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The Management and Nature of Depressive Illnesses in Late Life: A Follow-Through Study

By FELIX POST

Aims of the Investigation

Since the long-term results of the treatment of elderly depressives admitted to the writer's care between 1949 and 1951 were communicated (1962), further experiences (e.g. Colwell and Post, 1959; Post, 1968) have confirmed that affective illnesses in late life are associated with much subsequent mental invalidism and needs for further treatment. It was hoped that these needs might be met by increased use of out-patient and community care as well as by the introduction of thymoleptic drugs. A follow-up investigation of a further consecutive series of depressives over the age of 60 receiving in-patient treatment from the same psychiatrist in the same hospital during the years 1966–67 was undertaken with the following aims in view:

Firstly, it was intended to test the proposition that the less reluctant use of electro-convulsive therapy in old persons, as well as the introduction of antidepressant drugs and of more active after-care measures, had improved the long-term outlook in the affective illnesses of late life. It was realized that a comparison of two series of patients separated from one another by some 15 years might be vitiated by differences between the samples other than those due to changed methods of treatment. It would, however, have been unethical to withhold the new forms of management from a control group.

Secondly, therefore, only a limited therapeutic experiment was undertaken: Two sub-samples were drawn from the patients of the recent series; one was offered a routine follow-up service, while the other one was to receive specifically planned and actively pursued after-care.

Thirdly, during the planning stage of the investigation, the perennial controversies concerning the classification of depressive syndromes had entered a new phase (summarized by Kendell, 1968 and Slater and Roth, 1969). Earlier attempts (1962) at differentiating distinctive syndromes of affective illness in the elderly, characterized by differences in aetiology, symptomatology, response to treatment and long-term prognosis had failed; but in the light of current publications it was decided to score the case records of patients in the present series on the Newcastle Scale (Carney *et al.*, 1965), and to utilize for a further investigation of classification findings which had not been obtained at a single interview (as had usually been the case in other studies) but as the result of all accumulated information.

Methods and Results of the Investigations

(1) *Comparison of long-term outcome of elderly depressives treated between 1965 and 1967 with the earlier series*

The later sample consisted of 92 depressives over 60, consecutively discharged from the writer's care as in-patients. Absence of cerebral disease or deterioration had been confirmed at discharge conferences. The progress of these patients was assessed by a social worker 18 months after discharge, and the writer attempted to discuss this further with the patient's family doctor over the telephone. This procedure was repeated 36 months after the patient's discharge, but on this second occasion the writer set out to conduct a follow-up interview with the patient. On both occasions the social worker was required to record information on the following items: Community services used; changes in domestic set-up; relationships within the family; relationships outside the family circle; domestic activities (or performance at work where still applicable); and finally, symptomatology, an item which was supplemented and rated from hospital records. (Many patients had also been seen by the writer in his clinic in between the follow-up dates). The follow-up procedure was reasonably successful, as may be seen from Table I.

TABLE I

Method of follow-up

Successfully followed, both by social worker and psychiatrist personally, over three years	66
Personal follow-up by social worker only	4
Personal follow-up by psychiatrist only	4
Seen during follow-up period, but final contact postal* only	15
Postal* follow-up only	2
Lost from follow-up (at 22 months)	1
	92

* Includes reports from Doctors and Hospitals.

As feared, the recent sample of 92 patients and the 1950 sample of 81 elderly depressives without evidence of cerebral disorders were not otherwise comparable. During the intervening years, an increasing proportion of patients of the Bethlem Royal Hospital came to be admitted from the area of South London for which the hospital had accepted district responsibility. Probably related to this, the proportion of patients belonging to the semi- or unskilled classes had increased from 13·0 per cent in 1950 to 25·0 per cent in 1966, a change which just failed to be statistically significant. There were other differences in sex and age distribution, as well as a heavier incidence of external factors in the later sample, which might be regarded as prognostically unfavourable, but which did not exceed chance expectation. The most striking difference between elderly depressives admitted to hospital around 1950 and those becoming in-patients around 1966 arose from changes in their managment: During the earlier period, there were fewer out-patient facilities, and no specific remedies which could be used by family doctors with confidence. Accordingly, only 14·8 per cent of patients had had treatment for their current depressions before admission. By 1965, this proportion had increased to 60·9 per cent, a highly significant change ($p < \cdot001$). This suggested that patients requiring in-patient treatment during the more recent period formed a sample from which those with the most favourable short-term prognoses had been removed.

