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Scales of depression, ill-being and the quality of life—is there any difference? An assay in taxonomy

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The application of a model based on the three time dimensions of past, present and future can be used to generate an alternative taxonomy for the classification of depression, ill-being and quality of life. In relation to time, depression can be defined as the passage from a healthy past to a painful present, ill-being as the painful present of the individual and the quality of life (QOL) as the degree to which the subject's present life is commensurate with his aspirations. Such an approach opens up conceptual and methodological areas of research which will allow the construction of a new type of scale. Depression scales should be constructed with two time dimensions: past and present; ill-being scales only refer to the present and QOL scales should have two time dimensions: present and future. It would be possible to combine these three scales into a single scale with three dimensions. Such a scale would enable depression and ill-being to be quantified, accurately diagnosed and monitored. The relative importance of principal symptoms could be assessed, facilitating the choice of therapy and follow-up methods.

Key words: Depression, extrinsic quality of life, ill-being, intrinsic quality of life, three time dimensions, synoptic scale.

Introduction

There has been a rapid increase in the number of assessment tables, scales and questionnaires dealing with the depressive syndrome and certain of its constituents. A classification based on new criteria would seem to be of considerable use to general medical practitioner as well as to specialists in the area—psychiatrists, psychologists and psychotherapists. Before describing the model which has served as a basis for our taxonomy, an inventory and description of these scales would seem to be necessary. We shall not discuss here the so-called 'rating scales' by which an informed observer can judge the presence and intensity of a certain number of symptoms of depression. The analysis is limited to self-report scales: this point is important; there is no transmission of information by a third party, the subject is both his own observer and source of information. Subjectivity is therefore a parameter of paramount importance. The metrological qualities of the assessment tables for this kind of scale have been analysed in many articles.[1–13] The questions formulated in the scales are worded in the first person and are based on the description of the depression syndrome and its different manifestations, as given in the DMS-III-R.[14] The aim is to describe either the present state of the subject or the emotional traits which may be regarded as those habitual to him. The items are often grouped and form sub-scales such as anxiety, mood or life force. Such scales carry titles such as: Questionnaire of Depression, Quality-of-Life, Anxiety, Mood, Automatic thoughts, Life-Events, Self-esteem, Dysfunctional attitudes. This type of questionnaire, which can certainly gather extremely interesting information, would not however seem to be based on specific taxonomic criteria.

With regard to time dimensions, it would seem important to underline two points: one concerning the questions, the other the scales in their entirety. A single phase is often employed in the formulation of questions: in the past ('When I was young . . .', 'before . . .') the items concern the subject's former condition; in the present (at this moment . . .', 'during the last few days . . .') the items give a report; in the future ('in the future . . .', 'my feelings with regard to the future . . .') the items try to measure the wish for change, therapeutic expectations or hopelessness.

The questions may also employ two phases. These may be a combination of past and present ('I tend . . .', 'in general . . .') and are more a measure of personality traits than of present state—the permanent rather than the episodic. Past and present may also be compared ('I . . . more often than usual . . .', 'previously . . . but now . . .'). These items try to measure the

