The Hamilton Disorders

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A clinical syndrome is in accordance with DSM-III-R [1] a group of symptoms having shared phenomenology, i.e. the symptoms are associated with one another and covary over time. A mental disorder is by DSM-III-R defined as a clinically significant syndrome. As discussed by Spitzer and Williams [2], clinical significance means some pathological disturbance associated with current disability or with a significantly increased risk of suffering death. Major depression is a significant syndrome. It is a syndrome because the individual symptoms have shared phenomenology [3]. It is a significant syndrome, a mental disorder, because patients with major depression have an increased risk of suicidal death and have a major, current disability. The sequence approach introduced by WHO [4] has clinical disability as a consequence of a pathological, biological impairment. Health-related quality of life or handicap is then considered as a consequence of the clinical disability. The components of clinical disability are the PCASEE model [3], where P = physical symptoms, C = cognitive symptoms, A = affective symptoms, S = social symptoms, E = economic-psychological stressors, and E = ego or personality problems. Major depression includes symptoms within the PCASEE model. The Hamilton Depression Scale [3, 5] covers PCASEE components and a score of 18 or more is conventionally considered as major depression. Both DSM-III-R and ICD-10 [6] define major (or moderate) depression by the core symptoms of the Hamilton scale, but have introduced algorithms rather than total scores to endeavor interpsychiatrist reliability. The validity of the algorithms still needs to be tested. In contrast, the predictive validity of the Hamilton scale has been evaluated both in primary and secondary depression.

Among the first to use the Hamilton scale in medical inpatients were Schwab et al. [7]. They found that around 20% of medically ill patients scored over 20 on the Hamilton scale. In a recent monograph on depression in the medically ill patients Rodin et al. [8] have summarized the results with the Hamilton scale as well as with the various self-rating depression scales (e.g. the Beck and Zung scales). They conclude that depression in the medically ill patient has the same phenomenology as primary depression underlining that the mixture of somatic and psychic items in the Hamilton scale is valid. They also emphasize that the Hamilton total score above 13 is a significant syndrome. Thus, patients in this category have more current disability than the nondepressed patients with more frequent hospitalizations or clinic visits, higher mortality (especially cardiovascular and cancer) and higher risk of noncompliance.

From a treatment point of view, Paykel [9] has shown that patients with a Hamilton score of 13–17 ('probable major depression' or 'less than major depression') have the same good outcome on amitriptyline as patients with a Hamilton score of 18 or more ('major depression'). Patients with a Hamilton score below 13 had no better outcome on amitriptyline than on placebo. In patients with secondary depression clomipramine was superior to placebo in patients with 'less than

major depression' [10]. In patients with breast cancer it has been shown that those with a Hamilton score over 10 had a significantly increased risk of suffering death than matched controls with a score below 10 [11, 12].

Rodin et al. [8] have discussed the problem raised by Rosen et al. [13], who suggested that DSM-III-R be adjusted to include a 'V code for 'depressive reactions secondary to physical illness'. This approach was proposed to avoid the arbitrary assignment of a psychiatric diagnosis to distressed medical patients, while permitting the descriptive labelling of depressive symptoms that occur during the process of adjustment to physical illness. Rodin et al. [8] conclude that: '... there is little consistent data to support the view that a medical patient with a major depressive episode should be given a clinical diagnosis which is distinct from any other patient with this disorder'. This conclusion can be extended to include 'less than major depression' or a Hamilton score between 13 and 17.

When reviewing the new generation of anti-depressants (especially mianserin, moclobemide, and the selective serotonin reuptake inhibitors (citalopram, fluoxetine, fluvoxamine, paroxetine and sertraline) it was obvious [14] that they offer an acceptable anti-depressive effect comparable with the old generation of antidepressants (e.g. amitriptyline, clomipramine and imipramine) but with very few side effects. It is, however, difficult to perform controlled clinical trials in the medically ill patients due to the problems raised by Rosen et al. [13] about the labelling of a psychiatric disorder. This resistance is higher among the treating doctors than among the patients. This is especially the truth in cancer patients.

In her well-composed book on quality of life as the missing measurement in health care Fallowfield [15] says that 'there are still too many doctors who feel that depression and anxiety are to be expected in association with cancer and that these 'normal' reactions do not therefore merit treatment'. She continues: 'This is as nonsensical as saying that as pain is a "normal" reaction to surgery it does not require analgesia'. Other attempts than that of Rosen et al. [13] to replace diagnoses such as 'neurotic depression' or 'hypochondriacal depression' with terms such as 'atypical', 'situational' or 'reactive' depression have not been successful. Among the various terms for primary or secondary depression 'Seasonal Affective Disorders' or 'Winter Blues' seem to have obtained the most socially acceptable diagnosis. However, because the DSM-III-R or ICD-10 diagnoses of depression, including Seasonal Affective Disorders, apparently have higher reliability than validity, the term 'the Hamilton disorders' is hereby suggested. The Hamilton scale has been shown to be a reliable scale in all parts of the world covering both primary and secondary depression, and has a high validity [3]. It covers the depressive spectrum disorders including 'less than major', 'major', and 'more than major' depression [14], i.e. the Hamilton disorders.

It is 70 years since Boring [16] made the immortal statement that: '... Intelligence is what the tests test ...'. Since 1960 many depression scales have been constructed of which the Hamilton scale has stood the test of time. Depression, then, is to be the value on the Hamilton Depression Scale.

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