As expected, considerable changes in treatment after admission to hospital had occurred during the intervening 16 years (Table II). Around 1950, 46·9 per cent of patients were given support, occupational therapy, and psychiatric social work as the only forms of treatment, while only two patients (2·1 per cent) of the later series received these 'non-specific' therapies, only. Tricyclic anti-depressant drugs were, of course, unknown in 1950, but were employed in 59·8 per cent of patients of the 1966 series. However, there was no concomitant decrease in the use of electroconvulsive therapy. This was received by 51·9 per cent of patients at the earlier period, and by 52·2 per cent in 1965–67 (34·8 per cent received anti-depressant drugs as well, either before or after ECT). Additional forms of treatment were received by only one patient around 1950 (leucotomy). In the later sample also one patient was leucotomized, but a further 19 received other forms of additional anti-depressant therapies (monoamine oxidase inhibitors or lithium salts).

TABLE II

Therapies employed during initial hospital stays in the case of patients admitted around 1950 and 1966 respectively

Treatment during initial period in hospital	Proportion of patients	
	1950 (N=81)	1966 (N=92)
Supportive, occupation and social therapies, alone	46·9	2·1
Additionally, with electro-convulsive therapy	51·9	17·4
Additionally, with tricyclic drugs	—	31·5
Electroshock and tricyclic drugs, both successively used	—	28·3
Combination of these with other anti-depressive therapies	1·2	20·7
	100·0	100·0

An exhaustive presentation of the much increased further treatment experiences of the later series of patients might prove confusing, and a comparison with the earlier sample is given in a simplified form in Table III. During the six years following discharge in 1949/51, only 25·9 per cent received further specific therapies for an affective disorder, as against 93·5 per cent of the later series (in the course

of three years). From this may be subtracted 17·5 per cent of patients who eventually managed without anti-depressant medication, various kinds of which were required intermittently or continuously by the rest. The further additional use of ECT was resorted to more frequently (albeit to an insignificant extent) than during the earlier period.

TABLE III

Therapies employed after discharge from hospital around 1950 and 1966 respectively

Treatments applied during follow-up period	Proportion of patients	
	1950 (N=81, over 6 years)	1966 (N=92, over 3 years)
None for affective disorder ..	74·1	6·5
Tricyclics, eventually stopped ..	—	17·5
Tricyclics, intermittently ..	—	25·0
Tricyclics, continuously	—	13·0
Electroconvulsive therapy ..	12·3	19·6*
Other (usually additional) therapies	13·6	18·4
	100·0	100·0

* All but two of these patients also received anti-depressants.

It will be recalled that the 1969 sample of patients almost certainly contained more persons with persistent affective disorders than the earlier series. Any comparison of outcome (in the hope of demonstrating an improvement related to the introduction of new methods of management and treatment) was therefore affected by differences in prognosis likely to have existed between the two samples. In spite of this the initial period of in-patient stay was shorter around 1966: only 41·0 per cent remain in hospital for more than three months, as against 77·7 per cent in 1949–51. On the other hand, in the subsequent three years rather more patients (42·4 as against 33·3 per cent) had to be readmitted. Long-term outcome was assessed in various ways, using the same methods as in 1962. Comparison in terms of further symptomatology is shown in Table IV, and the progress of patients belonging to the first and second samples were also compared in a more global fashion. There was an impression that really good or really bad outcomes were rarer after treatment in 1965–67, and that intermediate results were more frequently achieved, but these trends fell considerably short of achieving statistical significance. Social adjustment during the follow-up period was remarkably similar in both samples. In view of the special difficulties in making retrospective comparisons in this area, too much should not be made of the finding that in the later sample 74·1 per cent continued to be usefully active (domestically or at work) as against only 40·5 per cent of the first series (followed up twice as long). It was disquieting to discover than seven patients in the recently followed sample made suicidal attempts after their initial period of in-patient treatment, and that these had proved successful in three cases (suicide as cause of death was confirmed in only one case of the earlier series with twice as long a follow-up; only three patients made attempts).

TABLE IV

Comparison of long-term symptomatology in two samples of elderly depressives

Long-term outcome	Proportion of patients	
	1950 (over 6 years)	1966 (over 3 years)
Lasting recovery	30·8	26·1
Further attacks with good recoveries	28·4	37·0
Some degree of depressive individism, usually with further attacks	23·4	25·0
Continuously ill	17·4	11·9
	100·0	100·0

Turning to a comparison of prognostic factors, definite evidence for the fresh incidence of cerebral disease or deterioration had occurred in 25·9 per cent of 81 patients in the earlier series (eight years' postal follow-up); this compares with an incidence of 6·5 per cent of 92 patients in the present series followed over only three years. The earlier figure was regarded (1962) as not significantly different from the 'expected' incidence of cerebral disorders in the non-psychiatric general population of the same

age structure, and the present figure confirms the now generally accepted view that depressive symptoms in late life are only rarely prodromal signs of dementing processes.