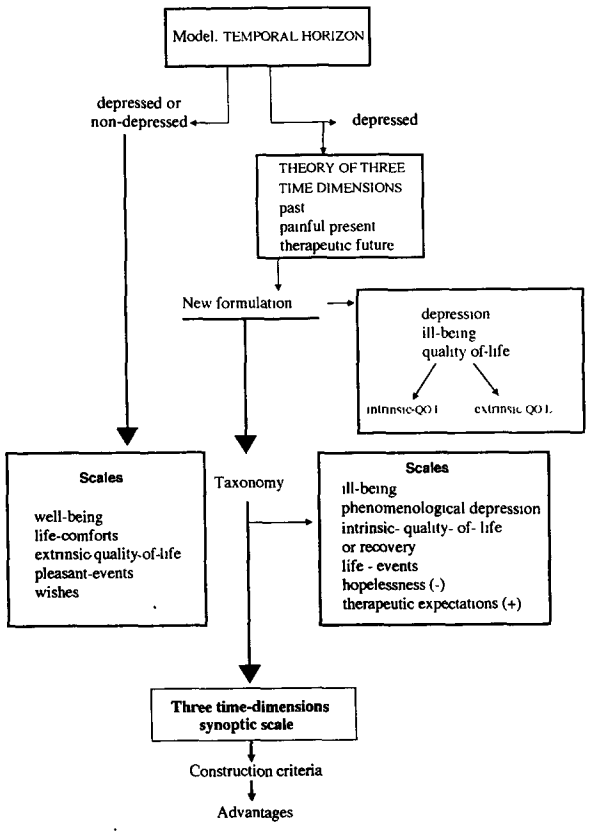

Figure 1. Plan of article.

frequency and intensity of specific behaviour during a particular period. Items may also mix present and future: ('I am satisfied . . .'), making wishes for the future coincide with present experience. It should be noted that as sometimes one, sometimes two phases are used, the time dimension in these types of scale is never pure. This observation would seem to be important and forms the basis for the model and classification that we suggest.

The plan given below should clarify the logic of the approach used in this article (Figure 1).

Model

The referential axis for the taxonomy of depression scales is therefore the notion of phenomenological time. This notion has been analysed with regard to depression and the construction of relevant scales in both the cognitive and behavioural theories,[15,20] and has been the subject of numerous experimental studies.[21–29] It has also been analysed and with great subtlety by phenomenologists.[30–42] It is continually present in the discourse of patients suffering from depression. The temporal horizon is therefore to be found at the crossroads of the different schools—cognitivist, experimental, phenomenological and clinical.

The model is based on awareness of time already experienced (past), the phenomenological present and time still to be experienced (future). We are concerned here with the temporal horizons of what is called the 'normal' individual, the description of his attitude with regard to time: how does he experience its transition and what is his attitude concerning the past, present and future? How are these three time dimensions structured? Is there one structure particular to the 'normal' individual and another to the depressed individual? Factors affecting the phenomenology of the temporal horizon such as age, sex, personality, intelligence, socio-economic status, health and culture will not be examined here.[43–69]

The proposed model will aim, above all, at serving as a basis for a new taxonomy of what are called depression scales, which will have consequences for the definition of the concepts of depression, ill-being and the quality of life, and for the construction of new scales for depression.[50]

Configuration of the time dimensions in the healthy individual

In these individuals the three time dimensions are related in an asymmetrical configuration, in which the earlier and later parts are combined differently (Figure 2). The binary structure of past–present forms a whole, with its energy directed towards the later part, a future, more or less distant according to the age, personality and intellectual or socio-cultural level of the individual.

The individual's past will not be recognized as such until it is woven into the present. The present has its roots in the past, is fed by it, gets its force from it and often its inspiration, motivation, prejudices. The present is therefore an extension of the past but is

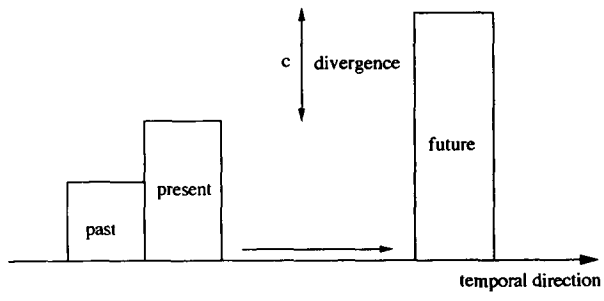

Figure 2. Outline of the temporal horizon of the healthy individual: c. measure of quality of life.

directed towards the future. The past, prologue to the present, is therefore its continual reference; it is the motor of the present. The future is hope, expectation, desire, life prospects. The normal psyche is an evolutionary wish and the absence of a future is a sign of a pathological state. Once there is a breaking up of the temporal horizon, a dislocation of the links between past, present and future, or a shrinking or inflation of one of these time dimensions, there is psychiatric illness. Pathological experience of the time dimensions is an abnormal manner of being.

