Severe and Mild Depression

THE MANIFEST SYMPTOMATOLOGY OF DEPRESSION IN ADULTS

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Introductory Remarks and Classificatory Criteria

The manifest symptomatology of the various depressive syndromes requires careful examination and evaluation. Nevertheless, even more than in the study of other psychiatric conditions, an approach confined to the observation and assessment of the manifest symptomatology of depressions leaves the clinician with an awareness of the limitation of the method. The psychotherapist senses the profundity of the syndrome with which he deals, realizes that he cannot go far with a surface investigation, and feels the need for a psychodynamic approach. This in fact will be the procedure followed in this book.

The manifest symptomatology of depression impresses the clinician as being relatively uniform, characterized at least in the majority of cases by one prevailing feature—the depressive mood. It does not present a multifaceted picture, leading to different sorts of inquiries, like that of the schizophrenic

disorder. Contrary to the schizophrenic syndrome, it does not confront the therapist with an image so different from the usual one of the human being, and so distorted. However, it does have an especially powerful impact on the clinician who is struck by the intensity of the sorrow that he witnesses and to which he immediately responds with a sense of affinity, so close is that image of sorrow to a common part of the human condition. Moreover the clinical picture has a few important secondary traits which are often overlooked in the context of the mood of depression. Any description of the manifest symptomatology of the syndromes included under the category of depression implies some agreement on the classification of these syndromes. But such agreement has never been reached, since some aspects of these conditions are far from being clarified and several others are controversial. Some features which at our stage of knowledge seem to be fundamental marks of distinction may be proved later to be not so basic.

Any classification and description which are based on partial knowledge tend to repeat traditional ways, established by previous generations of professionals working in the field.

At the present level of our understanding the following three questions seem of pivotal importance in classificatory attempts.

Is the depression primary or secondary? A depression is called primary

when it constitutes an important and/or essential component of a syndrome; for instance, in what is generally called “psychotic depression” or “severe depression.”

In manic-depressive psychosis the depression is also primary. In fact, although the syndrome may have manic attacks, the depression is an important and probably necessary component. We say probably and not absolutely necessary because there are rare cases of the illness characterized only by manic attacks. In these cases, however, the presumptive evidence is that the depressive attacks occur at a subclinical or subliminal level.

A depression which occurs in the course of epilepsy or an endocrine syndrome is not considered primary because the available evidence suggests that it would not have occurred in the absence of the original syndrome.

Is the depression severe or mild? At times this question is formulated with different terminology: Is the depression endogenous or reactive; or, is the depression psychotic or neurotic? These terminologies reflect the theoretical premises of the persons who use them. An endogenous depression is based exclusively on organic, presumably hereditary factors which manifest themselves in biochemical alterations of the organism. A reactive depression would be one which is precipitated by an event perceived by the patient as harmful or unpleasant.

This dichotomy is not substantiated by any sure evidence. Any depression must ultimately be mediated by a living organism, and therefore it requires neurophysiological mechanisms and biochemical changes. On the other hand, we are not justified in claiming that no precipitating events exist just because we have not been able to determine them. In all depressions there are both psychological and biological, nonpsychological components. Moreover the biological components may not necessarily be based on anatomical pathology, but may be functional. In other words, they consist only of changes in some functions of the organism, but not of anatomical structures.

The authors of this book believe that in most cases it is possible to recognize whether a depression is psychotic or neurotic. However, these two terms have come to be used in incorrect ways by many authors and clinicians. They are wrongly used when a depression is called psychotic only if some symptoms are present which occur also in schizophrenia and are acknowledged by everybody as psychotic; for instance, hallucinations, delusions, or ideas of reference. These symptoms are not specific for any type of depression or for manic-depressive psychosis. The issue here hinges on the definition of psychosis.

As I wrote elsewhere (1973, 1974), psychosis is a term used by many to designate a severe or major psychiatric disorder. In theory and clinical

practice the concept is more difficult to define because severity is not an inflexible characteristic. A certain number of cases diagnosed as psychosis may in fact be less serious from the point of view of the sufferer or of society than some cases included in other psychiatric categories. The term *psychosis* is at times indistinctly equated with insanity. The latter term, when used legally or in popular language, suggests a person who is so incompetent that he may require special control or supervision. However, psychosis indicates not only actual or potential severity, it also connotes that an unrealistic way of appreciating the self and the world is accepted and tends to be accepted by the sufferer as a normal way of living. This definition of psychosis lends itself to justified criticism because it implies that we know what is reality and what is unreality. Many philosophers would promptly indicate to us how naive we are in assuming that we have such knowledge.

In practical terms we can say that no matter what transformation the psychotic patient has undergone, that transformation becomes his way of relating to himself and to others and of interpreting the world. The organic psychotic patient has a cognitive defect but believes that the way he deals with the world is not defective. The schizophrenic undergoes predominantly a symbolic transformation, but he believes there is nothing wrong in living in accordance with that symbolic transformation.

The patient who is depressed to a psychotic degree has undergone

predominantly a severe emotional transformation, but he believes that his way of feeling is appropriate to the circumstances in which he lives. Thus he does not fight his disorder, as the psychoneurotic does, but lives within it. In many cases he even seems to nourish it. In this respect he resembles persons who are affected by character neuroses and do not even know the pathological nature of their difficulties. The distortions of the character neuroses, however, are susceptible to at least partial adaptation to the demands of society, whereas in psychoses such adaptation is impossible or very difficult.

The severely depressed person may neglect feeding himself to the point of starvation; he may be so inactive as to be unable to take care of even the most elementary needs; he may think he is justified in believing that there is nothing good in life and death is preferable. He also considers any attempt to improve his life to be worthless, and in some cases he feels guilty in the absence of reasons which would make other people feel guilty. He may actually attempt suicide if he has an opportunity to implement such a plan. He considers his mood consonant with what appears to him the reality of his situation. Thus he seems to have characteristics which would make appropriate the designation "psychotic." Only in a minority of cases do delusions, especially of guilt, and hallucinations occur.

On the other hand, there are some severely depressed patients who do

not accept their depression and utterly reject it. Technically, they should therefore not be considered psychotic. They are in this respect similar to the marginal schizophrenic who has at least partial insight into the pathological nature of his condition. However, both this type of severely depressed patient and schizophrenic patient can easily lose insight. If in the term psychosis we include the potential loss of insight, then they too can be called psychotic. If we do so, however, we step on unsafe ground. To obviate these difficulties, I suggest that we call a depression either mild or severe with the understanding that severe depression may be accepted by the patient as a way of living and therefore be syntonic, or unaccepted and therefore dystonic.

Our difficulties are not over. Many clinicians could correctly point out that many cases of depression cannot clearly be differentiated into mild or severe; rather, they reach an intermediate stage of intensity. Inasmuch as most cases could in their psychodynamic structure and clinical course resemble either the mild or the severe type of depression, I am inclined to classify these intermediate stages as moderate-to-mild depression and moderate-to-severe depression.

Are the age of the patient or particular contingencies in his life important to justify particular classifications? I mean, for instance, postpartum depression, adolescent depression, involutional depression, or senile depression, etc. They are justified only to the extent that they frequently have

some specific clinical or psychodynamic features. It is important for the therapist to familiarize himself with them. However, the basic mechanisms are presumably the same as in other types of either mild or severe depression.

Table 3-1 demonstrates the classification adopted in this book. It also includes varieties which, although not necessary to distinguish for therapeutic reasons or for the understanding of their psychodynamics, have been recognized by several authors on account of their specific characteristics. They are reported here for the sake of clarification and to facilitate a common ground of understanding.

Before proceeding to a description of the clinical syndromes in Table 3-1, we shall briefly consider other classifications or attempts to classify depression.

