American Handbook of Psychiatry

Affective Disorders

Manic-Depressive Psychosis and Psychotic Depression

Silvano Arieti

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MANIC-DEPRESSIVE PSYCHOSIS AND PSYCHOTIC DEPRESSION:
Manifest Symptomatology, Psychodynamics, Sociological Factors, and Psychotherapy

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As variable as their clinical pictures are, as controversial as their etiology continues to be, as unconfirmed as their dynamic interpretation remains in our time, affective disorders nevertheless strike the student of psychiatry for the facility with which their clinical concepts are grasped even by the beginner.

It is therefore appropriate to start the section on functional psychoses with the study of these conditions, for it can serve, in part, as an introduction to the study of other psychotic disorders that even at a manifest clinical level appear more complicated.

Needless to say, every psychotic disorder is multidimensional and any aspect of simplicity that we can see in it is only apparent or relative.

Introductory Remarks

Already, at this point, several questions may have occurred to the reader, on account of the fact that we have labeled these disorders "functional psychoses." Why psychoses, and why functional? Since many cases of affective psychoses are mild, and the percentage of these mild cases seems to increase in relation to the total incidence of the disorders, it would seem logical at first to call the conditions psychoneuroses rather than functional psychoses. The term "psychosis," however, does not indicate only an actual or potential severity of the disorders (a severity which may be reached even by some psychoneuroses), but also connotes the fact that the psychopathological way of living was, in a certain way, accepted by the patient. No matter what transformation the psychotic patient has undergone (either a predominantly symbolic transformation as in schizophrenia, or a predominantly emotional transformation as in affective psychoses, or a predominantly cognitive defect as in organic conditions), that transformation becomes his way of relating to himself and others and of interpreting the world.

The patient suffering from an affective psychosis does not fight his disorder, as does the psychoneurotic, but lives in it. In this respect he resembles persons who are affected by character neuroses and who do not even know of the pathological nature of their difficulties. The distortions of the character neuroses, however, are susceptible of at least partial adaptation to the demands of society, whereas in psychoses such adaptation is not possible.

Several psychiatric authorities sharply oppose the use of the word "functional" on the grounds that each condition is at the same time organic and functional, since an organ must always be there to mediate a function. Cobb, for example, states that "every symptom is both functional and organic."

In the neuropsychiatric frame of reference, this statement is perfectly valid: Every symptom is functional inasmuch as it consists of a physiological function of the organ, and organic inasmuch as it requires the organ that mediates it, either in its anatomical integrity or in its pathological alterations. The statement carries the implicit admission that such states as the functional and the organic do exist. Neither state, however, can exist without the other; we may conceive them separately as abstract concepts, but in the physical world they are always together.

How is it then that the term "functional" has been retained in American psychiatry and is so widely used? According to the present writer, its use is not maintained merely through semantic inertia. Like many other words in every language, it has enlarged some of its meanings and lost some others, and has come to convey a group of concepts which, at the present stage of our knowledge, may still be useful.

A functional point of view about a psychiatric disorder does not exclude

the possibility of a hereditary or constitutional predisposition that makes the functional transformation possible. It does not exclude recognition that any function is accompanied by a physical, molecular substratum. It does not even refer to the fact that functions are generally transitory and reversible, whereas organic alterations are not, because this is not true in every case. A memory trace may be permanent, and an anatomical alteration may reverse completely. The functional point of view focuses on the fact that no matter what the complex causality of the disorder may be, it is the particular form of functioning with its content that constitutes the predominant and primary (although not exclusive) essence of the disorder and leads to secondary sequels, both organic and functional.

It also implies that the dysfunction is predominantly determined by, or connected with, an emotional maladaptation, which, in its turn, is at least partially provoked by a human environment. For instance, it is obvious that functional cases differ from psychoses occurring with tumors of the cerebral hemispheres. Here, the normal functionality is made impossible by the anatomical alteration.

It is certain that the last word has not been said on this important subject; for the time being, however, the concept of functional disorder is found useful by many, and therefore retained in the classification adopted in this handbook. In the European literature, functional psychoses are generally

called endogenous. This classification implies that these psychoses are based primarily on heredito-constitutional factors or causes within the nervous system, in contrast to the disorders that are exogenous—that is, originating from causes outside of the nervous system. This classification is not accepted by the majority of American psychiatrists.

The following definitions of affective psychoses are based on the fundamental Kraepelinian concepts, and we shall use them only as elementary clinical notions, without any etiological or dynamic implication:

By *manic-depressive psychoses* is meant a group of mental disorders characterized by periodic attacks of melancholia or elation of marked proportions, accompanied by retardation or hyperactivity.

By *psychotic depression* is meant a mental disorder characterized by a single attack or periodic attacks of severe melancholia, in the absence of marked mood swings.

In this chapter, we shall give most attention to manic-depressive psychosis, which offers the most diversified or complete picture of the affective disorders. We shall describe psychotic depression separately only in those aspects in which it differs from manic-depressive psychosis. Involutional depression will be described and discussed in Chapter 30 of this volume by Rosenthal.

Historical Notes

The reader who is particularly interested in the historical perspective of the concept of manic-depressive psychosis is referred to the excellent article by Jelliffe and to the monograph by Zilboorg for the pre-psychoanalytical literature; for a historical survey of the analytical literature, the reader is referred to Lewin's monograph. In this volume, we shall restrict our discussion to a brief exposition.

Ancient Times

As Zilboorg wrote, manic-depressive is a condition which has been known since antiquity. According to Jelliffe, the disorder is "the only form [of psychosis] whose chief features may be unequivocally recognized down through the ages." According to Koerner, the earliest record in Indo-Germanic cultures is that of the melancholia of Bellerophon in the Homeric epics. In the writings of Hippocrates, we find many references to mania and melancholia. He considered manic and melancholic states to be chronic conditions, although he admitted the possibility of recovery in some cases. He distinguished various forms of melancholia and swings of mood, although it seems certain that he did not make any connection between the elation of the manic and the melancholia of the depressed patient.

Not until several centuries later, when Aretaeus appeared on the scene,

was any additional contribution made to this subject. According to several authors, Aretaeus lived in the second century of the Christian era, but other authors, such as Cumston and Zilboorg, think that he lived toward the end of the first century. Aretaeus was born in Cappadocia, a kingdom in a region of Asia Minor. The kingdom of Cappadocia was part of the Roman Empire, and it is possible that Aretaeus practiced most of his life in Imperial Rome. He was particularly interested in the condition that we call manic-depressive psychosis. His observations are so exact and deep as to be comparable to the modern views on this disorder. He not only described the symptomatology of manias and melancholias but also saw a connection between the two states. He observed that young people are more susceptible to mania and older people to melancholia, and that, although the two states are related, mania is not always an outcome of melancholia. He seems thus to have anticipated by at least seventeen centuries the contributions of Kraepelin. In certain ways, he went even further than Kraepelin, for he felt that spontaneous remissions were not reliable. The intermittent character of the illness was clear to him. He also described very well the religious, guilt-ridden, and self-sacrificing attitudes of the melancholic, and the gay and overactive behavior of the manic. He reported how a severe case of melancholia, about whom many physicians were pessimistic, recovered fully after the patient had fallen in love.

Classical Period of Psychiatry

The teachings of Aretaeus were soon forgotten or ignored, and not until 1851 did a French psychiatrist, Falret, again describe the condition and grasp its intermittent and circular character.[2] Kahlbaum's attempts in 1863 to consider mania and melancholia as two simple states of *vesania typica* (the general form in which he included all functional psychoses, with the exception of paranoia) were not successful.