Duration of unrelieved depression for more than two years before admission had been a significantly unfavourable prognostic indicator in the earlier study. In the present series this was present in only one of eleven patients with the best outcome, but in 7 of the 11 with worst outcome. However, long duration of depression before admission did not prove to be a reliable predictor for the great majority of patients pursuing (as we saw) intermediate courses. Full remission at the time of discharge had been a favourable prognostic sign, but was not relevant in the present sample, as many patients were discharged while still receiving anti-depressant medications. Instead, prognostic predictions were made at the discharge conference, using in addition to the patient's mental state some of the previously suggested predictive factors. However, the casting of a largely favourable prognosis turned out to have been mistaken in 47 per cent, and of an unfavourable only in 71 per cent of cases! The favourable import of a definite family history of affective illness (indicating the presence of a more classical manidepressive disorder) was not confirmed, but, as in the previous study, age over 70 was on the whole associated with a less favourable outcome ($p < \cdot 01$), as was the appearance of disabling physical illnesses ($p < \cdot 05$). These two adverse factors are undoubtedly interrelated, but it should also be noted that 12 of 30 patients did quite well in spite of being over 70, and that the presence of intercurrent disease failed to affect mental health seriously in 9 of 23 patients.

(2) *Comparison of two kinds of after-care*

It had been hoped to demonstrate that a more intensive surveillance of patients in the years following hospital treatment would have a beneficial effect on their mental health and general adjustment, because maintenance therapy would be carried out more effectively, social stresses might be alleviated earlier, and relapses occurring in spite of these efforts might be treated at an earlier stage. On account of staffing difficulties, intensive surveillance by psychiatric social workers of patients forming an experimental group (in comparison with a matched control group receiving only routine after-care) could not be uniformly carried through, and this part of the investigation will be described only briefly.

Experimental subjects were to be contacted by the psychiatric social workers attached to the geriatric in-patient service every four months in an attempt to discover signs of relapse at an early stage, unless, of course, the patients were known to be receiving psychiatric attention. Under these circumstances, any patient failing an out-patient appointment should have been encouraged to attend. In the case of the control group, follow-up appointments were given after discharge from in-patient treatment as often and as long as clinically indicated, but failure to keep appointments would not result in further action and patients were not contacted every four months. In the event, intensive surveillance was not carried out as planned in 23 of the 40 experimental patients. In spite of this the average number of PSW contacts per patient (3·6) was considerably higher ($p < \cdot 001$) than that experienced by members of the control group (·5). This did not, however, result in a greater use of various social services by members of the experimental group, who were also not seen more frequently than their controls by family doctors or psychiatrists; neither did experimental subjects spend less time in psychiatric hospitals during the three year follow-up period, nor did they receive more varied therapies as out-patients.

(3) *The classification of depressive illnesses in late life*

At a time when all patients had been admitted to the research, but the results of the three-year follow-through were not yet known, their case notes were examined, and in accordance with the method described by Carney *et al.* (1965) Diagnosis Scores were allocated on the Newcastle Scale. Although it suggested trimodality (see Fig. 1), the distribution of scores (with a mean of 3·86) was found not to differ significantly from a normal one ($\chi^2 = 11 \cdot 3$; using eight degrees of freedom). To test the possibility that scoring from case notes rather than immediately

after a personal assessment in this sample of 92 patients had affected the distribution of scores, it was compared with that of Diagnosis Scores in 49 consecutive elderly depressives admitted to the same unit and rated at admission conferences by two psychiatrists in the course of another research (Cawley *et al.*, in preparation). The mean score of this sample was very similar (4·02), and the distribution again did not differ significantly from a normal one.

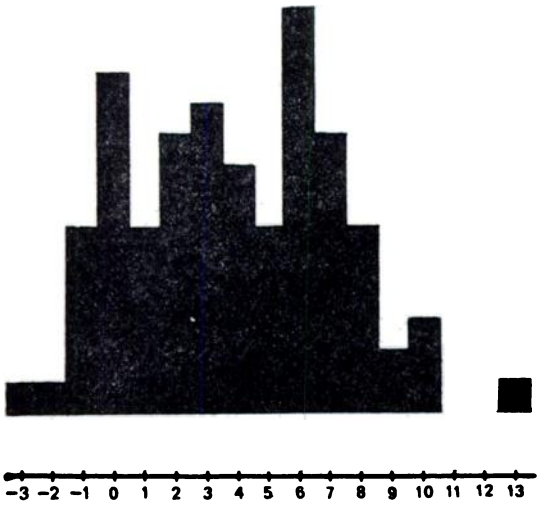

FIG. 1.