Table 3-1

Classification of Depressions

	Primary Depressions
Mild (dystonic)	a. Depressive Character or Personality
	b. Reactive Depression
	c. Depression with Anxiety

	d. Depression with Obsessive-Compulsive Symptoms
	e. Masked Depression
	f. Depersonalized Depression
Severe (syntonic)	a. Pure Depression
	b. Depression in Manic-Depressive Psychosis
	c. Depression in Schizo-Affective Psychosis
	Varieties
	1. Self-blaming
	2. Claiming
	3. Mixed
	4. Simple
	5. Acute
	6. Agitated
	7. Paranoid
	8. With stupor
Related to the Cycle of Life	a. Childhood Depression
	b. Adolescent Depression
	c. Postpartum Depression
	d. Involutional Melancholia
	e. Senile Depression

Secondary Depressions

a. Depression with Neurological Disorders or Organic Psychoses

b. Depression with Endocrine Disorders

c. Depression with Other Physical Illnesses

d. Drug-Induced Depression

e. Schizophrenic Depression

A classification based on genetic or biochemical mechanisms is not justified or possible at the present time. Frazier (1976) reminds us that

> A variety of hypotheses still exists about the role of chemical transmitter systems in the biology of depression, an area which has continued to be of interest to researchers. There has been a continuing debate between British and American psychiatrists regarding the relative roles serotonin and norepinephrine play in the biology of depression.

In a very scholarly paper Akiskal and McKinney (1975) tried to integrate ten conceptual models of depression, but they failed to draw a classification based on chemistry or on theories which would explain the "leap from chemistry to behavior." They wrote that "biochemical statements that propose a causal relationship between a chemical event in the brain and a set of observable behaviors or subjective experiences present serious philosophical problems." They quote Smythies (1973) in his assertion that attempts to explain mind only in terms of brain chemistry encounter irreducible and unsurmountable elements.

The Task Force on Nomenclature and Statistics of the American Psychiatric Association has proposed the following classification of mood disorders:

	Unipolar manic disorder
296.01X	Single episode
296.02X	Recurrent
	Unipolar depressive disorder
296.11X	Single episode
296.12X	Recurrent
	Bipolar mood disorder
296.20X	Manic
296.30X	Depressed
296.40X	Mixed
	Intermittent mood disorders

301.110	Intermittent depressive disorder
301.120	Intermittent hypomanic disorder
300.410	Demoralization disorder
	Other mood disorders
300.420	Other depressive disorder
296.610	Other manic disorder
296.620	Other bipolar disorder

An "X" as the sixth digit indicates that the current condition is further specified as: 1 = mild; 2 = moderate; 3 = severe, but not psychotic; 4 = psychotic; 5 = in partial remission; 6 = in full remission.

I participated in the "Working Conference to Critically Examine DSM-III in Midstream," which took place in St. Louis, Missouri on June 10-12, 1976. During the conference many participants objected to the classification proposed by the task force. The categories "intermittent mood disorders" seemed unclear and unnecessary to several participants who thought that

these conditions are only mild forms of affective disorders. Many also objected to the proposed term "demoralization disorder" intended to designate neurotic depression. Maria Kovacs of the University of Pennsylvania School of Medicine stated, "The use of the word *demoralization* seems out of place. In a sense, every patient who recognizes his illness and comes for treatment is demoralized. According to the dictionary, demoralization means loss of morale, loss of psychological well-being because one has lost one's sense of purpose and confidence in the future, or loss of task-related attitudes expected and shared by one's group. By this definition, the concept is true of practically all psychiatric patients as well as numerous other people who might not exhibit long-term, chronic low self-esteem."

I also objected to the term "demoralization disorder," as well as to the term psychotic depression as it was described in the proposed nomenclature; that is, referring only to a condition that presents delusions and hallucinations. I repeated the same objections made earlier in this chapter.

I also stated that the term "mood disorders" seemed to me less appropriate than "affective disorders." First, the word mood as commonly used in English generally refers to the usual disposition of the personality and to the usual gamut of variations found within the limits of normality. The word affective has a deeper impact, more commensurate with the depth that affective disorders can reach. Secondly, it is one of the aims of DSM-III to

preserve similarity with European nomenclatures. The word mood is very difficult to translate into foreign languages, especially those deriving from Latin. The French word *humeur* could not be used correctly. In several classifications the component *thymo,* from the Greek *thymos,* is used to mean affect. I suggested maintaining the term "affective disorders." I also pointed out that the use of the term unipolar to specify the disorders that have only depressive or manic episodes, although increasing in popularity, is incorrect and should be discouraged. Polarity means having or showing two contrary qualities, forms, or positions. The terms for two poles, like North Pole and South Pole, are called correlational terms; like husband and wife, one cannot exist without the other. If the earth were shaped like a pear, it would have one apex but not one pole. It is true that the term unipolar is used in electricity, but for something devised artificially. We would never say that a pear is unipolar. I suggested that the terms monophasic and biphasic be used instead of unipolar and bipolar.

Primary Depressions

Mild Depressions

Mild depressions can be classified into different types, but all or most of them share some characteristics which I shall describe here. Most conspicuous is the feeling of depression, except in those conditions called

masked depressions and in syndromes of depersonalization.

Depression as a symptom is difficult to differentiate from the feeling of depression as a normal emotion, generally called sadness, which is part of the gamut of feelings of the average individual. Depression as a rule is experienced with greater intensity than sadness. It is an unpleasant feeling, difficult to overlook or shake off. It does not tend to fade away spontaneously except after a more or less prolonged period of time. As a matter of fact, the person who feels depressed often does not see how he will be able to get rid of his depressed feeling. Often it appears to him that he will remain depressed forever. Actually the opposite is true; in almost every case of mild depression the feeling sooner or later subsides or disappears completely. In many cases, however, it also recurs.

The second characteristic of mild depression is that the patient does not want to have such a despondent feeling; he rejects it, but does not know how to get rid of it. He recognizes that his symptom is unwarranted or exaggerated, and that it is a handicap and to some extent disruptive of the normal functions of life. In other words, he is aware of the dystonic nature of the symptom. The patient is generally correct in this regard: the depressive mood delays his spontaneous behavior and planned activities, requires an extra effort for concentration and work, keeps him distracted from what he would rather do or think, and leaves little room for other emotions. In some

cases the patient is able to connect the depression with an event that almost everybody else also would consider unpleasant, but his reaction is nevertheless exaggerated. In Gutheil's words (1959) he is not only sad, but pessimistic. For Gutheil, pessimism is the added element that changes simple sadness into depression. We may add that this pessimism is often but not always accompanied by feelings of loneliness, unworthiness, and self-criticism.

Ideas that life is not worthwhile occur and suicidal projects present themselves, but not in an enduring fashion. Generally suicidal ideas are not carried out.

Psychosomatic and somatic symptoms accompany almost every case of depression. Appetite and eating habits change. In a large number of patients there is a noticeable but not excessive loss of weight. On the other hand, in a considerable number of patients there is a considerable increase in weight. The patient eats in an effort to assuage his depression.

Sleep dysfunction is also a frequent symptom. Many patients complain of insomnia; yet they may sleep longer than usual, either because they do not want to face the day or because they really believe, at least at a manifest level, that their sleep requirements have increased. They claim that unless they sleep longer hours they feel fatigued, but fatigue remains a common symptom

even if they do sleep longer than usual. Constipation is also a common complaint. Many mildly depressed patients complain of a decrease in sexual libido, and yet some of them indulge more than usual in sexual behavior in an attempt to find solace.

In addition to all or most of these characteristics, mild depressions have other traits that permit special classification. In some cases it is impossible to ascertain to what type the depression should be ascribed. The whole issue of whether such classification is warranted also is a matter of debate.

One of these varieties can be called depressive character (Bemporad, 1976) or depressive personality. In these cases, according to Bemporad, "depression appears to be a *constant* mode of feeling lurking in the background during everyday life." It is a conscious reaction to the loss of a state of well-being. Contrary to some of the other character or personality disorders, the patient is dissatisfied with his condition and would like to change it. The unpleasant feeling often occurs after seemingly insignificant frustration. Bemporad reports that in the depressive character it is easy to find the primary triad of cognitive sets described by Beck (1967): a negative view of the world, the self, and the future.