Configuration of the three time dimensions in the depressed individual

The physiological, psychological and environmental factors which affect phenomenological time are not discussed here. The individual suffering from depression, whether endogenous or exogenous, has a rent between his past and his present. The past has distanced itself from the present; it has become remote and no longer nourishes the present; it deprives the present of energy (Figure 3). This dislocation of the past–present dyad diminishes the present and devitalizes it. The present becomes ill-being, suffering and is experienced as interminably long. To paraphrase the poet 'time has suspended its flight'. The pain of the present is relentless. Getting through the hours is exhausting. For the depressed person minutes weigh like hours and the present becomes eternal, whereas for the healthy person the present flies and future rapidly changes to past. In depression the past is no longer integrated into the present and no longer opens it up to its potentialities, the future therefore fades to no more than a shadow. While the future for the healthy person is the summit to be reached, completeness, the goal of present impetus, its absence is a sign of disease, the inability to achieve, despair, a death wish, even disguised auto-destruction (drugs/alcohol) or suicide.

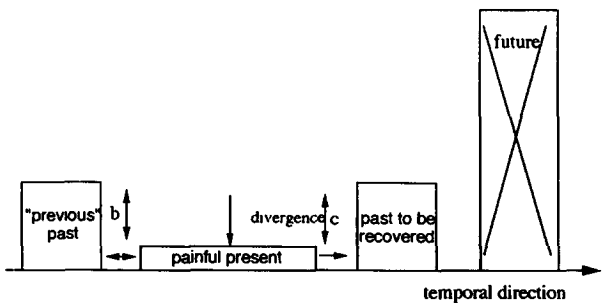

Figure 3. Outline of the temporal horizon of the depressed individual. b. measure of depression, c. measure of quality of life.

As every psychological life must have a future, what time dimension can the depressed person use to replace the future which he lacks?

The following theory could be the outline of a solution to the problem.

Theory of three time dimensions

The present of the depressed person is dissociated from his past and is experienced as being interminably long, and without future. His negative thoughts about future are accompanied by references to the past. Not aspiring to a future and only wishing to get well, the person in whom depression is not too severe turns to his past ('I only want one thing, to be like before'). This searching for the past becomes his future: he must recover his past to escape from his depression and be cured (Figure 3).

A depressed person therefore has two pasts: his 'previous' past, when he was well, and a past which he wishes to regain or past to be recovered. This past to be regained by the patient will be called a 'therapeutic future' with the idea that, as he recovers his healthy past, he will rebuild a future and progress towards a cure. When on the path to recovery through regaining his past, the depressed person will see this past rejoin the present and the beginnings of a future appear. The present will again be vitalized and will reconstruct the future. The therapeutic future is a necessary stage if the subject suffering from depression is to remake his own future. Figures 4 and 5 show the dynamics of the therapeutic process.

Between moment 1 and moment 2 of the therapeutic process the present becomes shorter and less painful; the 'therapeutic future' or 'past to be recovered' becomes reincorporated into the present and in so doing rejoins the 'previous' past to the present and revitalizes the future. The distance (a) in Figure 5 between the two moments is reduced and the future grows in importance. This general notion is an outline representation of the temporal horizon. It is purposely a simplification in order to enable a taxonomy to be worked out, new types of scales to be constructed and a new way of defining depression, ill-being and the quality of life in relation to time to be attempted.

New definitions

The state of ill-being is taken to be the patient's

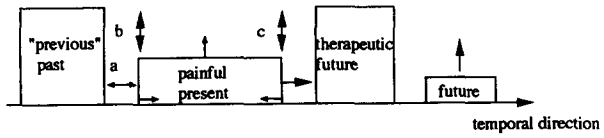

Figure 4. Moment 1 of therapeutic procedure. a. distance between present and previous past, b. measure of depression, c. measure of quality of life.