As was found by Kendell and his fellow workers (1968, 1969, 1970) in their investigations of younger depressives, only few patients in our two samples aged over 60 could be classified as clearly belonging either to a neurotic depressive group characterized by low, or to an endogenous group with high Diagnosis Scores. But the clinical pictures presented by the patients differed in a more varied fashion, chiefly in terms of a small number of the more clearly definiable items of the Newcastle Scale. Where patients were rated as exhibiting 'depressive psychomotor activity' (retardation or agitation), as well as 'distinct quality of depression' (as against the phenomena of ordinary sadness), their depression was classified as 'severe'. It was called 'mild', when only one of these two features was present. Overt depression was rated as absent, if neither of them were noted. Other unambiguous and clear-cut items of the Newcastle Scale were nihilistic, somatic, and paranoid delusions, as well as feelings of guilt. It was possible to classify patients in these terms of depressive mood disorder and mental content as shown in Table V. It will be seen that these groupings of patients by diminishing depression, and delusional as well as self-derogatory thought content, are reflected in their mean Diagnosis Scores. This is due to the positive values carried by depression as a 'distinct quality' (Carney *et al.*, 1965), by depressive motor activity, by delusional content, and by preoccupations of guilt. All these features were completely absent in members of group F with the smallest mean Diagnosis Score. These patients came to require in-patient care for states characterized by poor sleep and appetite, loss of interest in outside matters, and also by non-delusional preoccupations with unpleasant internal physical sensations, tensions, and anxiety. Their condition tended to be similar to that shown by members of group E, who had, however, exhibited either 'distinct quality' depression or some depressive thought content. Numbers were too small for a meaningful comparison of these six groupings, but it seemed to make clinical sense to combine patients in groups E and F and to label them

TABLE V

Classification of patients in terms of salient features of their mental states

Clinical picture	N	Mean Newcastle diagnosis score
A. Severe depression with delusions and/or guilt ..	27	6·78
B. Severe depression without delusions or guilt	7	5·43
C. Mild depression with delusions and/or guilt	14	4·79
D. Depressive delusions or guilt without overt depression	8	2·75
E. Mild depression without either delusions or guilt ..	16	2·00
F. Neither overt depression nor depressive thought content	20	0·65

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descriptively as 'neurotic depressives'. At the other end of the continuum, groups A and B will be discussed as 'severely psychotic depressives', and the intermediate group C plus D was formed by a somewhat smaller number which we shall call 'intermediate depressives'. The distributions of Newcastle Diagnosis Scores within each of these three groups is shown in Fig. 2, and it will be seen that there is still a considerable amount of overlap. All the same it seemed appropriate to investigate whether these clinical groupings reflected the existence of two or perhaps three syndromes (using the term in the same way as Garside *et al.*, 1971). Patients in the three groups were accordingly compared in terms of a number of fairly easily defined variables of their mental states and of their previous personalities, as well as in terms of more problematical aetiological factors; finally, long-term outcome was related to clinical grouping. Only those variables are selected for presentation which at first sight had seemed to be unequally present in patients of the three clinical groups, or which were perhaps of particular interest.

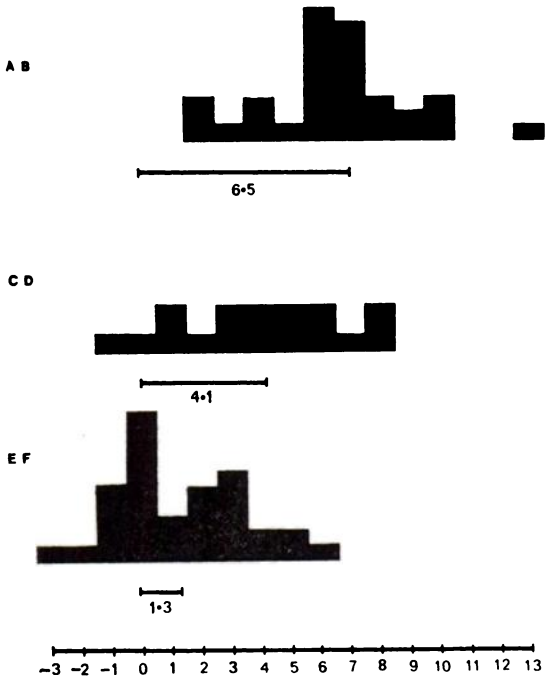

FIG. 2.

Only one patient belonging to the Severely Psychotic group exhibited during the initial period of in-patient observation histrionic and complaining rather than self-blaming attitudes (Table VI). These features were present in a larger number of patients of the Intermediate Depressive, and in nearly half the members of the Neurotic group. Though the presence of symptoms which are sometimes rather loosely termed 'hysterical' differentiated the three groups at a highly significant level, it should be noted that 'psychotic' patients were by no means free of these 'neurotic' features. Anxiety is another affective disturbance which is often and mistakenly regarded as a neurotic phenomenon. Significantly fewer patients labelled Severely Psychotic exhibited this disturbance when compared with patients in the two other groups taken together; all the same, anxiety was recorded as present in nearly half of the Severely Psychotic patients (also, Table VI). But it has to be admitted that in this type of patient it was more difficult to ascertain the presence of psychic anxiety (and to differentiate it from deep depressive distress with agitation and perplexity) than in less disturbed patients; objective measures of anxiety could not be used in the present study.