The main feature of this variety of mild depression is its constant or almost constant character, so that the depressive mood becomes an

important feature of the character. The patient is usually referred to as a depressed person. In some cases the patient does not describe himself as depressed, but as a person who is bored and has lost “la joie de vivre,” or sees no possibility of joyful excitement in his life.

The variety of depression which we are going to describe now has received much more consideration in psychiatric literature—that is, reactive depression. This condition is characterized chiefly by the fact that it starts after the occurrence of an unpleasant happening in the life of the patient, or after an event which is considered by the patient to be adverse or unwelcome.

Bereavement, or loss through death of a person dear to the patient, is probably the most common precipitating factor of reactive depression. As we shall describe in greater detail in chapter 5, sadness due to mourning is a normal experience. Whereas the normal person sooner or later recovers from the experience of grief, however, the person who becomes depressed finds himself unable to shake off this unpleasant feeling. On the contrary, the anguish lingers and may become even more severe.

In my experience reactive depression connected with marital difficulties is very common. Also frequent is the depression over the end of a love relation, or over the loss of the loved person as an object of love. Loss of employment, disappointments at work, lack of promotion, financial

difficulties, breaking up an important friendship, loss of status and prestige, and insults received are precipitating factors of reactive depression that can be easily understood even at a reality level.

The situation is more complex when the loss apparently does not justify the intensity of the depression; for instance, when the death of a bird, the loss of a handkerchief, or the inability to get tickets for a show provoke a depression. It seems easy to conclude in these cases that the precipitating event has a symbolic value, as we shall see in greater detail later in this book. In some cases of reactive depression other symptoms occur often, but not always: irritability, anger, an insatiable desire to get or obtain, and even a desire to alienate or manipulate others.

Another type of mild depression is “depression with anxiety.” It consists of a clinical picture in which depression and anxiety occur concurrently. It is generally included under the group of depressions if the depressive mood is the prevailing one, although anxiety plays an important role in the total picture. In addition to being depressed, the patient is anxious, worried, expects something bad to happen, and is generally fearful of his own usual activities. In some instances he gives the impression of preferring to be depressed rather than anxious, and that the depression is an escape from anxiety. However, if the depression reaches great proportions, it may become more intolerable than the anxiety.

Another variety, more frequent than it would seem from eases reported in the literature, is the combination of depression and obsessive-compulsive symptoms. In addition to being depressed, the patient presents obsessions, compulsions, and rituals of the obsessive-compulsive kind. Contrary to what occurs in typical cases of obsessive-compulsive psychoneurosis, the obsessive and especially the compulsive symptoms are not very resistant. In some cases at least they are more easily overcome in obsessive-compulsive depression than in a typical obsessive-compulsive psychoneurosis.

Obsessive-compulsive depression is not uncommon in very religious persons who have learned to practice rituals in a compulsive way. Some of these cases are not mild and can be classified more properly as cases of severe depression in which obsessive-compulsive symptoms also appear.

The next two types of depression are characterized by the absence of depression as a feeling state of which the patient is aware. The first of these conditions is called masked depression. Doubts about the existence of such a clinical entity stem not only from different criteria of classification, but also from semantic and philosophical sources. In fact, can we talk of a feeling which is not felt? Can we talk of a felt experience which is not experienced? Freud too felt that an idea may become unconscious but an emotion by definition must always be felt.

In 1944 Kennedy reported that in many patients the symptomatology consists almost exclusively of somatic dysfunctions, which he called manic-depressive equivalents. Such terms as masked, hidden, or missed depression have appeared especially in the German literature. In 1937 Hempel published a paper on depression in which he characterized autonomic nervous disorders, and in 1949 Lemke wrote about depression of the vegetative system. Perhaps imitating the terminology used in reference to epilepsy, Ibor Lopes (1966) wrote about depressive equivalents and of *depressio sine depressione.*

According to Berner, Katschnig, and Poldinger (1973) most of the authors who use the expression masked depression mean "a depression in which the physical manifestations conceal the psychopathological symptomatology." Other people mean "a depression not recognized by a previous examiner who believed it to be a somatic disease." Still others call masked depression "any depression characterized by masked physical signs and symptoms." These are circular definitions. When we say that masked depression is a depression characterized by physical symptomatology, we offer only a tautologic statement deprived of any explanatory value. In fact we would have to demonstrate that the physical symptomatology is indeed a form of depression.

Geisler (1973) made a study of patients suffering from masked

depression who were diagnosed as suspected of suffering from internal diseases such as angina pectoris, autonomic nervous dystonia, cardiovascular disorders, cholecystitis, colitis, diverticulitis, food allergy, neoplasm, and pernicious anemia. Thirty-six patients suffering from masked depression complained of sleep disorders, lack of appetite, abdominal symptoms, anxiety, cardiac symptoms, constipation, and so on. According to Geisler, the most frequent combination of symptoms consisted of complaints referring to organs, sleep disorders, poor appetite, and anxiety.

According to Braceland (1966) the six most frequent symptoms of masked depression are insomnia, tiredness, gastric and epigastric discomfort, anorexia, headache, and general abdominal pain. In many of these cases the differential diagnosis from hypochondriasis or psychosomatic conditions is difficult to make. In some cases the diagnosis reflects the classificatory habits of the therapist more than the nature of the condition.

In my opinion a common form of masked depression is the condition which is generally referred to as alcoholism. A considerable number of depressed people hide their depression by making immoderate use of alcohol, and therefore they are considered alcoholic. They often reveal their depression during the alcohol-free intervals. That they are fundamentally depressed also is revealed by the fact that most of them respond satisfactorily to antidepressants like imipramine.

An uncommon type of depression without depressive feeling is one which often assumes the characteristics of the syndrome of depersonalization. The person no longer feels like himself. Sensations are dull; perceptions are changed; reality may appear modified or transformed; a sense of distance and of space seems unreal. The person's voice or part of his body seems not to belong to him. The patient is depersonalized insofar as he has the feeling that he is not the same person and he cannot think, feel, act, or be motivated as he used to be. Up to this point the picture seems unrelated to depression, but the fact is that at times the patient does feel depressed. Another characteristic that suggests the depressive nature of this syndrome is the fact that some of these patients (but not all) respond well to electric shock treatment, at least for a temporary remission. They also improve with amphetamine and amphetamine derivatives. By no means is it implied here that all or even most patients suffering from depersonalization are depressed.

There is an additional remark to be made about both masked depression and depersonalization. It is more than doubtful that if they belong to the category of depression, they should be included under the group of mild rather than severe depressions. In some of these cases the symptomatology is quite marked and incapacitating.

Severe Depression

Severe depression as a clinical entity has been known since antiquity. Its features are generally very pronounced, easily recognizable, and much more easily definable than those of mild depression.

What seems to have remained unchanged from the time of Hippocrates to the late 1950s is a picture of an intense state of depression in which one can almost always recognize a profound and overwhelming theme of self-blame, hopelessness, and self-depreciation. Although cases with this classic picture are still very common, others—with a picture which I call claiming depression—occur with increasing frequency.

We shall review the various syndromes of severe depression with the understanding that the division into types and varieties is not very well established and in many cases still a matter of controversial debate.

Classic Form Of Severe Depression

Severe depression is characterized by the following triad of psychological symptoms: (1) a pervasive feeling of melancholia; (2) a disorder of thought processes, characterized by retardation and unusual content; and (3) psychomotor retardation. In addition there are accessory somatic dysfunctions.

The pervasive mood of depression at times has its onset quite acutely

and dramatically, at other times slowly and insidiously. The patient generally has had previous attacks of depression which, because they were mild in intensity, passed unnoticed or were considered by the patient and his family as normal variations of mood. Even an attack that will later appear severe in intensity is misunderstood at first. An unpleasant event has occurred, such as the death of a close relative or a grief of any kind, and a mood of sadness is justified. However, when a certain period of time has elapsed and the unhappy feeling should have subsided, it seems instead to become more intense. The patient complains that he cannot think freely, feels unable to work, cannot eat, and sleeps only a few hours a night.