Kraepelin, who was obviously influenced by the works of Falret and Baillarger (another French psychiatrist who made important studies of this condition, at approximately the time of Falret), studied many patients and conceived the concept of manic-depressive psychosis as one syndrome which, in its many varieties, included simple mania, most cases of melancholia, and the periodic and circular insanity. It included also "some cases of amentia" and some affective moods, which, although not of such severe proportions as the previously mentioned disorders, were regarded by him as "rudiments" of the latter. Kraepelin's reason for including all these syndromes in a large nosologic entity was based on the fact that these syndromes, in spite of many external differences, (1) have common fundamental features, (2) not only cannot be easily differentiated but may replace each other in the same patient, and (3) have a uniform benign prognosis. The outcome was thus, for Kraepelin, as important a nosologic characteristic for manic-depressive psychosis as it was for dementia praecox. Kraepelin worked in the field of manic-depressive psychosis for many years, but it was only in the sixth

edition of his *Lehrbuch der Psychiatrie,* published in 1899, that he used the term "manic-depressive insanity," and only in the eighth edition (1913) that he fully expanded this nosologic concept.

At first, Kraepelin's concepts were not unanimously or universally accepted. Later, however, his concepts were generally accepted, although many psychiatrists continued to separate the single or recurring depressions from the complete manic-depressive circular syndrome.

Psychoanalytic Approaches

We must turn to the psychoanalytic school to find an attempt to go beyond descriptive and nosological concepts. Exceptionally, it is not Freud himself who introduced manic-depressive psychosis into the field of psychoanalysis, but his pupil Abraham. In 1912, Abraham had the original idea of comparing melancholic depression with normal grief. Both conditions are due to a loss that the person has suffered, but, whereas the normal mourner is interested in the lost person, the depressed patient is tormented by guilt feelings. The unconscious hostility that he had for the lost object he now directs toward himself. Abraham also assumed that there was a regression to an ambivalent pregenital stage of object-relationships, that is, a return to an anal-sadistic stage.

Freud, in the paper titled "Mourning and Melancholia," accepted

Abraham's ideas that there is a relation between mourning and melancholia and pointed out that, whereas in mourning the object is lost because of death, in melancholia there was an internal loss because the lost person had been incorporated. The sadism present in the ambivalent relationship is then directed against the incorporated love-object. This concept of introjection helped Freud to develop the concepts of ego ideals and, later, of superego. In a subsequent work published in 1921 *(Group Psychology and the Analysis of the Ego),* Freud advanced the idea that in mania there is a fusion between the ego and the superego. Thus, the energy previously used in the conflict between the two parts of the psyche is now available for enjoyment. Freud also pointed out that this fusion between ego and superego may be based on biologically determined cycles (something similar to the cyclic fusion of the ego and id, which periodically occurs every night during the state of sleep).

In later works, Abraham confirmed Freud's findings and clearly postulated the factors that are prerequisites for manic-depressive psychosis: (1) a constitutional and inherited over-accentuation of oral eroticism; (2) a special fixation of the libido on the oral level; (3) a severe injury to infantile narcissism, brought about by disappointments in love; (4) the occurrence of this disappointment before the Oedipus complex was resolved; and (5) the repetition of the primary disappointment in later life.

After Abraham and Freud, Rado and Melanie Klein have, perhaps, made

the most important psychoanalytic contributions to this subject. For Rado, "melancholia is a despairing cry for love." The ego tries to punish itself in order to prevent the parental punishment. The patient attempts to repeat the sequence—guilt, atonement, forgiveness—which, according to Rado, is connected with a previous sequence occurring in the infant—wakening rage, hunger, appearance of the mother's breast, and ensuing satisfaction. The excitement of being nursed by the mother is compared to a sexual orgastic experience, and mania is compared to an oral fusion, an equivalent of the breast situation.

Freud's and Abraham's theories about the incorporation of the object received further elaboration by Rado. He believed that there is a splitting of the incorporated object: The good part of it, by which the child wants to be accepted and loved, remains in the superego, whereas the bad part of it, which the child despises and even wants to kill, becomes part of the ego.

Melanie Klein saw in the infant baby the mechanism which may develop later into full psychosis. She described the paranoid position and the depressive position. Whereas the first consists of mechanisms by which the child "spits out" or eliminates or projects to others what is unpleasant, the second or depressive position occurs at the time of weaning, that is, around the sixth month of life. The child has an innate fear of death, and the "positions" are defenses to guarantee the survival. Thus, for Melanie Klein,

this depressive position is a normal event in the life of every child.[3] It is the inability to solve this position adequately that presumably leads, later, to the disorder. The mother who before was seen as two persons (one good and one bad), according to Klein is seen as one person; she continues, however, to be internalized as a good or bad object. The child is afraid that his instinctual aggressive impulses will destroy the good object, and interprets the loss of mother's breast and milk at the time of weaning as the result of the destructive impulses.

Bibring considered depression a conflict within the ego, rather than between ego and superego. Predisposition to depression is not always caused by "oral fixation" but is often the result of "the infant's or little child's shock-like experience of and fixation to the feeling of helplessness." A loss of self-esteem is the main factor in depression. According to Bibring, "The emotional expression of a state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanisms which establish the self-esteem, contributes the essence of the condition." Cohen et al. studied twelve manic-depressive patients and tried to differentiate some psychodynamic patterns. Their patients depended on approval from others, were conventional, and adhered to the expectations or mores of the group to which they belonged, and to status consciousness.

Among the contributions of the Neo-Freudian schools are to be

mentioned those of Beck, Bemporad, and Arieti. According to Beck, depression is predominantly a cognitive disorder. The mood of depression is caused by three major cognitive patterns that force the individual to view himself, the world, and his future, in an idiosyncratic way. Beck believes that early in life the individual develops a wide variety of concepts and attitudes about himself and the world. The vulnerability of the depression-prone person is attributable to the constellation of enduring negative attitudes about himself, about the world, and about the future. A special feedback mechanism is often established: The more negatively the patient thinks, the worse he feels; the worse he feels, the more negatively he thinks.

Bemporad considers depression:

> as an affective reaction elicited by the individual's realization that an important source of self-esteem and meaning is lost. The sense of loss is intensified by the awareness that the deprivation is final; it cannot be repaired. What is lost is not simply a love object, but the source of meaning and satisfaction in one's life. . . . What seems to be characteristic about the depressive is that he seems to depend almost exclusively on some external agency for his self-esteem.

Psychoanalytic and predominantly psychodynamic views of affective disorders have been criticized by various authors, not only by authors who follow an exclusively biological approach, like Kraines, but even by such scholarly students of psychoanalysis as Grinker and Mendelson.

Grinker et al. wrote:

> From these theoretical psychoanalytic discussions, there has developed a stereotype of the psychodynamics of depression which is unrelated to the variations in the clinical picture. It is this stereotype which has influenced psychiatrists today to assume that, once given a symptomatology of depression, the formation of the psychodynamics can be reeled off with facile fluency. These basic formulations, stereotyped though they may be and agreed upon as they are by so many, have never been validated and despite their universal acceptance by many authors, they are far from applicable to individual cases or groups of cases.

In concluding his book on psychoanalytic concepts of depression, Mendelson wrote:

> It would have been pleasing to be able to report that this body of literature represented, in essence, a progress through the years of a Great Investigation. It does so in part. But perhaps even more does it represent a Great Debate with the rhetorical rather than scientific implications of this word. Indeed at times it bears the stigmata not of an exchange of ideas but of a Monologue—a Not-So-Great Monologue.

Mendelson later adds that his book represents the summary of an era:

> This era was chiefly characterized by boldly speculative theoretical formulations and by insightful clinical studies. It was a richly productive era in which sensitive and intuitive observers mapped out whole continents of the mind that had previously been unexplored. It was an era of large scale conceptualizations and generalizations. This era is drawing to a close.

I dare say that Mendelson's prediction is premature, and I hope to demonstrate this point of view in the rest of this chapter.

The Existentialist School[4]

It is difficult, within the limits of the assigned space, to give an adequate account of the contributions of the existentialist approach to manic-depressive psychosis. Any account presupposes a familiarity with existentialist philosophy, and especially with the works of Heidegger, which most psychiatrists do not have. Moreover, the interpretation of these writings is not an easy task for those who are not well acquainted with the intricacies of German philosophical language. A brief resume will, however, be attempted here.