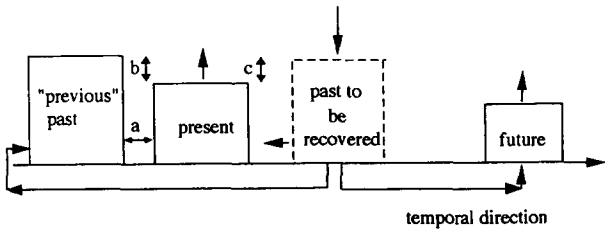

Figure 5. Moment 2 of therapeutic procedure. a. distance between present and previous past; b. measure of depression; c. measure of quality of life.

painful phenomenological present corresponding to the nosographic criteria given in the DSM-III-R. It therefore includes the classical symptoms of mood and somatic and psychic disorders. There will be varying degrees of loss of interest, anhedonia, anxiety, feelings of guilt or failure, and self-disparagement which may go as far as ideas of suicide. Various somatic disorders may accompany this dysthymia, including insomnia, loss of weight and appetite, decline in libido. Psychic disorders may also be found: psychomotor inhibition, diminished ability to think or concentrate, memory loss. In short, ill-being, as defined above, corresponds to the definition of depression generally given in scientific literature.

Depression will be defined as phenomenological depression, the feeling of degeneration experienced by the subject. It is not to be a 'state' but the perception of a discrepancy between a healthy past and a painful present. The present, in the original meaning of the word, is depressed in comparison with the past and the greater the discrepancy between the painful present and the past, the greater the depression. In other words, for the same degree of ill-being, the greater the health of the past, the greater the depression which will be experienced; and in the case of equivalent pasts, the greater the level of ill-being, the more severe the depression experienced.

The quality of life (QOL), usually considered as the degree to which the phenomenological present and future aspirations are commensurate, would in the present scheme be defined as the discrepancy which is perceived between the future and the present. QOL would therefore be inversely proportional to the degree of discrepancy perceived between the aspirations of the subject and his phenomenological present. The less the discrepancy between future aspirations and the phenomenological present, the better the QOL. For the same level of ill-being, the higher future aspirations are, the lower will be the QOL. For the same level of future aspirations, the greater the state of ill-being, the lower will be the QOL (Figure 2(c)). This present/future commensurability is applicable in the case of people who are not depressed, but as we have shown in the theory of three time dimensions, in the case of the depressed subject, the present is painful and the future is blurred or even non-existent and is replaced by a past to be recovered or a therapeutic future, i.e. a past which, having been regained in the process of healing replaces, as it were, the missing future.

For the depressed person, QOL is therefore the degree of commensurability between his painful present and therapeutic future, or past to be recovered which, as it is recovered, reinvigorates the present by reuniting it with the past and reconstructing the diminished future (Figures 3, 4 and 5(c)). His quality of life will be all the better as the discrepancy he perceives between what he wishes to be ('to be like before', when he was well) and what he experiences at present becomes less and he gets nearer to recovery. In other words, the QOL of the depressed person is inversely proportional to the severity of his depression.

It is generally agreed that the depressed person has little or no QOL. This loss is an integral part of the depression syndrome. At the risk of being simplistic, it could be theorized that the lessening or absence of a future causes a reduction in or absence of a QOL which, coming back to the definition of the QOL, would mean that the future is lacking. The absence of a future in depression is, in any case, an important indication of the absence of a quality of life. How can QOL for the depressed and the non-depressed be reconciled?

The intrinsic and extrinsic quality of life

At this level of analysis it is necessary to distinguish between two types of quality of life, both considered as divergencies: the intrinsic QOL which is the commensurability of a therapeutic future with a painful present (Figure 3, 4 and 5(c)), and the extrinsic QOL which is the consequence of the commensurability of a future and a present (Figure 2(c)).

These two subjective concepts are part of the same continuum with upstream the intrinsic and downstream the extrinsic QOL. There is a causal relationship between the first and the second: the intrinsic being

the root or basis of the extrinsic. Consequently the force or weakness of the intrinsic fortifies or weakens the extrinsic QOL. It is a necessary but not sufficient condition. One cannot talk of the QOL in the case of a person suffering from depression without any precision. Extrinsic QOL can only exist in the presence of a real future, not a therapeutic future. The reconstruction of a future is the result of successful therapy and predicts recovery. Having been cured, the subject of the depression regains his intrinsic QOL than the measure of extrinsic QOL is possible.

According to our model, the depressed person is characterized by present ill-being, a therapeutic future and a reduced intrinsic QOL. The non-depressed person is characterized by present well-being, a future and an extrinsic QOL which varies in degree but is based on the presence of an intrinsic quality of life, Figure 6 shows the analysis of the two concepts.