TABLE VI

Distinguishing features of the mental state
(Percentages: *** $p < \cdot001$; * $p < \cdot05$)

	Severely psychotic (N=34)	Intermediate (N=22)	Neurotic (N=36)
Histrionic features ..	2·9***	22·7***	47·2***
Conspicuous anxiety ..	47·2*	68·2	75·0

As might be expected, following admission to to hospital ECT rather than anti-depressant drug therapy had been first choice of treatment in the Severely Psychotic patients (in 59 per cent of this group, as compared with 27 per cent of Intermediate, and 24 per cent of Neurotic depressives). However, both kinds of therapy came to be (consecutively) used in the two Psychotic groups (in 18 per cent) only slightly less frequently than in the Neurotic group (24

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per cent). ECT, rather than drug therapy, appeared to have rendered patients fit for discharge a little more often in the case of the Severely Psychotic patients (in 53 per cent as against 36 per cent of Intermediate, and 41 per cent of Neurotic depressives).

Patients' case records were scored for the presence of a number of abnormalities of their original adult personalities at the end of the follow-through period. At that time, more information was available than had been gathered at the time of admission, but admittedly a more favourable picture of personality might have emerged in the case of patients who ultimately did well: unduly gloomy accounts are often given by informants, especially where patients have been ill for some time. Table VII shows that in many ways the more 'neurotic' patients had shown more deviations from ideal personality functioning than the 'psychotic' ones. Sexual maladjustment and the presence of 'other abnormalities' (which included many instances of psychopathic behaviour) were more commonly reported in the Intermediate group, characterized by delusional content and poor communication of depressive affect. As numbers were small, and with one exception all observed differences statistically insignificant, the possibility that these patients more often exhibited paranoid and schizophreniform admixtures, in keeping with previous personality defects, was not investigated. Obsessive-phobic traits were significantly more frequently reported in Neurotic depressives as compared with the two Psychotic groups taken together. They usually coloured the clinical picture as well, and this

TABLE VII

Abnormalities of previous personality
(Percentages: * $p < .05$)

	Severely psychotic (34)	Intermediate (22)	Neurotic (36)
Longstanding interpersonal difficulties	50·0	63·6	75·0
Sexual maladjustment ..	32·4	54·5	50·0
Dysthymic traits ..	32·4	36·4	44·4
Obsessive-phobic traits	23·5	18·2	44·4*
Other abnormalities ..	26·5	54·5	41·5
'Inadequate personality'	38·2	45·5	55·6

occurrence of obsessional symptoms in depressive illnesses of every type and severity is in keeping with clinical experience. The item 'Inadequate Personality' comprised all patients who failed to fulfil the definition by Carney *et al.* (1965) of 'Adequate Personality' as having been 'free from any history of neurotic breakdown and without disabling neurotic symptoms or serious social maladjustment'. The proportion of patients with 'good' previous personalities among the most psychotic was only insignificantly bigger. Considerable uncertainties were experienced while scoring patients on this item of the Newcastle Scale on account of difficulties in applying the quoted definition, and an attempt was made to devise a deviation score of personality. This was obtained by totalling the scores given to all items (except 'Inadequate Personality') in Table VII. Using this rough measure, personality abnormalities had been at least frequently present in the Severe Psychotics (Mean Deviation Score of 1·88); intermediate in frequency in the Intermediate Depressives (Mean Score of 2·55); most frequently recorded in Neurotic depressives (Mean score of 3·08). These differences of deviation scores of personality between all three groups were significant ($p < .01$).

Turning from personality to constitution, it seemed informative to use the term in its widest sense, and to assume that a constitutional predisposition to affective disorders may be inherited, but also acquired through childhood experiences, through having suffered repeated depressive breakdowns, or in relation to ageing. The frequencies of inborn and acquired constitutional factors found in the three clinical groups are presented for comparison in Table VIII. Though failing to exceed chance expectation, some of the observed constitutional differences may perhaps be commented on. While the occurrence of definite affective illnesses in first degree relatives of patients scoring at the 'endogenous' end of the Newcastle Scale was most frequent, such positive family history was only insignificantly less often found in patients with low ('neurotic') Diagnosis Scores. The preponderance of family histories of dubiously affective and other functional disorders (e.g. alcoholism) in Intermediate (and perhaps

atypical) Depressives is interesting. These patients had also experienced insignificantly most frequently loss of a parent before they were 15 years old. The overall frequency of early loss of a parent was very similar to that obtained in the same hospital (admissions between 1949 and 1965) for depressives over 60 by McDonald (1969). The occurrence of previous depressions was equally frequent in all three groups, and the age at which the first mild or more severe breakdown had occurred was not related to the clinical picture. It may here be mentioned that on a retrospective assessment (only occasionally made more reliable by access to previous case records) a high proportion (64·7 per cent) of Severe and Intermediate Psychotics with previous attacks appeared to have experienced among their earlier breakdowns some of neurotic-depressive type, while 34·4 per cent classed as Neurotic during their index admission had suffered at times from psychotic illnesses during their earlier attacks. The occurrence, at some time, of manic symptoms was suspected in 17 patients (including five where they might have been precipitated by therapy). Fourteen of these patients were among the 56 member of the two Psychotic groups, and only three among the 36 Neurotics.

