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BMHP6029-Psychopathological Classifications and Provisions

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Introduction

Depression is a common mental health problem in the UK. In England, around one in five people report experiencing a common mental health problem, such as anxiety or depression, in any given week (Mind, 2025). It can have an impact on a person's mood, thoughts, emotions, and ability to function in everyday life. Some of the common features may include reduced interest in activities, tiredness, tearfulness, and changes in sleep patterns and appetite. In more severe cases, depression may be associated with self-harm or suicidal thoughts, while anxiety may also occur alongside depression (National Institute for Health and Care Excellence, 2009).

This report will examine depression within the ICD-11 classification system, where depressive disorders are categorised under Mood disorders. The report will focus specifically on 6A70, Single episode depressive disorder, and 6A71, Recurrent depressive disorder. It will examine the classification and diagnosis of these disorders, followed by an evaluation of treatment and rehabilitation approaches. The report will also consider current debates and emerging issues relating to depression before providing recommendations and a conclusion (World Health Organization, 2024).

Classification and Diagnosis

In the International Classification of Diseases, 11th Revision (ICD-11), depressive disorders are classified within the category of Mood disorders. 6A70 Single episode depressive disorder refers to an individual experiencing a single depressive episode. The disorder can be classified according to severity as mild, moderate or severe, and can also be identified as occurring with or without psychotic symptoms. 6A71 Recurrent depressive disorder applies when an individual has experienced two or more depressive episodes, with periods between episodes where the person has recovered. Recurrent depressive disorder can also be classified according to severity (World Health Organization, 2024).

The distinction between single episode and recurrent depressive disorder provides a way of recognising different patterns of depression. However, depression is a complex disorder influenced by a combination of social, psychological and biological factors, meaning that people's experiences may differ considerably. This highlights the importance of using the

ICD-11 classification as a framework for identifying depressive disorders while also considering the individual circumstances and experiences of the person when assessing their needs (World Health Organization, 2025).

To be diagnosed with depression using ICD-11, symptoms must last for at least two weeks and be a clear change from how the person usually feels. Key signs include feeling persistently low, losing interest in things they normally enjoy, and feeling tired or lacking energy. Other signs may include feeling bad about oneself, finding it hard to concentrate, sleeping or eating differently, feeling restless or slowed down, and thinking about death or suicide. How severe the depression is — mild, moderate, or severe — depends on how many symptoms there are and how much they affect daily life (World Health Organization, 2024).

In UK practice, healthcare professionals talk through symptoms and consider how much they affect everyday life to decide the level of depression. The terms mild, moderate, and severe are used to describe how much impact symptoms have (National Institute for Health and Care Excellence, 2009). However, diagnosing depression has traditionally been based on talking to the person and looking at their history — a method still widely used but which depends on the clinician's own judgement. To help make things more consistent, structured questionnaires and other tools have been developed; these work reasonably well when used correctly and help pick out people who need a full assessment. Older medical tests have been used in the past, and newer methods looking at genes and biology are being developed — but these are not yet reliable enough for everyday use (Smith et al., 2013).

ICD-11 uses the term “disorder” when classifying depression rather than presenting it as a disease with one clearly established physical cause. Within the ICD-11 approach, mental disorders are understood in terms of clinically significant disturbances that can affect areas such as emotional functioning and everyday life. The use of the term “disorder” therefore reflects the complexity of mental health conditions and avoids suggesting that their causes are fully understood (World Health Organization, 2024).

Treatment and Rehabilitation

Standard Treatment Approaches

Treatment for depression is matched to how severe the symptoms are. NICE now divides depression into less severe and more severe groups, based on symptoms, duration, and impact on daily life (National Institute for Health and Care Excellence, 2022). For less severe depression, the first approach is usually watchful waiting, guided self-help based on CBT principles, or group exercise classes, while antidepressants are not recommended as a first choice (National Institute for Health and Care Excellence, 2022). For people experiencing more severe depression, NICE recommends considering different treatment options, including psychological therapies, antidepressant medication, or, in some circumstances, a combination of both (National Institute for Health and Care Excellence, 2022). Selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed as a first option (National Institute for Health and Care Excellence, 2022). These medications can take several weeks to begin working and should usually be continued for at least 6 months after symptoms improve to help prevent relapse (National Health Service, 2023; National Institute for Health and Care Excellence, 2022). NICE also advises that after a first episode there is roughly a 50% chance of depression returning, rising to 70% after a second episode and 90% after a third — so longer-term support or medication may be needed for those at higher risk (National Institute for Health and Care Excellence, 2022).

Effectiveness and Limitations of Treatment

While many people improve with treatment, it does not work for everyone. Studies show that roughly 10% to 30% of people show little or no improvement with treatment (Al-Harbi, 2012). Some people who do not respond adequately to treatment may be considered to have treatment-resistant depression, and they are more likely to continue struggling with daily life, physical health, and mood. Reasons for poor response can include the dose being too low, stopping treatment too early because of side effects, other health conditions, or biological differences in how individuals respond to medication (Al-Harbi, 2012). A major independent review of antidepressant research also found that antidepressants show only a small advantage over placebo, and that positive results are far more likely to be published than negative ones — meaning their real effectiveness may have been overestimated (Pigott et al., 2010). The STAR*D analysis also raised concerns about the effectiveness of antidepressant treatment and reported increasing dropout across successive treatment

stages (Pigott et al., 2010). When one approach does not help, options include increasing the dose, switching to a different medication, combining treatments, or adding specialist therapies — but even so, a significant minority continue to struggle (Al-Harbi, 2012).