As the symptoms increase in intensity, the patient himself may request to be taken to a physician. Often, however, the illness is advanced to such a degree that the patient no longer is able to make such a decision and he consults a physician at the initiative of family members. When the physician sees the patient, he is impressed by his unhappy, sad appearance. The patient looks older than his age, his forehead is wrinkled, and his face, although undergoing very little mimic play, reveals a despondent mood. In some cases the main fold of the upper eyelid at the edges of its inner third is contracted upward and a little backward (sign of Veraguth).

In most cases the examiner is led astray by the complaints of the patient, which consist of physical pain, a feeling of discomfort, digestive

difficulties, lack of appetite, and insomnia. The physician may interpret these complaints as simple psychosomatic dysfunctions. They may persist and constitute a syndrome of severe masked depression. In the majority of cases, however, the mood of melancholia sooner or later becomes prominent and leads to an easy diagnosis.

The patient is often at a loss to describe the experience of melancholia. He says that his chest is heavy, his body is numb; he would like to sleep, but he cannot; he would like to immerse himself in activities, but he cannot; he would even like to cry, but he cannot. “The eyes have consumed all the tears.” “Life is a torment.” There is at the same time a desire to punish oneself by destroying oneself, which at the same time would end one’s suffering. Suicidal ideas occur in about 75 percent of patients, and actual suicide attempts are made by at least 10 to 15 percent. Often the suicide attempt occurs when it is not expected, because the patient seems to have made some improvement and the depression is less pronounced. In a minority of suicide attempts, the suicidal idea was carefully concealed from the members of the family. The desire to end life applies only to the life of the patient himself, with one important exception to be kept in mind always: young mothers who undergo psychotic depression often plan to destroy not only themselves but their children, who presumably are considered by the patient to be an extension of herself. Newspaper reports about mothers who have killed themselves and their little children in most cases refer to patients suffering from

unrecognized attacks of severe depression.

The other important symptom of depression concerns the content and type of thinking. As far as the content is concerned, the thoughts of the patient are characterized by gloomy, morbid ideas. In some cases, at the beginning of the attack, ideas occur that at first may not be recognized as part of the ensuing picture of psychotic depression. They may be phobic, obsessive, or obscene. They are followed by discouraging ideas which acquire more and more prominence. The patient feels that he will not be able to work, he will lose his money, something bad will happen to his family, somebody is going to get hurt, or the family is in extreme poverty. There is no great variety in the patient's thoughts. It is almost as if the patient purposely selects the thoughts that have an unpleasant content. *They are not thoughts as thoughts; they are chiefly carriers of mental pain.*

The distortion caused by the unpleasantness of the mood at times transforms these melancholic thoughts into almost delusional ideas or into definite delusions. They often represent distortions of the body image and hypochondriasis. The patient thinks he has cancer, tuberculosis, syphilis, and so on. His brain is melting, his bowels have been lost, his heart does not beat. Delusions of poverty are also common. Ideas of guilt, sin, and self-condemnation are very pronounced, especially in serious cases. At times these self-accusatory ideas are so unrealistic that the name "delusion" seems

appropriate for them. “It is all my fault;” “It is all my responsibility.” In some cases the tendency to blame oneself reaches the absurd; the patient blames himself for being sick or for “succumbing to the illness.” In some cases, he feels that he is not really sick but he acts as if he were sick. This impression is almost the opposite of what we find in some schizophrenics, in whom there is the idea that the world is a big stage, and what happens in the world is an act or a play. The depressed patient, on the contrary, feels that he is acting the part of the sick person. Incidentally, this idea occurs generally when the patient starts to recover from his depressed attack.

These delusional ideas cannot always be traced back to an exaggeration or distortion of mood. In cases that have a mixed paranoid and melancholic symptomatology, the delusions are more inappropriate and bizarre and are in no way distinguishable from those of paranoid patients.

In a small percentage of severely depressed patients there are obsessive-compulsive thoughts, similar to those occurring in obsessive-compulsive psychoneuroses or in mild depression with obsessive features. The pervasive mood of depression prevails, however, in the context of the complex symptomatology.

In the classical or traditional type of psychotic depression, the main theme is a self-blaming attitude. In severe cases the patient seems to transmit

the following message: “Do not help me. I do not deserve to be helped. I deserve to die.” Together with this peculiar content of thought, there is a retardation of thinking processes. The patient complains that he cannot concentrate; he cannot focus his attention. At first he can read, but without retaining what he reads. Writing is more difficult for him and composing a letter requires tremendous effort. If the patient is a student, he cannot study any longer. Thoughts seem to follow each other at a very slow pace. Speech is also slow. In a severe state of stupor the patient cannot talk at all.

Hallucinations in severe depression are described by many authors, especially in the old textbooks. According to the experience of many psychiatrists, however, they are much less common in severe depression than they used to be. This difference is not apparent, in the sense that patients who hallucinate are now diagnosed as schizophrenics. I have found that hallucinations do occur, although rarely, in some severely depressed patients. They have the following characteristics:

1. They are very rare in comparison to their occurrence in schizophrenia.

2. They do not have the distinct perceptual and auditory quality that they have in schizophrenia. The patients often cannot repeat what the voices say; they sound indistinct. The patients describe them as “as if rocks were falling,” or as “bells which ring.” Often they seem more like illusions than

hallucinations, or as transformations of actual perceptions.

3. They can be related to the prevailing mood of the patient much more easily than in schizophrenia. Their secondary character—that is, secondary to the overall mood—is obvious. They are generally depressive and denigratory in content, often commanding self-destruction or injury.

4. More frequently than in schizophrenic patients, they occur at night, less frequently during the day. The depressed patient, who is in contact with external reality more than the schizophrenic, possibly needs the removal of diurnal stimuli in order to become aware of these inner phenomena.

Another important sign of the classic type of depression consists of retarded hypoactivity. The actions of the patient decrease in number, and even those which are carried out are very slow. Even the perceptions are retarded. Talking is reduced to a minimum, although a minority of patients retain the tendency to be loquacious. Working at the usual daily tasks of life is postponed or retarded. The patient avoids doing many things but continues to do what is essential. Women neglect their housework and their appearance. Every change seems to require a tremendous effort. Interpersonal relations are cut off. In some less pronounced cases, however, the opposite at first seems to occur. The patient, who is prone to accuse himself and extoll others, becomes more affectionate toward the members of his family and willing to do many things for them in an unselfish manner.

However, when the disorder increases in intensity later, he becomes indifferent to everybody.

The physical symptoms that accompany classic depressive attacks are reduction in sleep, decrease in appetite, and considerable loss in weight. These symptoms do not seem to be due to a specific or direct physiological mechanism, but rather are related to or are a consequence of the depression. Many patients complain of dryness of the mouth, which is to be attributed to decreased secretion of the parotid glands (Strongin and Hinsie, 1938).

Other frequent symptoms are constipation, backache, amenorrhea, and dryness of the skin. There is a definite decrease in sexual desire, often to the point of complete impotence or frigidity. In many patients sugar is found in the urine during the attack. The basal metabolism tends to be slightly lower than normal.

The Claiming Type Of Depression

As we have already mentioned, since the late 1950s there has been a decline in the number of cases showing the classic type of depression, either as part of manic-depressive psychosis or as part of pure depression. Moreover, the cases that we do see seldom reach those severe degrees which used to be very common. Another type of depression is frequently observed now, whose symptomatology has the appearance of an appeal, a cry for help.