In the existentialist school, manic-depressive psychosis is not, as a rule, studied as a unit; mania and melancholia are the objects of separate studies. Contrary to what we find in the other schools (particularly in the psychoanalytic schools, where melancholia receives the main consideration), it is mania which has attracted the interest of the existentialists. Binswanger has devoted six long articles to mania. He asks himself the usual existentialist question: What, for the manic, is the way of being in the world? It is a world of festivity, of the victory of the instinct over restraint and inhibitions. It is a world that tends to abolish logic and real difficulties; it is a direct and immediate world, the world of optimism itself. Optimism is a special style of thinking and living. In this way of living the patient becomes big and the world small.

In the flight of ideas, we have three factors —the regression, the play on words, and the logorrhea. Because of the regression, language ceases to be a means of communication and ends by becoming an end in itself, a kind of play at the service of the existential joy *(Daseinfreude).* Playing has invaded the whole human structure of the manic, and play on words is part of it. The logorrhea manifests a *grossmauling* way of existence.

The ambivalence of the manic-depressive is different from that of the schizophrenic. Whereas the latter may hate and love at the same time, the manic-depressive, at certain periods of time, may only love or hate, although alternately he does both.

Binswanger attributes to the flight of ideas the following characteristics: (1) an affective tone of optimism, (2) a particular way of experiencing space and time, (3) a volatile and confused character of thought and meanings, and (4) the prevalence of projections.

Existentialist studies of depressions have been made by LeMappian (quoted by Roi) and by Ey. For these authors, as well as for other existentialists, the depressed state is constituted by an arrest or insufficiency of all the vital activities. It is a "pathetic immobility, a suspension of existence, a syncope of time" according to Ey. As a consequence, the patient experiences a feeling of incompleteness, of unreality, and of impotence; a special,

inhibitory way of living then ensues. Most authors emphasize the particular attitude of the patient toward time. Only the past counts; it extends into the present to torture the patient and to remind him of his guilt, his unworthiness, and his inability to accomplish. “Time was lost,” the future is not even contemplated. Sommer points out how the patient, although self-accusatory, does not want to repair; he wants to be punished.

The studies of the existentialist authors give us a more accurate account of the uniqueness of the subjective experiences of the patient, permitting us to become more aware of their particular ways of living, and offering an enrichment of the understanding obtained by the dynamic, sociocultural, and formal approaches.

The Manifest Symptomatology of Manic-Depressive Psychosis

In 1944, Zilboorg wrote that manic-depressive psychosis seems to have changed comparatively little in its symptomatology since antiquity—much less than other mental disorders. This statement, correct in 1944, is no longer so today. Changes such as the less frequent occurrence of the disorder, the relative mildness of many attacks, the relative rarity of the manic episodes, and others to be described, are now noticed and may have appeared at other times in history.

What seems to have remained unchanged from the time of Hippocrates

to the early 1960s was the picture of an intense state of depression in which one could almost always recognize a profound and overwhelming theme of self-blame, hopelessness, and self-depreciation. Although cases with this classic picture are still common, others, with a picture which this writer calls claiming depression, occur with increasing frequency.

Manic-depressive psychosis manifests itself with recurring attacks of depression and of manic elation in various forms and cycles. We shall take into consideration (1) the classical or self-blaming type of depression, (2) the claiming type of depression, (3) other varieties of depression, (4) the manic attack, (5) the course of the disorder, (6) the specific characteristics of pure psychotic depression, as an entity separate from manic-depressive psychosis, (7) diagnostic criteria.

Classical Depression

Depression is characterized by the following triad of psychological symptoms: (1) a pervading 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 pervading mood of depression at times has its onset quite acutely and dramatically, at other times slowly and insidiously. The patient generally

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 the psychotic attack is misunderstood at first. An unpleasant event, such as the death of a close relative or a grief of any kind, has occurred, and a certain amount of depression is justified. When, however, a certain period of time has elapsed and the depressed mood 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 is no longer able to make such a decision and he has to consult a physician at the initiative of the members of the family. When the patient is seen by the physician, the latter is impressed by his unhappy, sad appearance. He 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 lip at the edges of its inner third is contracted upward and a little backward (sign of Veraguth).

In most cases, the examiner is often taken 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; in the majority of cases, however, the mood of melancholia is prominent and leads to an easy diagnosis.

The patient is often at a loss in describing 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, and at the same time to 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, as 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 depressions often plan to destroy not only themselves but their children, who are presumably considered by the patient as extensions 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 manic-depressive psychosis or psychotic depression.

The second 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 which cannot be recognized as part of the ensuing picture of psychotic depression. They seem to be neurotic obsessions, phobias, what the patient calls "unclean thoughts." 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 selected the thoughts which 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 definite delusions. They often represent distortions of the body image and hypochondriasis. The patient thinks he has cancer, tuberculosis, syphilis, etc. His brain is melting, his bowels have been lost, the heart does not beat, etc. 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 acts as if he would be sick. This impression is almost the opposite of that which we find in some schizophrenics. In the latter, there is the idea that what happens in the world is an act, a play, the world is a big stage. The depressed patient, on the contrary, feels that he is acting the part of the sick person. This idea, incidentally, occurs generally when the patient starts to recover from the 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 this classical or traditional type of psychotic depression the main theme remains a self-blaming attitude. In severe cases, the patient seems to transmit the following message to the observer: "Do not help me. I do not deserve to be helped. I deserve to die."

Together with this peculiar content of thought, there is retardation of thinking processes. The patient complains that he cannot concentrate, he cannot focus his attention. At first, he can read but cannot retain what he reads. Writing is more difficult for him because composing a letter requires tremendous effort. If the patient was a student, he cannot study any longer.

Thoughts seem to follow each other at a very slow pace. Talk is also slow. In a severe state of stupor, the patient cannot talk at all.

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

1. They are very rare in comparison to their occurrences 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 would fall," or as "bells which ring," etc. Often, they seem more illusions than hallucinations, or as transformations of actual perceptions.

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

4. More frequently than in schizophrenic patients, they seem to occur

> at night, seldom during the day. The manic-depressive, who is more in contact with external reality than the schizophrenic, possibly needs the removal of diurnal stimuli in order to become aware of these inner phenomena.

The third important sign of the classic type of depression is psychomotor retardation. 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. Solving of the usual small 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, discontinue the use of make-up, and always wear the same dress. Every change seems a tremendous effort. Interpersonal relations are cut off. In some mild cases, however, the opposite seems to occur at first. The patient, who is prone to accuse himself and extoll others, becomes more affectionate toward the members of the family and willing to do many things for them in an unselfish manner. Later, however, when the disorder increases in intensity, he becomes indifferent to everybody.

The accessory 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 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.

Other frequent symptoms are backache and amenorrhea. 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. Kennedy believes that in many patients the symptomatology consists almost exclusively of these somatic dysfunctions. He calls these syndromes "manic-depressive equivalents."

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, as part of manic-depressive psychosis or as pure depression. Moreover, the cases that we 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 the 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 that looms with the depression apparently receding. Badly hidden are also feelings of hostility for people close to the patient, like 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 several cases, the patient does not want to get up from bed and wishes to return to it several times during the day.

Clinical Varieties of Depression

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

Simple depression is characterized by a relative mildness of the

symptoms and may make the diagnosis of psychosis difficult. Delusions and hallucinations are absent. Although retarded, the patient is able to take care of the basic vital needs. Suicidal ideas and attempts, however, occur in this type, too. In recent years, cases of simple depression seem to have increased in number, relative to the total incidence of manic-depressive psychosis.

In *acute depression,* the symptoms are much more pronounced. Self-accusation and ideas of sin and poverty are prominent. Some depressive ideas, bordering on delusions, 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 are secondary to the prevailing mood of the patient. They disappear easily when the mood changes. Hallucinations may also occur, although rarely.

Depressive stupor is the most pronounced form of depression. Here there is more than retardation: The movements are definitely inhibited or suppressed. The patients are so absorbed in their own pervading feeling 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. Since they 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. They lose up to a hundred pounds in certain cases; they are constipated, and their circulation is enfeebled.

The Manic Attack

In the manic attack, as in 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 mobility. Accessory bodily changes also occur.