This notion, which is not the subject of the present article, is developed in Reference 51.

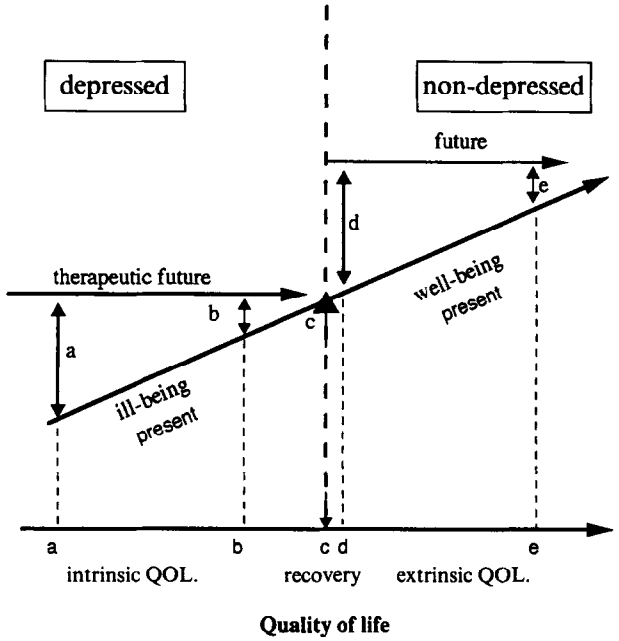

Figure 6. Quality of life model according to the three-dimensions theory. (a) Intrinsic QOL is weak: large divergence between the therapeutic future and present ill-being. (b) Recovery of intrinsic QOL: divergence between the present and the therapeutic future diminishes; the present becomes less and less ill-being. (c) Pivotal point: the state of ill-being becomes a state of well-being, the therapeutic future achieved disappears to the benefit of a real future and the intrinsic QOL continues as an extrinsic QOL, i.e. the depressed subject has reached the recovery stage; he has returned to the non-depressed state. (d) Existence of intrinsic QOL, but extrinsic QOL weak: the divergence between weak present well-being and the future is great. (e) High extrinsic QOL: he divergence between strong well-being and the future is small.

Practical repercussions of this interpretation

The continuum which serves as a graphic model for the quality of life scale is composed, as we have seen, of intrinsic and extrinsic QOL, the latter being dependent on the former. Consequently, the measurement of the extrinsic QOL is in practice only reliable if it is certain that the intrinsic QOL exists, or that the subject is not depressed. A weak intrinsic QOL means that this measurement is tenuous. In doing so, two types of scale should be applied: one, which will cover only the limited area of the symptoms of depression, while the other will cover a great range of very different areas—material, spiritual, emotional, relational, intellectual and physiological. Both these scales, if they apply the principle of the three time-dimensions model, will measure the divergence between actual experience and future aspirations, therapeutic or real. In concrete terms, starting from the central theory of three time dimensions described above, an analytical taxonomy of depression scales may now be proposed without the need to dwell on item content. This is based on the DSM-III-R and is almost identical in all scales.

Taxonomy

To the best of our knowledge, no taxonomy exists which classes depression scales and questionnaires according to a theory and following an interpretation of the concepts of ill-being, depression and quality of life. The taxonomy proposed here provides the criteria which are necessary for the construction of new psychometric tools. It may be visualized by a double entry matrix with two variables. The first variable is time: past, present and future. Past is defined as the subject's experience, present as his phenomenological state at the moment, future as the sum total of all his hopes and expectations, real or therapeutic. The second is the state of the subject: depressed and both depressed and non-depressed (Figure 7).