Rehabilitation and Recovery Beyond Clinical Treatment

Recovering from depression involves much more than just symptoms improving, and many factors beyond medical care shape how a person heals. A major review of nearly 1,000 people's experiences identified strong social support from family and friends as the single most important help, alongside feeling in control of one's own care, rebuilding confidence, and having hope for the future (Wedema et al., 2026). Practical things — having enough money, safe housing, and healthy habits — also made a real difference, while stigma, waiting lists, and feeling dismissed by professionals held people back (Wedema et al., 2026). This is strongly supported by separate research following over 5,000 adults, which found that belonging to social groups such as clubs or community organisations was associated with a lower risk of depression and relapse. Joining just one social group reduced the risk of relapse by 24%, and joining three groups reduced it by 63% (Cruwys et al., 2013). Group membership may provide a sense of shared identity, belonging and purpose that can complement clinical treatment (Cruwys et al., 2013). Overall, professional treatment is very valuable, but it works best when combined with empathy, social connection, and care that respects the whole person (Wedema et al., 2026).

Current Debates and Emerging Issues

There is ongoing debate about whether the current way we classify depression is accurate enough. Parker (2025) argues that the International Classification of Diseases criteria for mood disorders have important weaknesses, including unclear descriptions and inconsistent definitions that can make diagnosis confusing. This concern is supported by research showing that diagnosis continues to rely heavily on clinical assessment and professional judgement, which can contribute to differences in how symptoms are interpreted. Different professionals may assess the same person quite differently, and symptoms often overlap with other conditions (Liu and Jiang, 2016). These long-standing difficulties mean that even widely used systems may not be capturing the true nature of depression as clearly or consistently as they should.

Antidepressant medication is another area of ongoing debate, particularly regarding individual differences in treatment response and the potential disadvantages of medication. This highlights the importance of monitoring individual responses and considering the balance between the benefits and potential disadvantages of antidepressant treatment (NHS, 2025). Earlier research has also raised concerns about the risks associated with antidepressant medication and the fact that the mechanisms through which these medicines work in the brain are not fully understood (Ebmeier et al., 2006). While many people benefit from antidepressant treatment, these uncertainties demonstrate that understanding of depression and its treatment continues to develop, and that further research is needed to identify which treatments are most effective for different individuals. Neurodivergence is also becoming increasingly relevant to discussions about the assessment and treatment of depression. Recent research found significant differences in depression symptoms among neurodivergent individuals and identified interactions between neurodivergence and other aspects of identity, including gender and sexual orientation. The researchers suggest that mental health treatment should take these differences into account and provide more individualised and identity-affirming care (Kroll et al., 2025). This raises questions about whether existing approaches to assessing and classifying depression are sufficiently flexible to reflect the different ways people may experience and communicate mental health difficulties. However, further research is needed before changes to diagnostic classification can be justified.

Emerging Issues and Future Directions

The limitations of current treatments have driven the search for entirely new approaches. Existing antidepressants may take several weeks to produce their full effects, and a significant number of people do not respond to them at all. New research is now exploring treatments that work in completely different ways — targeting different brain chemical pathways, hormone and stress response systems, and brain stimulation techniques — with the hope of producing faster, more effective relief (Pathak et al., 2025). Alongside new medicines, there is also growing recognition that our understanding of depression may need to change. Depression is unlikely to have one single cause, and the evidence supporting the idea that depression is simply the result of a chemical imbalance is considered weak. This suggests that depression is more complex and may involve a combination of biological, psychological and social factors (Mind, 2023). These developments suggest that the future of depression care will likely combine more personalised treatments with a greater focus on prevention, early support, and understanding the many different ways depression affects people's lives.

Recommendations

Classification and Diagnosis

It is recommended that classification systems such as the International Classification of Diseases should be regularly reviewed to improve clarity and consistency. Standardised assessment tools should be used alongside clinical discussion to reduce variation in diagnosis, while research into objective diagnostic methods should be prioritised to improve accuracy and fairness.

Treatment and Rehabilitation

Treatment should follow a stepped care approach matched to severity. For less severe depression, options such as guided self-help, watchful waiting and exercise should be considered, while antidepressants should not routinely be offered as a first option. For more severe depression, treatment should be tailored to the individual's needs and may include psychological therapy, antidepressant medication, or a combination of both.

Practice, Policy and Research

Professionals need clear guidance and time to understand each person's individual circumstances. Policy should ensure updated guidelines, reduced waiting lists, and services designed around people's recovery needs. Research should focus on better classification, faster treatments, and understanding why outcomes differ so widely. Ultimately, care should move towards a more personalised approach that values social wellbeing alongside clinical treatment.

Conclusion

This report has examined depression through the International Classification of Diseases framework, explored how it is diagnosed and treated in the UK, and considered ongoing debates and emerging directions in care. It is clear that while systems such as ICD-11 and NICE guidance provide a helpful structure for identifying and supporting people, there remain important limitations in how depression is classified, diagnosed, and treated. Diagnosis still relies heavily on conversation and professional judgement rather than objective measures, and there is still no single treatment that works reliably for everyone — with a significant proportion of people seeing little improvement or becoming unwell again.

Treatment approaches have advanced considerably, combining medication, talking therapies, and self-help matched to severity. However, evidence consistently shows that medical care alone is not enough: social connection, practical support, and feeling in control of one's own recovery can also make an important contribution to long-term wellbeing. Looking forward, there is a need for more consistent classification, faster and more effective treatments, and a broader approach that values social and personal factors alongside clinical care. Ultimately, supporting people with depression means understanding not just their symptoms, but the whole person and the world they live in.

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