It is difficult in many instances to determine the beginning of an attack. The patient is often in a lively mood. His personality is described as that of an extrovert, active individual who likes to talk a lot and do many things. At the time of the attack, however, the over-joyousness of the patient seems somewhat out of proportion, occasionally even inappropriate, as, for instance, when he easily dismisses things which should make him sad and continues to be in his happy mood. The patient seems exuberant, very sociable, and, at times, even succeeds in transmitting his happiness to the surrounding

persons. This mood, however, although pronounced, is not a constant or solid one. 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 sees 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 the verbal productions of the patient. 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 is allowed to affect the patient. The thoughts expressed are not disconnected but maintain some apparent ties. We can always determine that the individual ideas are connected by the elementary laws of association, but the talk as a whole is verbose, circumstantial, 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 of escaping from intruding thoughts which may bring about depression. In not too-pronounced cases, the patient realizes that he unduly allows details to interfere with the original goal of his conversation and tries to go back to it, but again he is 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, etc. In some 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 and Lorenz, 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 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 content of thought 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, etc. These statements receive flimsy support. When asked to prove them, the patient attempts to do so but is soon lost in a web of unnecessary details. If he is reminded of the goal of the conversation, he may become excitable. Disturbances of the sensorium are generally of minimal intensity and are caused by the exalted mood or distractibility rather than by intellectual impairment.

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

Accessory somatic symptoms consist in loss of weight, generally not as pronounced as in depression, decrease in appetite, and constipation. Insomnia is marked. The blood pressure is generally lowered. Menstruations are irregular. Sexual functions, although frequently increased in hypomanic

states, are eventually decreased or disturbed in various ways.

As in the states of depression, many forms of manic states have been described by the early authors. Following is a brief description of them:

Manic Varieties

In *hypomania,* the symptoms are not of a marked intensity. As mentioned before, it is difficult at times to say whether what the patient shows is his usual "extrovert" personality or the beginning of the illness. He seems full of pep and in a good humor. He wants to do many things. His verbal abilities are accentuated. Although he always had a talent for foreign languages, now he speaks many of them without hesitation, unconcerned with the mistakes he may make. Some of these patients increase their activities to such an exaggerated degree as to show very poor judgment. Actually, they do so 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. The sexual activity is increased, and lack of control may bring about unpleasant results. Illegitimate pregnancies in hypo-manic women and venereal diseases in hypo-manic men and women

are relatively common.

The excitability, richness of movements, and euphoric mood, give a bizarre flavor to the 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 have become marked gradually from a previously hypo-manic state, or rapidly from a normal condition. The patient is in a state of such 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 immediately accepted.

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 frequently occur.

In addition to the above-mentioned types, Kraepelin has described *mixed states* which are characterized by a combination of manic and depressive symptoms. He distinguished 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 combinations of the chief symptoms. Of the six types the most common is, perhaps, agitated depression. In this condition, a motor restlessness, more typical of a manic excitement, is superimposed on a markedly depressive symptomatology.

Course

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

The melancholic attack and the manic, which at first sight seem so different, have an intrinsic similarity. In fact, 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 one finds a flight of ideas and increased motility.

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

The attack may occur in different successions, which old textbooks of psychiatry described at great length and with many illustrations (which represented the manic attack as a positive wave and the depression as a negative wave). If we have a sequence of a manic and a depressed attack (or an attack of depression followed by a manic one), we have the typical 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 attack.

There seems to be no relation between the duration of the attack and the normal intervals. At times, short attacks recur several times in short succession, but frequently the series is interrupted by a long 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 he had reached his middle

sixties or even seventies. Many attacks of depression which occur later in life and which by many authors are considered as a subtype of senile psychosis, must be considered instead as late occurrences or relapses of manic-depressive psychosis, as Kraepelin illustrated. This fact has been confirmed by the recovery that these patients make as a result of convulsive electric treatment; the genuine senile patients do not improve.

According to Pollock et al., 58.1 percent of patients have only one attack; 26.1 percent have two attacks; 9.3 percent have three attacks; and 6.5 percent more than three. Occasionally, one finds a patient who has had twenty-five or more attacks.

The age at which the first attack occurs varies. It may happen in childhood, in rare cases. By far the largest number of first attacks occurs between the ages of twenty and thirty-five. Manic attacks are slightly more frequent between ages 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.[5]

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 the manifest symptomatology. Much more rarely than in schizophrenia, the manifest symptomatology of manic-depressive psychosis will 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 is uncertain as to the possibility of recurrence. Rennie,64 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 have a second attack; 63.5 percent a third; and 45 percent a fourth. The more frequent the attacks, the worse the prognosis.

Psychotic Depression

Psychotic depression, or as it is called by some authors, "psychotic depressive reaction," is a psychosis which is distinguishable from the depression occurring in manic-depressive psychosis by virtue of the following characteristics : (1) absence of manic attacks or even cyclothymic mood swings; (2) obvious importance of environmental precipitating factors.

Among these precipitating factors, the following are frequent: death of husband or wife, death of a parent, death of a child, death of a sister or brother, disappointment in love, loss of position, business failure, etc. It is really debatable whether the presence of a definite precipitating factor is enough to establish the differential diagnosis from manic-depressive psychosis. As a matter of fact, the present author is convinced that the same precipitating factors may unchain specific attacks of manic-depressive psychosis. A recurrence of depressive episodes is also not enough to exclude the diagnosis of psychotic depression. In my experience, psychotic depressions tend to recur unless adequately treated with psychotherapy. It seems to this writer that the only differential diagnosis consists in the absence of manic attack or of marked mood swings which indicate a cyclothymic personality.

Diagnostic Criteria

Typical cases of manic-depressive psychosis are generally easy to diagnose, even if the examination is limited to the study of the manifest symptoms, although the beginner may have some difficulties in some cases.

An elderly man, who has lost a lot of weight, is depressed, and complains that he may have cancer, may be mistaken for a manic-depressive or for a person suffering from psychotic depression when actually he really

has some sort of malignancy with reactive depression. An accurate physical examination will determine the condition. In psychiatric practice, however, the opposite occurrence is more common: An elderly patient has lost weight, has many hypochondriacal complaints, fear of cancer, and is depressed; negative physical findings, retardation, and insomnia, as well as the past history, will generally determine that he is suffering from a depression.

Some patients, who are very retarded, have lost accessory movements, and present a masklike expression on their faces, are occasionally confused with post-encephalitics.

According to the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-II), 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 transform drastically his appreciation of his life? If the answers are yes, the diagnosis is bound to be one of affective psychosis.

Whether a different biological constitution is prerequisite for having psychotic depression instead of manic-depressive psychosis is a question which will not be discussed in this chapter. A differentiation in the

psychodynamics is again impossible to make, except that in typical manic-depressive psychosis the early events of life seem more important than in psychotic depression. The reverse is true for the later life events.

For the differential diagnosis between psychotic depression and involutional melancholia, the reader is referred to Chapter 30 of this volume.

Manic states may be confused with the following conditions:

1. Psychomotor epilepsy. Epileptic exaltation is impulsive but is deprived of elation. Furthermore, the electroencephalogram will lead to an easy diagnosis.

2. Toxic deliriums (or amential states). The wealth of disconnected hallucinations and the poverty of external perceptions (or of reactivity to the environment) will lead to recognition of the delirium.

3. General paresis. The physical symptoms of general paresis, and the serological findings, will lead to a diagnosis. Moreover, in the paretic, the sensorium is more defective and the actions and thoughts are more incongruous than the degree of exaltation would permit, and superficial delusions more numerous.

4. Catatonic excitement. The excitement precedes or follows the catatonic state. The actions are more aimless, absurd, and deprived of any conscious feeling of guilt, the mood is more incongruous and inappropriate, and hostility toward others is more pronounced.

5. Attack of exaltation occurring in any mental diseases, including mental deficiency. The subsequent course will reveal the correct diagnosis.

Psychodynamic Mechanisms

The characteristics that we have described in the previous section constitute the manifest aspects of processes of a much more subtle nature that were unfolding for a long time. Because psychotherapy of manic-depressive patients or patients suffering from psychotic depression presents great difficulties in a large number of cases (even greater than those presented by schizophrenic patients), our knowledge of the psychodynamics of these cases is still fragmentary. Some fundamental factors, however, stand out sufficiently to permit us to explain grossly some of the most common mechanisms.

