Aim-relatedness and Unspecific Motivation” as well as a high MSI whereas endogenous depressive subjects show low scores on both scales.

Discussion

Influence of depressivity on reporting of biographical data

Contrary to common opinion the reporting of biographical data is not significantly influenced by depressive mood and depressive cognition, i.e. a significant change in mood has no significant influence on the recalling of events and of memories of events.

Concerning the MSI the correlation of the scores before and after inpatient treatment is not significant though the mean scores do not differ significantly. Some items of subjective assessment of life events by some subjects may change in an opposite way before and after inpatient treatment and for that reason the global degree of subjective stress remains the same. This means that mood does not influence the global score of MSI but some items for the assessment of subjective stress of life events. A reliable report of experienced biographical data is the presupposition for further investigation.

Prognostic effect of biographical data

A further result of our investigation shows that biographical data in a strict sense are no significant overall predictors by multiple regression for the duration of inpatient treatment, for changes in depressivity as well as in mood states, and in severity of impairment. But there is a prognostic effect for neurotic depressives of neuroticism and of aim-relatedness on mood changes. The higher the scores for neuroticism and for aim-relatedness, the less the changes in mood during inpatient treatment. The reason for this seemingly inconsistent finding is that neuroticism is an indicator for resistance to changes in mood, aim-relatedness, however, is an indicator for less latitude to changes, i.e. subjects with high scores on aim-relatedness have less potential for improvement because they are not so seriously disturbed.

The cause of the disappointing short-term prognostic effect of biographical data may be either a prognostic inefficiency of biographical data, autonomous biological processes in major depression, or a levelling influence of antidepressive drugs, i.e. their influence exceeds that of biographical variables. That both psychotherapeutic and psychopharmacological interventions were not considered in detail is no shortcoming of this study because the treatment of depressive disorders did not differ principally with respect to different subtypes of depression.

Before a predictive nihilism results as a consequence of our study, both more sophisticated biographical inventories are needed and the prognostic horizon should be widened to long-term prognosis including relapses and chronification, and last but not least an additional differentiation in major and minor depression as well as in dys-

Table 5

<table>
<thead>
<tr>
<th>function</th>
<th>Eigen-Value</th>
<th>percentage of variance</th>
<th>cumulative percentage</th>
<th>canonical correlation</th>
<th>after function</th>
<th>Wilks’ Lambda</th>
<th>Chi-square</th>
<th>degrees of freedom</th>
<th>significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>0.8225</td>
<td>83.66</td>
<td>83.66</td>
<td>0.6718</td>
<td>1</td>
<td>0.8616</td>
<td>20.259</td>
<td>4</td>
<td>0.0004</td>
</tr>
<tr>
<td>2*</td>
<td>0.1606</td>
<td>16.34</td>
<td>100.00</td>
<td>0.3720</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* marks the two canonical discriminant functions remaining in the analysis

Table 6

<table>
<thead>
<tr>
<th>discriminant function 1</th>
<th>discriminant function 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIOQ 1</td>
<td>0.67202</td>
</tr>
<tr>
<td>BIOQ 2</td>
<td>0.00706</td>
</tr>
<tr>
<td>BIOQ 3</td>
<td>-0.29865</td>
</tr>
<tr>
<td>NLE</td>
<td>0.11722</td>
</tr>
<tr>
<td>MSI</td>
<td>0.23480</td>
</tr>
</tbody>
</table>

| BIOQ 1 = scale 1 of BIOQUEST-AL; BIOQ 2 = scale 2 of BIOQUEST-AL; BIOQ 3 = scale 3 of BIOQUEST-AL; NLE = number of life events; MSI = Mean Subjective Stress Index.
thymic and adjustment disorders should be introduced. Biographical variables may show a higher impact on the improvement of the disease in a psychotherapeutic setting without treatment by antidepressive drugs. Such a procedure is possible for patients with lower scores in depressivity, minor depression and dysthymic and adjustment disorders but not for major depression which needs treatment by drugs in addition to psychotherapy.

Differences between neurotic and endogenous depression

The two groups differ significantly at the end of inpatient treatment, i.e. neurotic depressives show less improvement in therapy even if the difference in SDS score between the beginning and the end of inpatient treatment was statistically significant. Neurotic depressives also show lower AMS scores at the beginning and higher AMS scores at the end of inpatient treatment than endogenous depressives.

According to discriminant analysis there is no significant difference neither in the number of life events nor in the biographic scale between neurotic and endogenous depressives, a result which is in accordance with Benjaminsen, 1981; Brown and Harris, 1978; Brown et al., 1979; Forrest et al., 1965; Leff et al., 1970; Paykel et al., 1969; Perris, 1984b; Thomson and Hendrie, 1972.