TABLE VIII

Frequencies of inborn and acquired constitutional factors
(Percentages: none of the differences is significant as between groups, singly or in combination)

	Severely psychotic (34)	Intermediate (22)	Neurotic (36)
Definite affective heredity	44·1	18·2	30·6
Doubtful affective heredity	8·8	45·4	30·6
Loss of parent before aged 15	20·6	27·3	13·9
Other childhood deprivations	8·8	13·6	19·4
Previous depressive attacks	64·7	54·5	58·3
First depression before 50	41·2	36·4	36·1
First hospitalized before 60	29·4	27·3	27·8

Frequency and type of aetiological factors suspected of having precipitated current illnesses, because they were of an unusual nature in the patients' lives, and had occurred a few weeks or months before onset, are shown in Table IX. Such precipitating factors were found in 78·3 per cent of all patients, a figure very much of the same order as that reported for other samples of elderly depressives (summarized by the author, 1968). It is surely of interest that the most reliably identifiable precipitating events (bereavement, removal, or severe illness of a significant other) occurred against expectation most frequently (albeit to a statistically insignificant extent) in patients belonging to the most 'endogenous' group, who also carried the heaviest constitutional load (Table VIII). The presence of other psychogenic factors (such as retirement, loss of home, various disappointments) was only insignificantly more often recorded in Neurotic depressives with their more abnormal, and presumably psychologically more vulnerable personalities.

TABLE IX

Frequencies of suspected precipitating factors of current attack
(No significant differences)

	Severely psychotic 34	Intermediate 22	Neurotic 36
Loss or threatened loss of persons	41·2	31·8	27·8
Other psychogenic factors	17·6	18·2	30·6
Physical illness	11·8	31·8	25·0
No precipitating factors	29·4	18·2	16·6
	100·0	100·0	100·0

Though not strictly relevant to the present discussion, it may be reported that (as in most samples of elderly depressives) the mean age at the time of their first illness of patients with definite depressions in first degree relatives (46·3 years) was significantly ($p < ·01$) lower than that of patients without psychiatric family histories (57·8 years). On the other hand, patients in whom the depressive reaction type had first manifested itself late in life, and who had been shown to have less hereditary loading, were not characterized by a correspondingly higher incidence of precipitating factors in their present illness. The commonsense view that older persons so often start the 'depressive habit' in spite of the absence of inborn or early acquired constitutional predisposition, because in late life

bereavement, deprivation, and physical illness tend to occur more frequently, does not find support. As suggested earlier (Post, 1968), ageing itself comes up for consideration as a newly acquired constitutional predisposing factor.

Turning, finally, to long-term prognosis, no differences were found to exist between the three clinical groups in outcome over the course of three years, assessed either in terms of further symptomatology or in a more global fashion.

Discussion

Attempts to demonstrate that the introduction of new methods of management and treatment had improved the long-term outlook for elderly depressives proved inconclusive. The changes in psychiatric practice over as brief a period as 16 years had led to the earlier treatment of more patients within the community, and those admitted to hospital more recently tended to be more persistently ill. In spite of this, overall long-term progress of this more recently investigated group was similar to that of the sample treated during an earlier period, suggesting that the far greater use at the present time of after-care and maintenance drug therapy had been of some benefit. As in a previous study, few prognostic factors were discovered which might be of clinical use in individual patients. It was not surprising to confirm that relatively great age and serious intercurrent physical illnesses exerted an unfabourable effect on psychiatric progress.

The comparison of an intensive with a more routine method of after-care suggested that regular active supervision of discharged patients by social workers was unlikely to be carried out satisfactorily. It was concluded that in present circumstances an easily accessible psychiatric out-patient clinic in collaboration with community workers was more likely to mitigate the burdens imposed by affective disorders, which in the elderly are particularly prone to be frequently recurring or persistent.

An attempt at identifying two or three separate syndromes from within this sample of elderly depressives failed. On the basis of their mental states, it had been possible to differentiate three groups of patients. The first was characterized by severe and well-communicated alterations of affect of a depressive type, and in most of these patients hypochondriacal or paranoid delusions, poverty ideas, as well as diminished self-esteem (often of delusional severity) were easily identified; in members of the second group, these features of mental content were also present, but a depressive change of affect only to a diminished extent; sometimes it seemed almost absent. Both these groups might be labelled descriptively as psychotic. The third group was called neurotic because overt depression was either very mild or apparently absent, and often overlaid by anxiety. Hypochondriasis was based on apprehension rather than on firm convictions, with self-esteem entirely preserved, and blame placed on others or more often on circumstances. The striking differences between these three clinical pictures were underlined by the occurrence of so-called hysterical features largely in neurotic patients, and by the slighter but also significant preponderance of anxiety in the Intermediate and Neurotic groups. On the other hand, the three groups did not differ significantly in terms of aetiology, or of the further course of the illness; in particular, patients scoring high at the 'endogenous' end of the Newcastle Scale were as often 'reactive' as patients with low scores, and the most clearly recognizable precipitating events (loss or threatened loss of persons) were almost more frequently encountered in patients with the most marked constitutional predispositions and highest (endogenous) scores.