The Childhood of the Manic-Depressive Patient

It seems to be a fairly well-established clinical fact that the early childhood (at least the first year of life) of the future manic-depressive patient was not so traumatic as that of people who tend to become schizophrenics or even seriously neurotic.

The future manic-depressive is generally born in a home which is

willing to accept him and care for him. The word “accept” has a special meaning here: The mother is duty-bound and willing to administer to the baby as much care as he requires; she is willing to provide for him everything that he needs. This willingness of the mother is, in turn, accepted by the child, who is willing to accept everything he is offered; that is, early in life the child appears very receptive to the influence (or giving) of the significant adult (parent). There are no manifestations of resistance toward accepting this influence, as, for instance, the autistic manifestations or attempts to prevent or retard socialization, as one finds in schizophrenia. If we use Buber’s terminology, we may say that the “Thou,” that is, the other, is immediately accepted and introjected. The “Thou” is at first the mother, but this receptivity to the mother enhances a receptivity for both parents and all the important surrounding adults, and promotes a willingness to accept them with their symbols and their values. It promotes also a certain readiness to accept their food (either the milk of the mother or regular food) and thus predisposes some people (but by no means all) to overeating, obesity, and the seeking of compensation in food when other satisfactions are not available.

This receptiveness to the others and willingness to introject the others determine at this early age some aspects of the personality of the patient. He tends to become an “extrovert”; at the same time, he tends to be a conformist, willing to accept what he is given by his surroundings (not only in material things but also in terms of habits and values), and to rely less than the

average person on his own resources or on his own world. This readiness to accept, this psychological receptivity, will predispose him also to pathological (or exaggerated) introjection.

In the second year of life (earlier, according to some authors), a new attitude on the part of the mother drastically changes the environment in which the child was growing, and exposes him to a severe trauma. The mother will continue to take care of the child, but considerably less than before, and now she makes many demands on him. The child will receive care and affection provided he accepts the expectations that the parents have for him and tries to live up to them.

This brusque change in the parents' attitude is generally the result of many things; predominantly, their attitude toward life in general tends to evoke in the child an early sense of duty and responsibility—what is to be obtained is to be deserved. The parents are generally dissatisfied with their own life and harbor resentment, at times, toward the children, who represent increased work and responsibility. This hostility, however, is seldom manifested openly; generally, it is manifested by the fact that the parents increase their expectations too much.

Thus, the child finds himself changed from an environment which predisposes to great receptivity to one of great expectation. These dissimilar

environments are actually determined by a common factor: the strong sense of duty that compelled the mother to do so much for the baby is now transmitted at an early age to the child. Generally, the families of manic-depressive patients have many children, and often, when the future manic depressive patient is in his second year of life, a sibling is already born and the mother is now lavishing her care on the newborn with the same duty-bound generosity that she previously had for the patient. This, of course, makes the change in the environment more marked for the patient.

This displacement by a younger sibling seems to be important in the dynamics of many cases of manic-depressive psychosis and of psychotic depression, although, again, no statistical proof of it can be given.[6] Statistical studies have so far concerned themselves more with birth order.[7]

In many cases, the brusque change had to occur because of unexpected events, such as the child had to be abandoned by the mother because of illness, economic setback, forced emigration, political persecution, etc. The child was then left in custody of an aunt, grandmother, cousin, stranger, or orphan asylum, and was subjected to a violent and unmitigated experience of loss.

For several patients, the abrupt change that we have described has already taken place at the time of weaning. Future affective patients are

generally breast-fed in their infancy and then suddenly deprived of mother's milk. No bottles, no rubber nipples, and no pacifiers are used. There is a sharp transition from the breast to the glass. In a minority of patients, this loss of the breast plays an important role.

In many other patients, the abrupt change occurs later, but generally still in the preschool years.

How does the child try to adjust to the new threatening situation? The child who is likely later to develop an affective psychosis tends to adopt special mechanisms. A common one, although decreasing in frequency, is that of finding security by accepting parental expectations, no matter how onerous they are. The child does not reject the parents emotionally, or avoid them (as the schizoid often does), but consciously accepts them. He must live up to their expectations no matter how heavy the burden. It is only by complying, obeying, and working hard, that he will recapture the love or state of bliss which he used to have as a baby, or at least maintain that moderate love which he is receiving now. Love is still available, but not as a steady flow. The flow is intermittent, conditioned, and therefore does not confer security. The child feels that if he does not do what he is supposed to, he will be punished—mother may withdraw her love totally. At the same time that the anxiety of losing mother's love sets in, hope is given to the child that he will be able to retain this love, or to recapture it, if and when it is lost. The child thus feels he

has choice, the freedom of retaining the parental love or not. No matter what he chooses, however, he has a hard price to pay: submission or rejection. He also feels that mother is not bad, in spite of her appearance, but, on the contrary, that she is good. She is good even in punishing him, because by punishing him she wants to redeem him, make him again worthy of her love. Thus, the mechanism is different from that occurring in many pre-schizophrenics; although the pre-affective patient has an image of himself as bad, he does not feel that he is beyond the possibility of redemption, as the preschizophrenic often feels. The anxiety about being unable to fulfill parental expectations changes into guilt feelings. If affection or forgiveness is not forthcoming, the child feels that it is his own fault; he has not lived up to what was expected of him, and he feels guilty. When he feels guilty, he again expects punishment. He wants to be punished, because punishment is the lesser of the evils. He would rather be punished than lose mother's love. If he is not punished, he often works harder in order to punish himself.

A little later, but still at a very early age, many of these children assume responsibilities such as the support of the family. If they engage in a career, it is often in order to bring honor and prestige to the family. In a relatively large number of cases, the family belongs to a "marginal" group of society because of religious or ethnic minority status, and the child feels that it is his duty to rescue the family with his own achievement.

In addition, in several patients, incestuous wishes toward parents and, as frequently, toward siblings of opposite sex elicit strong guilt feelings which the patient feels must be atoned.

Other facts make the picture more complicated and difficult to understand, for instance, the impression often received that the parents of several patients are not strict but overindulgent. This is due to the fact that, in this second stage of childhood, the parents do not need to enforce any rules with their actions. The rules, the principles, have already been incorporated by the patient. As a matter of fact, some of the parents now regret that the children take rules with such seriousness.

The parents of the patient generally give a picture of cohesiveness and stability. There is no serious talk of divorce; the family seems on stable ground, reinforced by the conventions of society. Those family conflicts or schisms described in schizophrenia are not seen as frequently in the family of patients suffering from affective psychoses.

The second important mechanism by which the child tries to cope with the sudden change in environmental circumstances is an attempt to make himself more babyish, more dependent. If the child makes himself aggressively dependent, the mother or other important adults will be forced to re-establish an atmosphere of babyhood and of early bliss. The child, and

later the adult, will develop a very demanding and at the same time clinging, dependent type of personality.

Since the 1950s, this second type of mechanism has become much more common, at least in the United States.

Secondary mechanisms also occur concomitantly with the two main ones. The child harbors a strong resentment against the parental figure who, in the first type of mechanism, has made so many impositions, or who, in the second type, has not given enough. Such resentment manifests itself in attacks of rage, anger, rebellion, or even violence. When such anger becomes manifest, it often is enough to dispel an oncoming feeling of depression. For this reason, some therapists believe that any depression hides an underlying anger. This is true only to a limited extent. The anger is consequent to a situation that already existed and was unacceptable to the child. Anger alone is not a solution to the conflictual situation, although it may be a temporary defense against future depression.

In many cases feelings of anger are promptly checked and repressed, not only in childhood but throughout the life of the patient. Sadistic thoughts and impulses are, at times, very pronounced but seldom acted out. Together with the consequent guilt feelings brought about by these impulses are feelings of unworthiness and depression. The patient soon learns that

rebellion does not pay; on the contrary, it increases the atonement he must undergo later. The stronger his sadistic impulses, the stronger become the masochistic tendencies. He soon desires peace at any cost; any compromise is worthy of peace. The mechanisms which will permit him to maintain a certain equilibrium is the repression of this resentment. The resentment is, however, retained unconsciously, as it appears from dreams and occasional outbursts which reach consciousness.