The patient is anguished but wants people near him to become very aware of his condition. All his symptoms seem to imply the message, “Help me; pity me. It is in your power to relieve me. If I suffer, it is because you don’t give me what I need.” Even the suicidal attempt or prospect is an appeal of “Do not abandon me” or, “You have the power to prevent my death. I want you to know it.” In other words, the symptomatology, although colored by an atmosphere of depression, is a gigantic claim. Now it is the gestalt of depression that looms in the foreground with the claim lurking behind; now it is the claim which looms, with the depression apparently receding. Poorly hidden also are feelings of hostility for people close to the patient, such as members of the family who do not give the patient as much as he would like. If anger is expressed, feelings of guilt and depression follow. Whereas the patient with the self-blaming type of depression generally wants to be left alone, the claiming type of patient is clinging, dependent, and demanding. Self-accusation and guilt feelings play a secondary role or no role at all in this type of depression.

Whereas in the self-blaming type of depression there is a decrease of appetite and insomnia, in the claiming type the appetite is not necessarily diminished and quite often there is a need and ability to sleep longer than usual. In some cases the patient does not want to get up from bed and wishes to return to it several times during the day.

Other Clinical Varieties Of Depression

Some authors distinguish several varieties of severe depression: the simple, the acute, the paranoid, and the depressive stupor.

Simple depression is characterized by the moderate intensity of symptoms and may make the diagnosis of psychosis difficult. Delusions and hallucinations are absent. Although there is psychomotor retardation, the patient is able to take care of his basic vital needs. Suicidal ideas and attempts also occur in this type. In recent years cases of simple depression seem to have increased in number.

In *acute depression* the symptoms are much more pronounced. Self-accusation and ideas of sin and poverty are prominent. Some depressive ideas bordering on delusion are present. The loss of weight is very marked.

In *paranoid depression,* although the prominent feature remains the depressed mood, delusional ideas play an important role. The patient feels that he is watched, spied on, or threatened. Somebody wants to hurt him. Hypochondriacal delusions with pronounced distortion of the body image may occur. As in the case of hallucinations, these delusions seem secondary to the prevailing mood of the patient. They disappear easily when the mood changes. Hallucinations may also occur.

Depressive stupor is the most pronounced form of depression. Here there is more than psychomotor retardation: the movements are definitely inhibited or suppressed. The patients are so absorbed in their own pervasive feelings of depression that they cannot focus their attention on their surroundings. They do not seem to hear; they do not respond. They are mute, with the exception of some occasional utterances. Even mimic expressions are absent and the face seems mask-like, in a way reminiscent of the faces of some post-encephalitic and Parkinsonian patients. Since the patients cannot focus on anything, they give the impression of being apathetic, whereas they are actually the prey of a deep, disturbing emotion. These patients cannot take care of themselves. Generally they lie in bed mute and have to be spoon-fed.

Unless they are successfully treated during the attack, physical health may suffer severely. Patients lose up to a hundred pounds in certain cases; they are constipated, and their circulation is enfeebled.

All the types of depression that we have so far described are also characterized by a lack of manic features or episodes during their course.

Depressive Phase Of Manic-Depressive Psychosis

All the clinical varieties of severe depression that we have described also appear as the depressive phase of manic-depressive psychosis.

In manic-depressive psychosis the classic type of depression is probably the most frequent. However, the claiming type, or mixed self-blaming and claiming type, also appears with typical or atypical symptomatology, as well as forms of simple depression, acute depression, paranoid depression, and depressive stupor.

What chiefly characterizes the depression occurring in manic-depressive psychosis is that it is followed regularly or occasionally by manic episodes. Inasmuch as the depressive picture is not dissimilar to the ones so far described, this section will be devoted to examination of the manic episode. The manic attack is not an attack of depression. Nevertheless we shall describe it here because it is a frequent component of a syndrome in which primary severe depression is an important part.

In the manic attack, as in an attack of severe depression, the symptomatology is characterized by: (1) a change in mood, which is one of elation (2) a disorder of thought processes, characterized by flight of ideas and happy content; and (3) an increased motility. Accessory body changes also occur.

It is difficult in many instances to determine the beginning of the episode. The patient is often in a lively mood. He strikes the observer as being an extrovert, active individual who likes to talk a great deal and do many

things. At the time of the attack, however, the over joyousness of the patient seems out of proportion and occasionally inappropriate; for instance, when he easily dismisses things which should make him sad and continues to be in his happy mood. The patient appears exuberant very sociable, and at times even succeeds in transmitting his happiness to the surrounding persons. This mood, however, is not constant or solid. We are not referring here to the alternations with depression, but to the fact that this euphoric mood may easily change into one of irritation or even rage and anger, especially when the patient becomes aware that the environment does not respond to his enthusiasm or does not react in accordance with the exalted opinion that he has of himself.

The thinking disorder is prominent and reveals itself in verbal productions. The patient talks very fast and cannot concentrate on any subject for more than a few seconds. Any marginal idea is expressed; any secondary, distracting stimulus affects the patient. The thoughts expressed are not disconnected but maintain some apparent ties. We can always determine that the ideas are connected by the elementary laws of association, but the talk as a whole is verbose, circumstantial, and not directed toward any goal or toward the logical demonstration of any point which is discussed. The ensemble of these thought and language alterations is called “flight of ideas.”

Actually this type of verbal behavior has a goal—that of maintaining this

superficial effervescent euphoria and escaping from intruding thoughts which may bring about depression. In less pronounced cases the patient realizes that he has unduly allowed details to interfere with the original goal of his conversation, and he tries to go back to it but again gets lost in many details.

In this incessant logorrhea, the patient makes jokes. The propensity toward associations leads to repeated clang associations which the patient uses to make jokes, puns, and so on (Arieti, 1950). In rare cases the lack of thought inhibition facilitates a certain artistic propensity which does not, however, lead to achievement because of the lack of concentration.

Lorenz and Cobb (1952) and Lorenz (1953), who made an accurate study of speech in manic patients, reported that in manic speech there is a quantitative change in the use of certain speech elements, namely: (1) a relative increase in the use of pronouns and verbs; (2) a relative decrease in the use of adjectives and prepositions; and (3) a high verb-adjective quotient (that is, the proportion of adjectives is decreased). These authors found no gross disorganization at the level of structural elements, and they postulated that the defect in manic speech occurs at higher integrative levels of language formulation. They concluded that, “If the assumption of a correlation between emotional states and verb-adjective quotient is correct, the manic patient’s speech gives objective evidence of a heightened degree of anxiety.”

The rapid association ability that the manic possesses enables him to grasp immediately some aspects of the environment which otherwise would pass unnoticed. The patient is in the paradoxical situation in which his ability to observe and grasp environmental stimuli has increased, but he cannot make use of it because of his distractibility.

The patient's thought content often reveals an exalted opinion of himself. The patient may boast that he is very rich, a great lover, a famous actor, a prominent businessman. These statements receive flimsy support. When asked to prove them, the patient attempts to do so but soon is lost in a web of unnecessary details. He may become excitable if he is reminded of the goal of the conversation. Disturbances of the sensorium are generally of minimal intensity and are caused by the exalted mood or distractibility, not by intellectual impairment.

Motor activity is increased. Manic patients are always on the go, in a state that ranges from mild motor excitement to incessant and wild activity. They talk, sing, dance, tease, destroy, move objects. In severe states these actions or movements remain unfinished and purposeless. In spite of their constant activity, manic patients do not feel tired and have tremendous endurance.

Accessory somatic symptoms consist of loss of weight which is generally

not as pronounced as in depression, decrease in appetite, and constipation. Insomnia is marked. The blood pressure is generally lowered. Menses are irregular. Sexual functions, although apparently increased in hypomanic states, are generally decreased or disturbed in various ways in manic conditions.

Manic Varieties. As with depression, many forms of manic states have been described by early authors. A brief description of them follows.