Previous studies suggesting an endogenous-neurotic dichotomy of affective illness as reflected in the demonstration of two separate syndromes (both affecting some patients simultaneously) have been based, not on prolonged personal contact with patients and members of their families, but mainly on single interviews, supplemented by information from the nursing staff and/or response to ECT, or on case notes prepared by other psychiatrists treating patients never seen by the investigators. In the last study (Garside *et al.*, 1971), for instance, data were collected from the subjects '. . . by one observer within 24 hours of their admission to hospital . . .'. Many of the items of the Depressive Category-Type Scale used in that investigation

were quite recondite, and the information on some of them would have been sketchy at that early stage of contact with the patient, and with the patient only. As in earlier investigations, quite elaborate techniques of statistical analysis were then applied to these data. The logic of approach in these investigations has recently come under considerable criticism (Eysenck, 1970, and subsequent correspondence), but it should in any case seem obvious that an analysis of data classified as either 'black' or 'white' (with an occasional allowance made for 'grey') even though referring to complex phenomena (like 'personality', 'precipitating factors', or 'course independent of events'), would lead to equally simple and clear-cut results, e.g. the existence of a dichotomy. The nature of even the lowliest biological process is highly complex; human psychic life is much more so, and it would be surprising if a disorder like depression were to be determined in its content, form, and course by two or three main factors.

A much more complex interplay is suggested by the results of the present study, but only a very simple kind of evaluation will be attempted. Before embarking on this, attention will be drawn to two relevant issues. Firstly, the development and meaning of concepts like 'endogenous', 'exogenous', 'psychotic-endogenous', and 'neurotic-reactive' have recently been authoritatively scrutinized by Lewis (1971), and as a result it would seem wise to avoid these terms. Secondly, the subjects of this study were representative of only a portion, albeit an important one, of the spectrum of affective illness: patients were over 60 years old, and they were of a type requiring hospital admission after, in a majority, ambulant treatment had failed.

Though patients within this selected group of depressives exhibited strikingly different symptomatologies, constitutional factors (such as heredity, childhood trauma, and earlier tendencies to affective illnesses) on the one hand, and precipitating life situations on the other, were registered with similar frequencies. There was, however, one statistically significant differentiating trend, and this was related to previous personality. Personality was reported as well functioning most often in patients with the most severe and clearly psychotic illnesses, and as most seriously deviant in neurotic depressives. Those patients with little or no overt depression but with predominant anxiety also exhibited (at a similar level of statistical significance) more often longstanding obsessive-phobic propensities. Turning from previous personality to precipitating aetiological factors, it was confirmed that these could be identified in the great majority of depressive illnesses of elderly patients, just as had been the case in Lewis's (1934) sample of younger cases. In the few patients where 'one had not the slightest inkling why the illness had broken out', Lewis suggested that this might be attributed to reticence on the part of patients and of their relatives, or to failure in recognizing 'the importance for the patient of events, not striking to the observer, but 'conditioned' for the patient by previous experiences'. In the course of the present investigation patients not infrequently divulged precipitating events only after recovery, and it is suggested that if all factors were known all depressive illnesses would turn out to be 'reactive'. At the same time, it is obvious that everybody, certainly during old age, will come to suffer severe life experiences (especially the loss of emotionally significant persons), but that only a small minority will in fact react with affective disturbances which are sufficiently long-lasting and severe to lead them to see their doctors; even fewer will receive psychiatric treatment. It is suggested that members of this small minority of elderly persons who fall ill do so on account of an inborn or acquired predisposition, and that therefore all depressive illnesses (as defined above) are 'endogenous' as well as 'reactive'. This is not a new idea: Anderson (1965) pointed out that depressive reactions to adverse experiences '. . . share with the depressive illnesses proper one common factor, a constitutional prediposition, an 'Anlage' which, as Jaspers insists, must not only exist, but which must also be specific. Since the presenting form is depressive, the predisposition must be one determining this very response, since of course other reactions, e.g. psychogenic twilight states, anankastic and paranoid reactions also occur, which presumably are deter-

mined in part by the individual's particular constitution'. In the same year, Mendels (1965) concluded that endogenous and reactive syndromes of depression only occurred in their 'pure' form in a small proportion of cases. In regarding the majority of patients as suffering from endo-reactive depressions, he thought to apply Weitbrecht's (1953) criteria of what that author called 'endo-reactive dysthymias'. (In actual fact Weitbrecht looked upon these disorders as relatively rare psychoses, marginal to manic-depressive illnesses). Mendels' investigation lent 'support to the concept that there is always an endogenous element to a depressive illness, and that the reactive element is more variable'.