An additional dynamic mechanism which is found in some cases of manic-depressive psychosis is the following:

The child senses that the acceptance or introjection of parents is too much of a burden and, without realizing it, shifts the directions of his incorporations; other adults in the environment (much older siblings, uncles, aunts, grandparents, friends, etc.) tend then to be internalized instead of parents. Not only is the common tendency of children to introject adults exaggerated here, but peripheral adults become parent-like figures. The child unconsciously resorts to this mechanism in order to decrease the burden *pi* the parental introjection, but in many cases this defense does not prove useful. As Fromm-Reichmann noted, there will be no single significant adult to whom the patient will be able to relate in a meaningful way. The relationship with these other grown-ups again is determined by a utilitarian purpose, duty, or role. The introjection of such adults eventually fails to

provide what is needed and may end by confusing the child (How can he satisfy all the adults?) and increasing his burden and feeling of guilt.

Prepsychotic Personality

The prepsychotic personality of the patient who will develop an affective psychosis is colored by one or the other of the main psychodynamic mechanisms which we have mentioned in the previous section and by some reactions to these mechanisms.

We shall describe first the personality of patients who have tried to overcome the initial trauma by living up to ideal parental expectations. The strong tendency of these patients to introject parental figures will also produce strong feelings of patriotism, religiosity, and loyalty to a political party. They often wish to have a military or ecclesiastic career. These organizations are not parent substitutes but additional parents. Group loyalty and *esprit de corps* play an important part in the psychological constellation of these people. Actually, under the pretense of belonging to a group, to a close-knit family, or to an organization, the individual hides his loneliness.

In many cases, we find a self-conscious individual, always motivated by duty, of the type of personality Riesman has called “inner-directed.” Unless he overcomes some of his difficulties, the individual cannot become a creative person, but remains an imitator. However, what he tries to do, he does well.

He has deep convictions, and his life is motivated by principles. He must be a dedicated person. He is generally efficient, and people who do not know him too well have the impression that he is a well-adjusted, untroubled individual. On the contrary, he is not a happy person. He selects a mate not because he loves her but because she "needs" him. Later, he will never divorce the mate because she is in terrible need of him. At the same time, he blames himself for being so egotistic as to think that he is indispensable. The necessity to please others and to act in accordance with the expectations of others, or in accordance with the principles that he has accepted, makes him unable to get really in touch with himself. He does not listen to his own wishes; he does not know what it means to be himself. He works incessantly and yet has feelings of futility and emptiness. At times, he conceals his unhappiness by considering what he has accomplished, just as he conceals his loneliness by thinking of the group to which he belongs. But when he allows himself to experience these feelings of unhappiness, futility, and unfulfillment, he misinterprets them again. He tends to believe that he is to be blamed for them. If he is unhappy, if he finds no purpose in life, it must be his fault, or he must not be worthy of anything else. A vicious circle is thus established which repeats itself and increases in intensity, often throughout the life of the patient, unless fortunate circumstances or psychotherapy intervene.

The patient often has partial insight into his own mechanisms but does not know how to solve them. For instance, he is willing to accept the role in

the family and in society which has been assigned to him, and yet later he scolds himself for playing this role, for not being spontaneous. But if he tries to refuse the role, he has guilt feelings. The conclusion is that no matter how he tries to solve his problems, he will feel he has made the wrong choice. A female patient told me that she "felt like a little girl who pretends to be grown up but is not. I am acting." But she must live in that way; that's her duty. It is her fault that she "acts" and does not accept social behavior as spontaneous or real life.

The patient also tends to put his superiors or teachers in a parental authoritarian role. Again, and quite often, he feels angry at them as they seem to expect too much, or they themselves have been found at fault. The patient does not know how to act: Should he continue to accept the authority of these people and the burden that this acceptance implies, or should he remove them from the pedestal? But if he removes them, a void will be left. His authorities are part of him, of his values, and of the symbolic world upon which he sustains himself, and to do without them is impossible. Furthermore, he would feel very guilty. The patient often realizes (as Cohen and co-workers have illustrated) that he tends to underestimate himself. It is his "duty" to "undersell" himself. On the other hand, he tends to blame himself for underestimating himself and giving himself no chance to develop his own talents and potential abilities.

In spite of the fact that this type of patient may at times give the impression of living independently or of being involved in his work, the equilibrium he has been able to maintain, even if precarious, is sustained mainly or exclusively in relation to one person in his immediate environment. I have called this person the *dominant other.* The dominant other provides the patient with the evidence, real or illusory, or at least the hope, that acceptance, love, respect, and recognition of his human worth and meaning of his life are acknowledged by at least another person. The dominant other is represented most often by the spouse. Far less often, in order of frequency, follow the mother, a person to whom the patient is romantically attached, an adult child, a sister, the father. Also, frequently, the dominant other is represented, through anthropomorphization, by the firm where the patient works, or a social institution to which he belongs, like the church, the political party, the army, the club, and so forth. All these dominant others are symbolic of the depriving mother, or to be more accurate, of the once giving and later depriving mother. If the real mother is still living and is the dominant other, she will act in two ways—as her present role is actual in the present and also symbolic of her old one. If the dominant other dies, he becomes even more powerful through the meanings attached to his death. A relationship of subtle dependency exists between the patient and the dominant other.

The relationship of dependency is not so subtle in the other type of prepsychotic personality, which has adopted the mechanism of obvious

leaning on mother and maternal substitutes after the initial trauma. Contrary to the persons described above, this type includes people who, even at a superficial examination, appear maladjusted. These patients have never forgotten the bliss of the first year of life and still expect or demand a continuation of it. They demand and expect from others, feel deprived and sad when they do not get what they expect. They are demanding but not aggressive in the usual sense of the word, because they do not try to get what they want through their own efforts: they *expect* it from others. They have not developed that complex of duty and hard work typical of the accepting, introjecting patient.

These patients alternate between feeling guilty and having the desire to make other people feel guilty. They generally find one person on whom to depend, and they make this other person feel guilty if he does not do what the patient wants. The sustaining person (generally the spouse) is empowered with the capacity to make the patient happy or unhappy and is supposed to be responsible for the despair and helplessness of the patient. Relatively often, we find in this group women who depend entirely on their husbands, who are generally much older. In these cases, the dominant other is not only the person who is supposed to accept, love, respect, but also the person who protects and gives material things. At times, the request is immense; the patient seems almost to request, metaphorically speaking, milk or blood.

In some cases, there is an apparent variation in the picture inasmuch as the patient tries desperately to submerge himself into work and activities, hoping that eventually he will find something to do which will make him worthy of recognition from other people. Whereas the first type of prepsychotic personality looked inwardly for a solution to his conflicts, the second type looks externally.

A third type of prepsychotic personality is observed in some cases either as the prevailing type or as a temporary characterological structure which replaces from time to time one of the two structures previously described. This third type, the forerunner of the manic, is lively, active, hearty, and friendly. On closer scrutiny, the apparent health and liveliness are found to be superficial. In a certain way, the patient actually escapes into actions or into reality but remains shallow and dissatisfied. If he happens to be engaged in work in which not concentration but action is required, he may do well and maintain a satisfactory level of adjustment; otherwise, he may sooner or later get into trouble. He claims that he has many friends, but, although the interpersonal relations seem warm and sincere, they are superficial and lack real kinship. One patient said, “I joke, I laugh, I pretend; I appear radiant and alive, but deep down I am lonely and empty.” This type of person is, only in certain respects, the opposite of the duty-bound individual. He tries to escape from his inner directions, but he does not correspond to what Riesman has called the “other-directed” person. Imitating Riesman’s terminology, we could

call this hypomanic-like person “outer-directed,” but not “other-directed.” He does not escape into others, he escapes *from* his inner self (because the inner self has incorporated the burdening others). As we shall see later, he does make an attempt to contact others, but not to integrate with them. He escapes into the world of superficial reality where meditations, reflections, or deep emotions are unnecessary. Such an individual may, at times, seem so free as to be considered psychopathic. Actually, his deep concern with conventional morality often necessitates this pseudopsychopathic escape. Some of the pseudopsychopathic hypomanics have shown asocial behavior since childhood, when, for example, in order to escape from inner and external restrictions, they run away from home or school.