In *hypomania* the symptoms are not of a marked intensity. As mentioned before, it is difficult at times to say whether the patient is showing his usual extrovert personality or the beginning of an illness. He seems full of pep and in good humor. He wants to do many things. His verbal abilities are accentuated. Although he has always had a talent for foreign languages, he now speaks many of them without hesitation, unconcerned with the mistakes he makes. Some of these patients increase their activities to such an exaggerated degree that they show very poor judgment. They are actually compelled by their inner excitability and by their exalted mood. They may walk for miles and miles. Generally they have a goal (for instance, to reach the next village), but not a necessary one. They may send out hundreds of unnecessary letters or greeting cards and make a large number of lengthy telephone calls. They often go on spending sprees, with disastrous economic consequences. Their sexual activity is increased, and lack of control may bring

about unpleasant results. Illegitimate pregnancies in hypomanic women and venereal diseases in hypomanic men and women are relatively common.

The excitability, richness of movements, and euphoric mood give a bizarre flavor to the manic's behavior. A female patient, in order to show a sore to a physician, completely undressed in front of him. Occasionally even thefts and fraudulent acts are committed. The patient retains the ability to rationalize his actions, at times to such an extent that the layman is confused and believes in the patient's sanity.

In *acute mania* the symptoms are much more pronounced. They may accelerate gradually, from a previously hypomanic state, or rapidly, from a normal condition. The patient is in such a state of extreme restlessness that his behavior may be very disturbing and difficult to control. He may disrupt theatrical audiences, sing or scream in the street, or ring bells. If an attempt is made to control him, he may become belligerent. The mood is one of such exaltation that spontaneous thoughts of self-aggrandizement are accepted immediately.

A subtype which Kraepelin differentiated from acute mania is delusional mania, characterized by an abundance of grandiose delusional ideas reminiscent of those found in the expansive type of general paresis.

Delirious mania represents an extreme stage of excitement. The patient

is incoherent, disoriented, restless, and agitated. He may easily injure himself and others in his aimless activity. Restraint, chemical or physical, is an absolute necessity to avoid exhaustion which may lead to death. Hallucinations and delusions are frequent.

In addition to the types just mentioned, Kraepelin has described *mixed states* which are characterized by a combination of manic and depressive symptoms. He distinguishes the following six principal types: (1) manic stupor; (2) agitated depression; (3) unproductive mania; (4) depressive mania; (5) depression with flight of ideas; and (6) akinetic mania.

The names given to these types indicate the combination of chief symptoms for each. Of the six types, perhaps the most common is agitated depression. In this condition a motor restlessness, typical of a manic excitement, is superimposed on a markedly depressive symptomatology.

Although the types of manic-depressive psychosis have been described as if they were separate entities, all the types are related, as Kraepelin saw when he first formulated the large nosological concept of manic-depressive psychosis.

The melancholic and the manic attack, which at first seem so different, have an intrinsic similarity; the same mental functions are altered, although the alterations are in a certain way opposite. Whereas in depression the mood

is one of melancholia, in the manic attack it is one of elation; whereas in depression the thought processes and motor activity are retarded, in the manic attack a flight of ideas and increased motility are found.

One of the main characteristics of manic-depressive psychosis is the recurrence of the attacks, which has conferred to the disorder the designation, often used in Europe, of intermittent psychosis.

The attack may occur in different successions, which old books of psychiatry described at great length and with many illustrations that represented the manic attack as a positive wave and the depression as a negative wave. A sequence of a depressed phase followed by a manic phase is the typical pattern of circular psychosis. We may observe, however, that the attacks of depression far outnumber those of mania. Some patients may undergo a conspicuous number of depressions without ever having a manic phase.

There seems to be no relation between the duration of the attack and of normal intervals. At times, short attacks recur several times in short succession, but occasionally the series is interrupted by a long normal interval. I have seen several cases in which an attack of depression in the patient's early twenties was not followed by a second one until the patient had reached his middle sixties or even seventies. Kraepelin illustrated that

many attacks of depression occurring later in life, which many authors consider as a subtype of senile psychosis, must instead be considered to be late occurrences or relapses of manic-depressive psychosis.

According to Pollock et al. (1939) 58.1 percent of patients have only one attack, 26.1 percent have two attacks, 9.3 have three attacks, and 6.5 percent have more than three attacks. Occasionally, one finds a patient who has had 25 or even more attacks.

The age at which the first attack occurs varies. It may even happen in childhood in rare cases. By far the largest number of first attacks occur between the ages of twenty and thirty-five. Manic attacks are slightly more frequent between the ages of twenty and forty. After forty, their ratio to depressive attacks decreases further. Women are more susceptible to this psychosis than men. (About 70 percent of patients are women.)

The illness generally results in recovery as far as the individual attack is concerned. Repeated attacks usually cause very little intellectual impairment. Death, however, may occur in two instances: suicide in depression, and exhaustion or cardiac insufficiency in cases of delirious mania. Another situation which we shall discuss later is the change of the manic-depressive symptomatology into a schizophrenic one, either shortly after the onset of the illness or even after many years of hospitalization.[1]

Prognostic criteria as to the future course of the condition are very difficult when the patient is examined only from the point of view of manifest symptomatology. Contrary to what happens in schizophrenia, the manifest symptomatology of manic-depressive psychosis will rarely permit prediction as to whether the patient will have only the present attack, a few, or many in his lifetime. The prognosis is almost always good as to the individual attack, but it is uncertain as to the possibility of recurrence. Rennie (1942) in an accurate statistical study found that the prognosis is worse when attacks occur after the age of forty. He found that 70 percent of all patients had a second attack; 63.5 percent a third; and 45 percent a fourth. The more frequent the attacks, the worse the prognosis is.

Involutional Melancholia

A common type of depression occurs during the climacterium (menopause), or shortly before or after, and is generally called involutional melancholia. This diagnosis was made more frequently in the past, before the advent of electric shock treatment, drug therapy, or psychotherapy on a large scale. Patients were admitted to psychiatric hospitals where at times they remained for very long periods of time, in some cases even for the rest of their lives. The majority of patients remained sick from one to five years. I myself while working at Pilgrim State Hospital saw many patients so diagnosed who had remained in the hospital for even more than ten years.

The advent of electric shock treatment dramatically changed the picture and permitted the complete loss of symptomatology which had persisted for so long. All the mentioned types of treatment have drastically changed the course of the illness and permit a much more favorable prognosis.

Involutional melancholia is a syndrome characterized by severe depression which generally occurs for the first time during the so-called involutional age—between the ages of forty to fifty-eight in women, and fifty to sixty-five in men. It is much more common in women.

The onset may be gradual and be manifested by anxiety, apprehension, hypochondriasis, and in some cases by quasi-paranoid attitudes toward acquaintances, relatives, friends, co-workers, and so forth. Irritability and pessimism predominate at first, together with an excessive preoccupation with bodily functions and a fear of illnesses. Restlessness and frank motor agitation subsequently become the main feature in most cases. Psychomotor retardation, typical of other severe types of depression, is absent in many cases or not very pronounced. However, the patient is definitely less active than before the onset of the illness. The lack of purposeful activity at times contrasts with the motor restlessness. Female patients often are prompt to attribute their symptoms to menopause and to minimize psychological factors of any sort. In some cases that run a very acute and serious course, the examiner feels he is dealing with a person who considers his/her life already

coming to an end. The remaining years are seen as a prolonged agony which it would be better to terminate with a self-imposed coup de grace.

In the past the most pronounced forms of depression were seen in involutional melancholia even more than in the depressive phase of manic-depressive psychosis or in other types of severe depression. Prior to the introduction of three types of treatment—electric shock treatment, drug therapy, and psychotherapy—the current belief of the medical staff in psychiatric hospitals was that only "about one-third of hospitalized cases lived through their psychosis to survive" (Bigelow, 1959). We must remember that these were hospitalized cases, and that this evaluation did not include milder cases which were never hospitalized. Today the prognosis is quite different. If suicide is avoided, recovery or very marked improvement occurs in 100 percent of cases.

In early studies of this condition, the prepsychotic personality of the involutional patient was described as being characterized by rigid adherence to the ethical code, narrow range of interests, meticulousness, stubbornness, and poor sexual adjustment (Titley, 1936). Others stressed obsessional, sadomasochistic, introverted personalities (Palmer and Sherman, 1938). Rosenthal (1968, 1974), who has made recent studies of involutional melancholia, does not give much credit to the findings of Palmer and Sherman and of Titley. He states that "one is hard-pressed to find any recent studies

that confirm these findings with more sophisticated statistical techniques."