According to this classification, depression scales can be ranged in five main groups: (1) ill-being scales; (2) phenomenological depression scales; (3) intrinsic-quality of life or recovery scales; (4) life-events scales

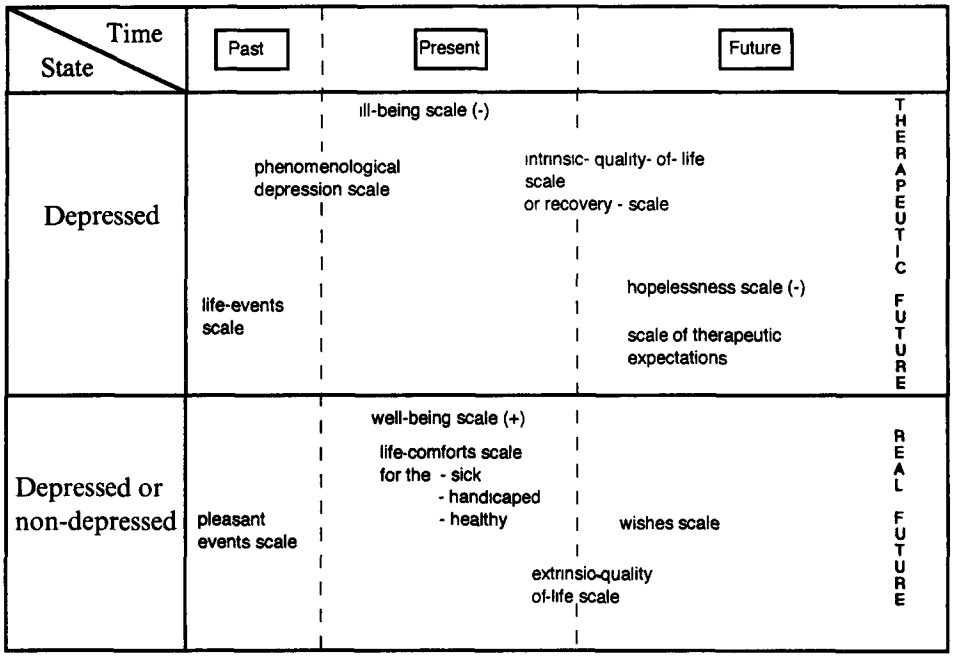

Figure 7. Taxonomy of what are called depression scales.

and (5) hopelessness scales and therapeutic expectations scales.

To simplify matters, we choose to name only just a few of those tests.

Scales considered as ill-being scales involve one time dimension—the present. They measure the intensity of the depressed state. The great majority of depression scales (Beck,[1] Pichot[71]) and, among others, scales assessing obsessions, compulsions (Marks,[17–18]) and automatic thoughts (Hollon[72]) anxiety state (de Bonis,[73] Spielberger,[64]) can be classed here.

Scales considered as phenomenological depression scales involve two time dimensions—past and present. They measure the relationship between the subject's present and previous 'self-image'. The therapist obtains information concerning the subject's 'self-image' before his depression and in this way can determine the phenomenological intensity of the depression. It is not important whether the patient over- or under-estimates the self-image which he attributes to his past and present, because how he experiences his depression will be influenced by this evaluation and this is precisely what the scale tries to measure.

Scales considered as intrinsic quality of life scales involve two time dimensions—present and future. They measure the relationship between the subject's 'wish to get well' (therapeutic future) and his painful present state. The progress towards a cure, whether or not there is psychological and/or pharmacological therapy, is measured by these scales which are, in fact, recovery scales.

Scales considered as life-events scales involve one time dimension—the past. They assess the attitude and behaviour of the depressed subject with regard to traumatic life events (Cottraux[7]).

Hopelessness scales involve one time, dimension the future (negative pole). They assess both suicidal tendencies and those dysfunctional cognitive patterns of which the absence of positive projection in time is the common denominator (Beck[75]). Therapeutic expectations scales involve one time dimension—the future (positive pole). They assess what the patient expects from his psychological and/or pharmacological treatment (Marks-Cottraux[7]).

Only the phenomenological depression and QOL scales are bipolar with regard to time—past–present, present–future—their common standard being the phenomenological present of the subject.

If we leave the immediate subject of patients suffering from depression and analyse the time dimensions used in scales which can be applied equally well to the depressed and non-depressed, we find: 1, well-being scales; 2, life-comforts scales; 3, extrinsic quality of life scales; 4, pleasant-events scales; 5, wishes scales; 6, satisfaction with life scales; 7, daily mood assessment scales.