Going beyond the commonplace dictum that each depressive patient is an individual, the results of the present investigation lead to the suggestion that at a deeper level also every depressive attack is an individual affair. It is not infrequently characterized by different symptom complexes at different times during the life of the same person. On each separate occasion the illness should be regarded as an individual amalgam multifactorially compounded of inborn and acquired predispositions to depression, current emotional trauma and existing personality defects, which are themselves, of course, a product of predisposition and life experience. It remains possible that there are two, or much more likely several, constitutional factors for unipolar and bipolar affective psychoses on the one hand, and for neurotic depressions on the other. No evidence for such a dichotomy was found in the present investigation of patients selected in terms of late age and considerable severity. Polarizing differences in predisposition might be discovered on examining depressives of all ages collected to form a representative sample from the community, as well as from the psychiatric clinic. Such an investigation will, however, be of no value unless the data obtained are of similar completeness and quality to those employed in the present investigation.

Summary

The progress of 92 depressives over the age of 60 after discharge from hospital was compared with that of 81 subjects of an earlier follow-up study. On account mainly of earlier, and presumably often successful treatment in the community, the recent sample of hospital patients turned out to be more seriously and persistently ill. In spite of this, long-term results were similar to those obtained during an earlier period, possibly because of more effective after-care and maintenance therapy with anti-depressant drugs, which had in the meantime been introduced.

In the after-care of elderly depressives, optional attendance at a psychiatric out-patient clinic was shown to be more practicable than, and equally efficient as, a more rigidly structured community care programme.

It was possible to classify patients as severely psychotic, intermediate psychotic, or neurotic on the basis of their mental states. Patients belonging to these three groups also differed from one another in frequency of abnormalities of previous personality. Hereditary and other constitutional characteristics, as well as precipitating factors and further course were evenly distributed among patients presenting with contrasting clinical pictures, which did not, therefore, indicate the existence of different syndromes. These findings were consonant with a view according to which, in the present sample at any rate, the phenomena observed in every depressive attack are uniquely shaped by the constitutional status of the patient at the time of the attack, by the emotional significance of preceding events, and by existing strengths and weaknesses of his personality structure.

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References

Anderson, E. W. (1965). 'Chairman's introductory remarks.' *Anglo-German Medical Review*, **2**, 707–14.

Carney, M. W. P., Roth, M., and Garside, R. F. (1965). 'The diagnosis of depressive syndromes and the prediction of E.C.T. response.' *British Journal of Psychiatry*, **111**, 659–74.

COLWELL, CATHERINE, and POST, F. (1959). 'Community needs of elderly psychiatric patients.' *British Medical Journal, ii*, 214–17.

EYSENCK, H. J. (1970). 'The classification of depressive illnesses.' *British Journal of Psychiatry*, **117**, 241–50.

GARSIDE, R. F., KAY, D. W. K., WILSON, I. C., DEATON, I. D., AND ROTH, M. (1971). 'Depressive syndromes and the classification of patients.' *Psychological Medicine*, **1**, 333–8.

KENDELL, R. E. (1968). *The Classification of Depressive Illness*. London.

—— (1969). 'The continuum model of depressive illness.' *Proceedings of the Royal Society of Medicine*, **62**, 335–9.

—— and GOURLAY, JANE (1970). 'The clinical distinction between psychotic and neurotic depressions.' *British Journal of Psychiatry*, **117**, 257–66.

LEWIS, A. J. (1934). 'Melancholia: a clinical survey of depressive states.' *Journal of Mental Science*, **80**, 277–378.

LEWIS, A. J. (1971). ' "Endogenous" and "exogenous": a useful dichotomy.' *Psychological Medicine*, **1**, 191–5.

MCDONALD, C. (1969). 'Parental deprivation and psychiatric illness in old age.' *Australian and New Zealand Journal of Psychiatry*, **3**, 401–3.

MENDELS, J. (1965). 'Electro-convulsive therapy and depression. II. Significance of endogenous and reactive syndromes.' *British Journal of Psychiatry*, **111**, 682–6.

POST, F. (1962). *The Significance of Affective Symptoms in Old Age*. London.

—— (1968). 'The factors of ageing in affective illness', in *Recent Developments in Affective Disorders* (eds. Coppen, A., and Walk, H.). British Journal of Psychiatry Special Publication No. 2.

SLATER, E., and ROTH, M. (1969). *Clinical Psychiatry*, 3rd edition. London.

WEITBRECHT, H. J. (1953). 'Offene Probleme bei affectiven Psychosen.' *Nervenarzt*, **24**, 187–91.

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