In addition, all the studies that relate involutional depression to the physical changes of the menopause or to other endocrine functions have led to no conclusive results.

Senile Depression

Senile depression must be distinguished from a depression which occurs in a predominantly organic condition, such as senile psychosis or cerebral arteriosclerosis.

Senile depression is a rather frequent form of generally moderate to severe depression, which is distinguished from the other types of severe depression because it occurs in old age in individuals who have not suffered from depression previously. It is characterized at first by psychosomatic and hypochondriacal preoccupations, followed by an overpowering feeling of depression, guilt, self-deprivation, inhibition of activity, retardation, and marked decrease in interest. At least two-thirds of the patients are women.

Some cases are relatively benign and are often diagnosed as cases of reactive depression because they occur after an unpleasant event has taken place. The most severe cases do not seem to be reactive to any specific event; rather, they seem to represent the unfavorable outcome of an entire life.

In a study reported by Charatan (1975) 52 percent of the patients who had been seen in a geriatric psychiatric outpatient clinic were diagnosed as suffering from an affective disorder—primarily psychotic depression.

In a considerable number of patients who are approaching old age, but who cannot yet really be called old—from their late fifties to middle sixties—the depression seems to be predominantly precipitated by sexual dysfunction or at least sexual preoccupations. Male patients complain that they have difficulty in erecting or that they lose the erection rapidly, ejaculate without strength or momentum, or without enough semen. Women complain of dyspareunia, complete frigidity, or even of total sexual disgust. In a minority of cases in both sexes there is also compulsive masturbation or even promiscuity in an attempt to overcome the depression. In many other cases, especially for widowers, loneliness is a much more frequent complaint than sexual dysfunction.

Postpartum Depression

All kinds of affective conditions may occur after childbirth, from the so-called postpartum blues to mania and psychotic depression. Inasmuch as I consider childbirth to be a precipitating event of great psychological significance although not physically related to the depression, postpartum depression is here included among the primary depressions.

The manifest symptomatology of postpartum depression is fundamentally not different from that of other severe depressions. In most cases there is a gradual increase of depressive characteristics. In some cases the condition is recognized several weeks after childbirth and only when a full-blown depression is present.

Frequent symptoms are insomnia, restlessness, hypoactivity, and disinterest or neglect of the child. In some cases there are also phobic and obsessive symptoms, which are quite distressing: the patient is afraid of harming or even killing the child. In less severe cases the patient is afraid that she will not be able to take care of her child. She considers herself a bad or unworthy mother. She either pities the child very much or is completely indifferent to him and considers him an intruder in her life. In still other cases the anxiety about not being able to be a good mother prevails over the feeling of depression.

In the most severe cases a deep depression, often accompanied by guilt and a total feeling of hopelessness, obliterates all other sensations.

Some postpartum depressions recover quite quickly, but most of them are of longer duration than other depressions and of severe intensity, irrespective of whether the depression is monophasic or part of a biphasic manic-depressive psychosis that has been precipitated by childbirth.

A very important distinction must be made in cases of postpartum depression in regard to the safety of the baby. If the patient in an obsessive or phobic way is afraid of hurting or even killing her child, the danger is minimal or practically nonexistent. The patient has to be reassured and told that she is suffering from a fear, not from a determination to do anything harmful. On the other hand, if the patient has no obsessive-compulsive or phobic symptoms, is very depressed, and expresses or nourishes suicidal ideas, the risk is great not only for her but also for the baby. What we mentioned before—that depressed women who commit suicide often include their children in the suicidal act and kill them too—applies especially in postpartum depressions. Twin babies are killed by depressed mothers just as easily as single children. The greatest surveillance is necessary.

Since all types of psychiatric conditions can occur after childbirth, the diagnosis may be difficult in atypical cases. The first diagnostic task consists in ascertaining whether the condition is a postpartum delirium, generally organic in nature, or any other psychiatric condition less frequently associated with organic factors. Delirium, which is characterized generally by confusion, extreme excitement, incoherent or irrelevant thinking, and a rather acute course, has become much less frequent in the last few decades probably because of improved obstetrical care and less probability of toxic conditions during pregnancy. The presence of schizophrenic symptoms such as delusions, hallucinations, or ideas of reference may lead easily to the

diagnosis of schizophrenia.

However, many authors differ in their reports of the incidence of schizophrenic and affective psychoses after childbirth. According to Davidson (1936), schizophrenic and manic-depressive psychoses each constituted 30 percent of postpartum psychiatric disorders. For Boyd (1942), manic-depressive psychosis constituted 40 percent, schizophrenia 20 percent, and delirium 28.5 percent. Strecker and Ebaugh (1926) reported 34 percent delirium, 36 percent manic-depressive, and 20 percent schizophrenic. Protheroe (1969) in England reported almost twice as many cases of affective psychosis as of schizophrenic psychosis. In a review article, Herzog and Detre (1976) state that the discrepancy between English and American statistics may be due to the fact that American clinicians have tended to underdiagnose the incidence of affective disorders and overdiagnose schizophrenia. In my opinion, an additional confusion results from the inability to make a differential diagnosis between manic-depressive psychosis and a depression which is not related to manic-depressive psychosis.

It is a common belief that postpartum conditions are less common today, and as a matter of fact there are many fewer reports about these conditions in the current psychiatric literature than in the literature of a few decades ago. However, according to my clinical experience, this belief is not correct: perhaps postpartum deliriums and full-fledged psychoses are less

common because prenatal care and medical assistance during labor and puerperium have improved. Although I have not been able to develop adequate statistics, my bona fide impression is that less pronounced postpartum conditions are common, and that schizophrenic and affective psychoses are not at all rare.

Suicide

A relatively frequent outcome of severe depression is suicide, which we have already considered in relation to the self-blaming type of depression. We shall consider it here as part of the manifest symptomatology of every severe depression. The psychodynamics of suicide will be studied in chapters 6 and 8.

The occurrence of suicide in all types of severe depression is estimated variously. Rennie (1942) gave a conservative estimate of 5 percent in patients suffering from severe depression. According to Weiss (1974) more than 20,000 suicides are recorded each year in the United States, but Dublin (1963) has estimated that the correct number is 25,000, and Choron (1972) that it is 30,000. If we add to this number the attempted suicides whose exact number cannot be evaluated, we can conclude that the problem is of vast proportions indeed.

Although people who attempt successfully or unsuccessfully to commit

suicide are by no means all depressed persons, the depressed constitute by far the largest group. Feelings of helplessness, hopelessness, failure, and willingness to face death as the only way out are prominent in people who make suicidal attempts. Unfavorable prognostic signs are the seriousness of the depression, a history of previous attempts, the seriousness of intention, advanced age, and old age. The risk increases when the patient is alone and feels that nobody will oppose his plans, and when his depression has decreased in intensity to such a point that he does not feel slowed down in his motor actions or at least in his physical ability to carry out the suicide attempt. Opportunities that facilitate the attempt are also dangerous, like living on a high floor, having a large amount of sleeping pills, the possibility of drowning oneself, or the availability of guns and ropes.

Secondary Depression

Depression With Neurological Or Brain Disease

Depressions accompanying neurological disease are relatively common. Perhaps the most common is the depression occurring in various types of epilepsy. It is less common in epileptics suffering from grand mals, perhaps because the fits have antidepressant effects, like the convulsions produced by ECT. Depression is relatively common in epileptics suffering from petit mals or psychomotor equivalents, or in patients whose electroencephalograms

reveal diencephalic dysfunction or discharges from the temporal lobes.

The risk of suicide in depressed epileptics is very high because the patient has to contend not only with the depression but with the impulsive urges of the epileptic personality. Whether the depression occurring in epileptics is precipitated by the discomfort of the illness itself, or is an epileptic equivalent, or is just a depression that happens to occur in an epileptic person is difficult to determine in the majority of cases. These patients constitute serious therapeutic challenges.