According to this analytical taxonomy well-being scales should contain one time dimension—the present. They measure the non-depressed psychologi-

cal aspect (Arzin[76]). Some personality scales can be classified here. Life comforts scales should also contain one time dimension—the present. They measure such aspects of life as physical state, material conditions and the socio–cultural–economic context of the subject, whether ill, handicapped or healthy. This group includes so-called 'quality of life' scales drawn up by clinical doctors or psychologists which are adapted to correspond to the symptoms of a specific disease such as cancer, diabetes or cardiac disease or to a psychological state such as adolescence, pregnancy, menopause or old age.[52–70] They are intended to be used at given intervals and the changes which appear can provide, for example, an indication of the progression of an illness and its treatment, or of a state. It is therefore a repeated present. According to the reasoning followed here, it is incorrect to call these questionnaires 'quality of life' scales. To follow our taxonomic criteria, they would have to contain two time dimensions—present, future.

Extrinsic quality of life scales which do not describe the depression syndrome but rather assess the disparity between the phenomenological present and aspirations in numerous areas, such as the material, spiritual, affective, intellectual and psychological, must have two time dimensions—present and future. Pleasant events scales should contain one time dimension—the past. They assess the attitude and behaviour of the subject with regard to pleasant events in his past. Wishes scales should contain one time dimension—future. They measure what the subject expects from life. Satisfaction with life scales measure the result of a coming together of the present and future. They are close to QOL scales in underlying theory, but their construction, while giving the degree of satisfaction, does not, unlike the QOL scales, permit the intensity of the phenomenological present and future aspirations to be assessed separately. Is any disparity found due to the greater or lesser demands of future aspirations or to the dimensions of the phenomenological present? The newly constructed QOL scales, which give assessments in two time dimensions, present and future, can answer this question.[10] To conclude this nomenclature of scales, which is certainly not exhaustive the daily assessment of mood scales will be considered as having one time dimension—a repeated present.[7–15,18,77]

The advantages of the taxonomy suggested above are to give criteria for the construction of new scales, the ability to classify existing instruments, new formulations of depressed scales depending on the number and the type of time dimensions combined in them, and new ideas for the construction of scales for the depressed.

Advantages of this new taxonomy

Criteria for the construction and the method of measuring

To avoid any confusion about time dimensions in the scales, each item should be worded in a single tense, past, present or future; and each questionnaire should only contain items with the same tense: they must be homogeneous with regard to the time dimension chosen. The content of ill-being scales, and of two or three time dimensions scales, will be referred among other things to neurotic tendencies, the vital energy and psychosomatic distress.

With regard to the method of measuring used, it should be remembered that, as the concepts one wishes to quantify are subjective, it is logical that the subject himself should be his own referent: he is both source and object of the assessment. He estimates on his own behalf the emotional effect of the events which he experiences, has experienced and would like to experience. No one else can be his judge, because it is his own temporal horizon which must be quantified. The comparison between the time dimensions will therefore be intra-individual—present compared with past to quantify depression, and present compared with future to quantify QOL.

Classification

This taxonomy allows the classifying of existing instruments with regard to the time dimension chosen.

New definitions of depressed scales

This taxonomy allows new definitions of scales and also new constructions depending on the number and the type of time dimensions combined in them.

One time dimension. Ill-being scales measure the intensity of ill-being or intensity of ill-being or intensity of major depressive disorder by combining scores obtained from present tense items.

Two time dimensions. Phenomenological depression scale measures the intensity of the phenomenological depression (the feeling of degenerations experienced) by the disparity between scores obtained for the painful present and the past dimensions. The existence of a neurotic or an anxious personality can be determined according to the patient's score for neurotic or

anxious tendencies in the past, thus suggesting a neurotic or an anxious depression. Intrinsic QOL scale measures the level of the intrinsic QOL or progress towards a cure by the disparity between scores obtained for the present and the future. This measure can only be carried out where the therapeutic future is equal or superior to the healthy past. It provides information concerning the possible existence of suicidal tendencies. Where they exist, the score for the future will be less than or equal to that for the painful present.