Concerning the biographic scale in a strict sense our results are not correspondent to findings in the scientific literature. Parker (1979) found that neurotic depressives reported less parental care and greater maternal overprotection. Parker (1983) also communicated that in discriminant analysis low parental care scale scores best discriminate depressives from controls. He concludes that the “Parental Bonding Instrument” delineates and quantifies a risk factor to certain grades of depressive experience. Parker (1993) confirms the findings that nonmelancholic depressives are more likely to report their parents having been uncaring and more protective. Similar findings were reported by Perris et al. (1980; 1986) namely that love-depriving upbringing might be an important psychological variable in the background of depressive disorders. Emotional warmth and overprotection discriminate depressed patients and in particular unipolars from controls. They assumed that rearing practices which deprived the child of love might be an important risk factor predisposing to depression. Holms and Robins (1988) found a strong relationship between reports of harsh and unfair punishment during childhood years 6 to 13 and the adult diagnoses of alcohol abuse and/or dependence and of a major depressive episode. The sex of the child suffering harsh treatment might be a determinant of which diagnosis evolves: depression for female subjects and alcoholism for male. The Zurich Study (Ernst et al., 1992) shows that later depressives communicate slight differences in their relationship to parents, i.e. the parents were described as uncaring and punishing. According to Kendler et al. (1993) the lack of parental warmth has an impact on major depression.

Even if there is no difference between neurotic and endogenous depressives in the biographic scale in a strict sense there is nevertheless a difference between both groups: the neurotic depressives show a higher degree of impairment by life events. This may be caused by
different emotional or cognitive evaluation of the life events. Neurotic depressives may be more embarrassed by life events. The evaluation of life events may be mediated by intrusive cognitions generated by that event (see Spurrell and McFarlane, 1995). The MSI could be an indicator for such intrusive cognitions in neurotic depressives.

A further characteristic of neurotic depressives is a higher score on scale 3 of BIOQUEST-AL, i.e. they show more resolution and more aim-relatedness, more orientation to future, more self-esteem and more ego-strength.

It could be thought that both depressive groups differ in severity of depression and that this should be the reason for the differences between neurotic and endogenous depressives. But this is not the case because the groups do not differ significantly in SDS scores at the beginning of inpatient treatment. Our results are in this respect more in accordance with those of Matussek and Neuner (1990), Wittchen and von Zerssen (1988), Frank et al. (1994), and Brown et al. (1994) which report differences in life events between both depressive groups.

As a therapeutic consequence of our results, additional to drug therapy activation and training of basic skills, for example, in ergotherapy, it is suggested to improve deficits in aim-relatedness and unspecific motivation of endogenous depressives.

To decrease the impairment of neurotic depressives by life events, psychohygienic procedures, systematic desensibilisation of their subjective stress, Autogenous Training or meditative procedures should be introduced. Last but not least counselling seems to be a further and important procedure to decrease the impact of life events on depressive patients.

Because endogenous depressives show lower aim-relatedness and neurotic more impairment by life events and lesser improvement in therapy during inpatient period with a higher tendency to chronicisation (higher scores in depressivity at the end of inpatient treatment), the study shows that the construct of neurotic depression makes sense, even if it needs further clarification and additional operational criteria to reliably diagnose “neurotic” depression, because the diagnostic criteria of ICD-9 concerning neurotic and endogenous depression are not reliable enough and need improvement. The traditional construct of neuroticism does not differentiate between subtypes of depression because it seems to be a common trait of depressive disorders in general. To improve the criteria, an automatic classification according to biographical criteria is required. The hypothetical result of that classification may be a typology of depressive subjects which can be described as a personality- and/or biography-bound subtype by operational criteria and which show a better predictability of depressivity by biographical variables and a higher tendency to chronicisation. To prevent chronicisation, psychotherapy should be required for that subtype of depression.

This personality- and/or biography-bound subtype of depression is created by definition, it is based more on an analytical than on an empirical judgement, and as such – analogous to a classification – it cannot be regarded as empirically true or false but as useful and as such it covers cases which show an empirical importance. The empirical importance of such an operational definition of subtypes of depression could be a better predictability of their course and a more successful prevention of chronicisation.

References


Bühler KE, Bardeleben H. Biographic Questionnaire for Alcoholics (BIOQUEST-AL). In: http://rzsun02.rrz.uni-hamburg.de~kriminol/ts/tspsy.htm (chapter psychology; three texts by Bühler KE, Bardeleben H); 1996.