In patients suffering from Huntington's chorea, depressions with suicidal attempts are quite common, especially for female patients (Whittier, 1975). Depression often is seen in postencephalitics. According to Brill (1975) these patients are characteristic for their whining voice, clinging manner, and dependent and complaining attitude. Hypochondriacal symptoms, self-accusations, and delusions of guilt are also common. Neal (1942) found that the most frequent clinical picture was similar to that described by Brill. However, in his review of 201 cases he found that pathological depression was reported nine times, psychotic depression eight times, and hypomania eight times.

Mild to moderate depression and even severe depression is common in patients suffering from Parkinson's disease. This finding, and the observation

that depression often follows the use of drugs which affect the basal ganglia, have led to interesting hypotheses about the anatomical and biochemical nature of depression.

Many other chronic neurological diseases (muscular dystrophies, cerebellar atrophies) are accompanied by depression. In most cases the main therapeutic task is one of rehabilitation or adjustment to the condition. In many cases of multiple sclerosis, there is no depression in spite of the crippling features of the disease. On the contrary, the patient seems apathetic or nonchalant to his condition. Depression occurs also in mental defectives who are not so defective as to disregard their condition.

Depressed episodes occur in senile dementia and also in psychoses with cerebral arteriosclerosis. These depressive episodes do not last long and are generally not prominent in the general clinical picture. The patient feels mistreated, cries over alleged thefts of which he is a victim, and is confused.

Depression With Endocrine And Other Chronic Diseases

The thyroid is the endocrine gland more frequently involved in depressions that accompany endocrine disorders. Hypothyroidism of any kind can lead to depression, especially when myxedema occurs. Hyperthyroidism (whether or not it reaches the clinical level of Graves' disease) is often complicated by depression. The patient's despondent mood

is often accompanied or alternated by a mood of irritability and capriciousness.

I also have seen cases of depression in hyperparathyroidism and severe diabetes. Depression also occurs after coronary disease, although not so frequently as states of anxiety.

Many diseases, especially those running a chronic course, can be accompanied by depression. In all these cases it is difficult to determine whether the physical illness is etiologically related to depression or whether depression is merely a precipitating factor, that is, merely the patient's psychological response to the unpleasantness caused by his physical illness.

Drug-Induced Depression

The following drugs induce a depressive mood in some patients: steroids, chlorpromazine (Thorazine®), the butyrophenones like haloperidol (Haldol®), and especially the rauwolfia derivatives, like reserpine (Serpasil®). The depression is generally not severe and disappears with discontinuance of the drug.

Depression Occurring In The Course Of Schizophrenia

Depression may occur in the course of schizophrenia. It must be

distinguished from schizo-affective psychosis, a condition in which a mixture of schizophrenic and manic-depressive symptoms takes place from the onset of the illness. Many psychiatrists, including myself, do not as a rule consider the occurrence of depression in the course of schizophrenia in negative terms but, on the contrary, as a sign of growth and good prognosis, especially if it occurs after the patient has started to respond favorably to treatment and the schizophrenic symptoms have disappeared or diminished in intensity.

Differential Diagnosis

The diagnosis is made in two steps. The first step consists of determining whether the patient is really suffering from a depression or from a syndrome simulating a depression. A person who seems depressed is not necessarily depressed in the clinical sense.

He may be experiencing normal sadness (see chapter 5). He may also be depressed and suffering from many psychiatric disorders, not necessarily just from a clinical form of depression. Depression, like anxiety, is found as a concomitant symptom in most psychiatric conditions. However, we are justified in calling a syndrome depression when the depressive mood constitutes the main characteristic, irrespective of whether this mood belongs to a primary or secondary form of depression.

Once we have ascertained that the patient is suffering from a real

depression (and not from another syndrome), we proceed to the second step: What kind of depression is he suffering from?

An elderly person has lost a considerable amount of weight, looks depressed, and complains that he may have cancer. He may be mistaken for a person suffering from severe depression when he indeed has some kind of malignancy. If he also has depression, it may be precipitated by his appraisal of his poor physical condition. An accurate physical examination will determine the situation. In psychiatric practice, however, the opposite occurrence is more common: an elderly patient has lost weight, has many hypochondriacal complaints including a fear of cancer, and is depressed. Negative physical findings, psychomotor retardation, insomnia, and a despondent mood generally will determine that he is suffering from depression.

Some post-encephalitic patients and some parkinsonian patients are mistaken for depressed, even when their condition is not complicated by depression. The confusion is caused by the fact that patients with extrapyramidal syndromes have symptoms and signs which are reminiscent of characteristics found in depressed patients. These symptoms include loss of accessory movements, mask-like expression on the face, slow gait, posture with stooped body and flexed head, and general psychomotor retardation. Neurological examination and the medical history of the patient will lead to

the correct diagnosis.

The complete or almost complete immobility of the patient and a minimal response to external stimuli may make difficult a differential diagnosis between depressive stupor and catatonic stupor. Generally a history of depression leads to the diagnosis of depression, but not always; many catatonics have experienced some episodes of mild or severe depression before the catatonic attack. Often other concomitant symptoms such as negativism, the assumption of bizarre postures, the swelling of legs from standing, the closing of eyes, and the almost absolute absence of emotion lead to the diagnosis of catatonic stupor.

The diagnosis of schizophrenia is also to be ruled out in some cases of manic-depressive psychosis that resemble the schizophrenic syndrome, especially if manic phases occur. During the manic attack the patient's behavior may appear bizarre and there may be disorganization of thought processes. However, both behavior and thought processes are much more altered in schizophrenia. If hallucinations occur in manic-depressive psychosis, they have the differential characteristics mentioned previously; if paranoid ideation is present, it is only minimal. The total picture, including personality type which is cyclothymic in the case of manic-depressive psychosis, will lead to an easy diagnosis except for those cases that are usually placed in the schizo-affective category.

Once we have determined that we are dealing with a depression, we must proceed to the second step and ascertain the specific type of depression. The presence of another illness (for example, epilepsy or myxedema) will lead easily to the diagnosis of secondary depression. In the majority of cases it is not difficult to determine whether a particular case is one of mild (neurotic) or severe (psychotic) depression.

According to the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-n) (Committee on Nomenclature, 1968), the differentiation between psychotic depression and depressive neurosis "depends on whether the reaction impairs reality testing or functional adequacy enough to be considered a psychosis."

The reality testing in this case concerns the mood of depression. Does the patient consider his depression justified; does he want to maintain it; does it drastically transform his appreciation of life? If the answers is yes, the diagnosis is bound to be one of severe depression (psychotic depression) or manic-depressive psychosis. A history of manic attacks, or at least of a cyclothymic personality, will lead to the diagnosis of manic-depressive psychosis. In mild depression we can recognize the following differential characteristics which rule out a severe depression. (1) The depression is not so intense as to affect the total personality of the patient.

The patient wants to get rid of the depression. (3) Suicidal ideas are not a predominant feature. (4) The patient responds, although to a moderate degree, to cheerful aspects of the environment and to attempts to comfort him. (5) The psychosomatic symptoms are different inasmuch as (a) The loss of appetite is not excessive. In some cases there is increased appetite, (b) As a rule there is no premorbid anxiety, (c) The insomnia is relatively mild. In some cases there is an increased need to sleep, (d) There is no dryness of the mouth, (e) The constipation is less marked, (f) The skin is not dry. (g) There is no hypomenorrhea or amenorrhea.

Notes

[1] There are many psychiatrists who would deny such a statement. They feel that if a manic-depressive seems later to become schizophrenic, it is because the right diagnosis (schizophrenia) was not made. A considerable number of psychiatrists would call such a patient schizo-affective. Most psychiatrists, however, limit the diagnosis of schizo-affective psychoses to patients who present a mixed symptomatology from the beginning of the illness.

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