Three time dimensions. Construction of the new three time dimensions scale for the depressed is synoptic: the questions describing the depression syndrome are each worded in the three different tenses, past, present and future. In this way three scales—phenomenological depression, ill-being and quality of life—are united in one, with an identical content. The analysis of the temporal horizon of each item is possible by an intra-individual comparison. For the analysis of the results of the synoptic scale, the agreement between the subject's score for the present dimension and that obtained by a reference population of depressed subjects is indispensable. Here the comparison is inter-individual. The scale can therefore only be used with people thought to be suffering from depression.

Another advantage of the proposed scale is that therapy can be adapted, directed and weighed according to the intensity of the principal symptoms measured. It can be more pharmacological in the case of anxious depression, more psychoanalytic or cognitivist where there are strong neurotic tendencies, more behaviourist where there is a lowering of vital energy.

We realise that the proposed three time dimensions model is reductionist and can only be applied to primary depression where the present time dimension is inferior to the past. However by its originality with regard to traditional depression scales, the three time dimensions synoptic scale can diagnose different types of depression. It enables a distinction to be made between primary depression (a disturbance in present mood) from secondary depression (product of a painful present resulting from a painful past). Through repeated applications the diagnosis of unipolar or bipolar depression can be made or confirmed; a zigzag profile for successive presents would reveal a manic-depressive syndrome or a brief recurrent depression.[78] This three time-dimensions synoptic scale would appear to us to be novel in its design. The presentation proper of this scale is not the object of the present article. It will be developed and analysed, with its metrological qualities, the content of its items and measurement procedures in a future article.[79]

Conclusion

This study provides a theoretical basis for the classification of what are called depression scales, the titles of which do not appear to be based on any precise criteria. To this end and in order to classify only self-assessment scales measuring depression, variously called depression, ill-being or quality of life scales, we have formulated a theory from a temporal horizon model—the three time dimensions theory. This is the basis for a taxonomy which uses time as its criterion—time now, experienced time and time to come. The scientific importance of this criterion has been verified empirically and confirmed by the analysis of therapeutic discourse. This study, which is at the crossroads of the phenomenological, cognitivist and behaviourist schools, has an essentially psychometric aim. An analysis of existing questionnaires shows that they are not pure with regard to the time dimensions: they mix questions concerning the past, present and future while wording the great majority in the present tense.

The temporal horizon model developed in this study gives the configuration of the present, past and future time dimensions in both depressed and non-depressed individuals. In the former the future is blurred or has disappeared. The future is a condition necessary to all psychological life: it must be replaced and will be replaced by a 'past to be recovered' the time when 'he was well whereas at present he is sick'. This past to be recovered we have called the 'therapeutic future'. With the recovery of this therapeutic future the aim of the therapy—the depressed patient is cured. This idea is of capital importance in the model and is the basis for the distinction between intrinsic quality of life (existence of a therapeutic future) and extrinsic quality of life (existence of a real future) the latter being rooted in and deriving its strength and reality from the intrinsic quality of life.

This taxonomy, which is based on a new formulation of the definition of depression in the widest sense of the word, classifies the scales in five main families: life-events scales (past), ill-being scales (present), hopelessness (future −) and therapeutic expectations (future +) scales, all of which involve one time dimension; and phenomenological depression (past–present), intrinsic quality of life or recovery, scales (present–future), which involve two time dimensions.

Moreover the proposed taxonomy provides criteria

for the construction of a new type of questionnaire. The three time dimensions synoptic scale answers these criteria and consists of a single list of questions related to the depression syndrome and worded in the three time dimensions: past, present and therapeutic future. Self completion of this scale is quick and easy and should be carried out at different moments. To start with, the present, past and future time dimensions should be applied to give a measure of the intensity of the ill-being and phenomenological depression, the probability of recovery or the possibility of suicide attempts. In subsequent and successive applications, only the present and future time dimensions should be used: these will measure the retrieval of the intrinsic QOL in the slow move towards the recovery which will follow the elaboration of the treatment.

The scale can provide added diagnostic elements to determine whether the depression is major or dysthymic, primary or secondary, anxious or neurotic, unipolar or bipolar and can also provide other information useful for analysing the phenomenology of depression. Finally, our hope is that this type of scale will allow both interested general practitioners and specialists to carry out retrospective studies of states of depression, their variations and the effectiveness of the treatment used for them.

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