The above-described affective prepsychotic personality types are seldom seen in pure culture. When the patient changes or alternates from one of the first two types of personality to the third, he presents the so-called cyclothymic personality.

Precipitating Factors

The three types of personality that we have described*lead not to a stable equilibrium but to an almost constant state of dissatisfaction and mild depression (or hypomanic denial of depression). In this unstable background, we generally find precipitating factors that bring about the full-fledged

psychosis.

These precipitating situations may be classified into three categories: (1) the death of a person important to the patient; (2) the realization on the part of the patient of the failure of an important relationship (generally with the spouse); and (3) a severe disappointment in a relationship to an institution or work activity to which the patient had devoted his whole life, or the most important part of his time. This disappointment threatened the self-image which the patient cherishes. It may force a re-evaluation of the self which is hard for the patient to accept.

It is obvious that these situations are considered separately for didactic reasons, but actually may be reduced to a single cause: the loss of something very valuable. This "something," even if represented by a tangible object or concrete situation, is in reality something with a profound and vast psychological and spiritual meaning. At times, although the loss has not yet occurred, the fact that it is impending seems so certain that the patient experiences depression rather than anxiety. Anxiety is the emotion associated with the expectancy of danger; depression is the emotion associated with the experience of loss—the dangerous event has already come and has produced its havoc.[8]

All the precipitating situations are interpreted by the patient as the

proof of abandonment, of having lost the battle and consequently the purpose of life—the love of mother. The present situation reactivates the childhood threat of fear of loss of the mother's love and assumes the emotional form of the old feeling—with much greater intensity, however, because the threatened loss has already and finally occurred. All the efforts of the patient to prevent such loss (either by respect of duties and work, or by excessive, demanding dependency, or by hypomanic-like fervor) have failed.

The death of a person dear to the patient is a symbolic reproduction of parental abandonment. The patient feels depressed not only because he feels he has been finally abandoned—that is, deprived of the sources of love—but also because he feels responsible and guilty. The guilt feelings arise from two different levels. On one level, the patient feels that he has "killed" the dead person; his bad behavior has made the person unhappy and sick and more likely to die, or has made this person want to leave the patient. On another level, the patient feels guilty because he recognizes that, in those moments of re-emerging resentment, he wished the death of the lost person. The wish has now become reality; to the wish is attributed the primitive power of producing the reality; consequently, the patient feels guilty for having entertained the murderous desire.

On the other hand, if the patient, in his prepsychotic period, had the dependent, demanding type of personality that we have described, he

becomes aware that he cannot depend any more on the dominant other for his self-esteem. As Bemporad noted, it becomes obvious that he is incapable of autonomous gratification.

The second precipitative situation is the full realization of the failure of an important interpersonal relationship. The symbolic parent, generally the marital partner, is recognized, or half-consciously recognized, as a tyrant who took advantage of the compliant, submissive attitude of the patient, rather than as a person to be loved and cherished. The patient has tolerated everything, wanted peace at any cost, but it is impossible for him to continue to do so. He feels that he has wasted his life in devoting himself intensely to the spouse, in loving her or forcing himself to love her at any cost. The realization that the spouse deserves not devotion but hate (actually, in many cases what she got was only devotion, not love) is something the patient cannot accept because it would undermine the foundation of his whole life, would prove the futility of all his efforts. Thus, he tries to repress this hate; he will deny to his friends that he hates the spouse; on the contrary, he will blame himself, for if he does not love the spouse he will be found to be unworthy and will be finally abandoned. Again if the patient used to be a very demanding and dependent person, he now realizes that he cannot depend any more on this interpersonal relationship.

In the third instance, the loss is less personal. A sudden event, such as a

dismissal or a failure to obtain a promotion, makes the patient realize that his whole life has been a failure. The institution to which he has devoted so much of himself has badly disappointed him, and again the patient blames himself. In this third instance, too, the patient might have depended on this external agency for self-esteem. He may experience deprivation and lack of autonomous gratification.

Loss of employment is a relatively common precipitating factor. Malzberg found that during the economic depression of 1929 to 1937 the effect of loss of employment or of financial loss was statistically evident in manic-depressive patients. For instance, in the year 1933, 26.2 percent of first-admission patients in New York State hospitals diagnosed as manic-depressive psychotics presented as the precipitating factor loss of employment or financial loss, whereas in the same year only 9.6 percent of first-admission patients with the diagnosis of dementia praecox presented the financial loss as a precipitating factor.

In some patients, an attack is apparently precipitated not by a loss but by what even seems a pleasant event. For instance, women in their forties or fifties, who may have undergone previous subliminal attacks of depression, can develop a severe attack shortly after the marriage of an only son or daughter. Here, the event is experienced by the patient not as a pleasant happening but as a loss. The child whom the mother needed so much, and

who was her only purpose and satisfaction in life, is now abandoning her. These cases belong to the second category.

In other cases, an attack occurs after a promotion, which is interpreted by the patient as a new imposition. The patient is tired of new duties; furthermore, the new position with added responsibility removes the security the patient had established with painstaking effort. In other cases, the individual, faced with promotion, dreads the expected envy and rage of previous associates to whom he is closely bound. The expectation of such emotions in others separates him from them and thus leads to the depressive reaction.

Often, depressions are precipitated in a young parent by the birth of a child whom he had ostensibly wanted. Here, again, several mechanisms are put into operation by the birth. One is the desperation at the expectation of the increase in duty that the child will require, and a brooding again about the futility of life. In some young fathers, the birth of a child reactivates the trauma of replacement by a new sibling. In these cases, one finds unconscious fantasies about the lost breast (for now the baby will have the breast of the mother-wife). It is interesting that whereas the birth of the child precipitates a schizophrenic psychosis only in the mother, it may precipitate an attack of depression in fathers, too. As a whole, however, postpartum depressions are much less frequent than they used to be, and much less frequent than

schizophrenic reactions. Zilboorg, who has made a detailed study of postpartum depressions, explained them as the result of a psychosexual conflict. Nevertheless, postpartum psychotic depressions do occur and may reach very severe proportions. This author has seen several severe postpartum depressions, at first unrecognized or just dismissed as postpartum "blues."

The patient, who has just given birth, identifies with her own mother, who once deprived her of love; therefore, she feels sorry for the newborn who also will be deprived of love. She also identifies with the child, deprived of love. The mother of the patient, during pregnancy, labor, and puerperium, retains the status of dominant other, but the patient believes that the mother will no longer supply her with approval and love, because she will discover that the patient is not able to be a good mother. In these cases, generally, the husband has never become a dominant other.

Postpartum manic states are less common.

In many other cases, psychotic attacks do not seem to be precipitated by any definite happening or loss. Here, the precipitating factor is not a specific happening but a total reappraisal of life. The patient becomes more and more discontented; he claims that everything is all right, but an inner dissatisfaction, an inability to experience *la joie de vivre,* possesses him, and

he finally becomes openly depressed. *It is the denial of the dissatisfaction that has led many psychiatrists to believe that attacks of affective psychosis often occur without any psychogenic cause.* At other times, the precipitating event seems to be so small as to make the psychiatrist disregard the significance of it. Kraepelin, to show the relative unimportance of psychogenic factors, reported a woman who had had three attacks of depression, the first after the death of her husband, the second after the death of her dog, and the third after the death of her dove. Now, from what we have so far discussed, it is apparent that each of these deaths in itself was not the cause of the psychosis. One may guess that the death of the dove reactivated the sorrow the patient had experienced at the previous deaths, and was also symbolic of a much greater loss, perhaps that of the meaning or purpose of life.

Manic attacks are often precipitated by seeming successes. The patient wants to keep up the fervor that the success has produced, lest he find himself later in a state of depression. A girl, who later in life had several attacks, both manic and depressive, had her first manic attack, of a few days' duration, at the age of nineteen, after winning a local radio debating contest. She was supposed to participate again in a subsequent national contest, but she became so excited, hyperactive, and euphoric that this was impossible. The opponent whom she had defeated on the local contest won. Here, again, it is difficult to ascertain whether it was the success or the fear of not retaining it that precipitated the attack.

Often, however, manic attacks occur as a sudden reaction to creeping depression.

The Psychotic Attack

When the precipitating event or the precipitating situation reveals to the patient that he has "lost," the attack ensues either in the form of depression or in the form of mania.

What is the meaning of the psychotic attack? Does the patient really mourn his loss? Does he punish himself? Does he want to punish others? He probably does all these things in an intense degree.

As we have mentioned in describing the manifest symptomatology, the patient now assumes a prevailing self-blaming or claiming attitude. If he blames himself, he seems to send a message: "I do not deserve any pity, any help. I deserve to die; I should do to myself what you should do to me, but you are too good to do it." On the other hand, although he mourns his loss and feels guilty for the loss, he may want to make a desperate effort to redeem himself by punishing himself. The mechanism described earlier is again in effect, but in a more pronounced form. As Rado says, "Melancholia is a despairing cry for love." Probably, the patient feels: "Punish yourself as parents would do to you and you will be accepted again. You are acceptable but not accepted. Forgiveness is eventually available. The intermittent love

will be given again."

At this point, we must try to understand the meaning of the suicide attempt. Three possibilities must be considered: The patient (1) wants relief from suffering; (2) wants to punish himself; or (3) attempts to kill the introjected person (parent or spouse).

The first two possibilities are self-contradictory or self-exclusive until seen from the standpoint of the emotional state of the patient. The feeling that it is better to die than to suffer so much is certainly experienced. The patient would not carry out the suicidal ideas, however, if these ideas were not reinforced or sustained by the other idea that he deserves to die and that he must inflict on himself the supreme punishment. Thus, these two motivations, logically self-contradictory, coexist, and reinforce each other.

The more orthodox Freudian interpretation holds that suicide represents the attempt to kill the detested incorporated person.

According to our original interpretation of the psychological growth of the child in accordance with Buber's concepts of I and Thou, it appears that the manic-depressive patient, much more than the normal person, has accepted the Thou since his early infancy. At times, he let the Thou suffocate or smother the I. In this light, the suicidal attempt is the culmination of this process: It is the Thou who finally kills the I, not the I who kills the Thou. If

the I would kill the Thou, there would be a complete and sudden reversal of the previous and constant trend of denial of the self. Rado has ingeniously tried to solve the problem by assuming that the superego (the Thou) is divided into two parts, one which the patient wants to love, and one which the patient wants to kill. I am convinced, however, that, at least in my personal clinical experience, the patient really wanted to kill himself. By killing himself, he achieved a complete acceptance or a complete introjection of a distorted image of the Thou.

There are several other factors that support this point of view. First of all, many cases of suicide seem to occur not when the state of melancholia is at its peak but at an early stage of remission, when the worst is over. This characteristic may, of course, be interpreted in various ways. The first explanation is a simple and mechanical one. When the patient is very depressed, in, or almost in, stupor, he cannot act, is extremely slow or immobile, cannot move or think coordinatedly, and therefore cannot carry out his intentions. When he becomes less retarded, more capable of coordinating his thoughts, he goes ahead with his destructive intention. There is the alternative possibility that the patient, who has gone through terrible experiences at the acme of the depression, is afraid that these experiences may recur and, rather than face them again, he prefers to die (this, of course, corresponds to the first possibility mentioned).

Yet, neither of these interpretations seems adequate in my opinion. It seems more likely that the patient feels that even the depth of depression has not been enough, has not succeeded in relieving him entirely of his guilt feeling, and that only by killing himself will he entirely redeem himself.

This interpretation is supported by other factors. Significantly, there is almost complete relief after the suicide attempt, whereas the Freudian interpretation would lead one to expect an increase in guilt feeling (for having attempted to, but not actually succeeded in, killing the superego) and a consequent increase in depression. As Weiss and others have emphasized, in the attempt itself, that is, in the gambling with death, the patient feels that he has been punished adequately. He has done what the Thou wanted and now he can live peacefully. Often, of course, there is no need for the suicide attempt; after having gone through the acme of the depression, the patient feels suddenly relieved, and a marked improvement occurs.[9]

According to Kolb, "The suicidal maneuver is often determined by family indicated permission for acting out." In his clinical experience, the psychodynamic explanation for acting out which has been given for other antisocial acts is valid also for suicide. "In families where suicide has occurred the likelihood of suicide for the manic-depressive patient is much higher than otherwise. Where suicide has not occurred, one usually finds threats of suicide or intimidating actions suggesting suicide on the part of parents."

The relief experienced by the patient after the acute depression is remarkable. The patient feels guilt-free and accepted, and wants to settle down in his own life. Even reality seems pleasant now; he does not want to be alone; he feels that he wants to be close to his mate. This attempt, however, will not work out unless psychotherapy intervenes. Other attacks of depression are not acute and tend to assume a chronic course, unless successful therapy intervenes or the circumstances of life change radically.

As we have mentioned earlier, in the claiming type of depression the suicidal attempt seems to convey the message, "Do not abandon me. You have the power to prevent my death. You will feel guilty if you don't give me what I need and let me die." If we remember the involved psychodynamic mechanisms, it will be easy to recognize that in claiming depression the patient is still claiming the lost paradise or the state of bliss of the early life, when he was completely dependent on the duty-bound mother. The patient makes himself dependent on the dominant other and becomes more and more demanding the more deprived he feels. Any unfulfilled demand is experienced as a wound, a loss, and brings about depression.

The attack of psychotic depression, like every other psychotic defense, offers not a solution but a pseudo-solution. When the patient cannot find relief with the end of the depression, he may, in order to avert the danger of recurrence, develop hypomanic traits which may eventually explode into a

complete manic attack. We then have the typical circular psychosis. The manic attack thus must also be considered a defense against the depression. But in the manic attack the Thou is not eliminated or projected to the external world; it is only disregarded. The patient must continue to force himself into a distracted and frenzied mood, which shuts out introspection. In the manic state, there is no elimination of the Freudian superego, as perhaps there is in some psychopathies. The superego remains, and the manic frenzy is a method of dealing with it.

But neither the depression nor the manic state actually brings about a solution to the deeply rooted conflicts. Even after having paid the penalty of the psychotic attack, the patient, after a more or less free interval, will tend to be affected again with the same difficulties, which will be channeled in the same patterns, and the cycle will repeat itself.

Until the late 1950s, psychiatrists treated patients who, after having experienced one or more attacks of affective psychosis, developed a typical schizophrenic symptomatology. These cases still occur, but since the early 1960s they have become less common. In these cases, psychodynamic analyses indicate that there were always some projective tendencies present along with strong introjective tendencies. Once the manic-depressive mechanism has failed, the individual resorts to the projective mechanisms, which until then had occupied only a secondary role. In some cases, these

schizophrenic symptoms consist only of delusional, persecutory trends, and they are not in themselves of grave prognostic meaning, but if a typical hebephrenic picture ensues, the prognosis is serious.

As is mentioned in Chapter 24, the opposite sequence prevails today. An increasing number of cases, which had presented a typical schizophrenic symptomatology at the onset of the disorder, develop later a syndrome of depression.

Depression as a Feeling and as a Mechanism

We have so far attempted to retrace the psychodynamic developments that lead to depression (or more seldom elation), but we have not yet studied the question why depression is the outcome of these developments. In other words, what is the phenomenon of depression itself and why does the psyche experience it after the sequence of the events that we have described? Books of psychiatry generally fail to explain what depression is or they take for granted that the student, having experienced at times depression in his own life, has a certain knowledge of it. Of course, we all experience depression at times. Depression may be a normal emotion, a symptom, or a clinical entity. Some authors refer only to depression or melancholia when the emotion is considered abnormal. They use the terms “sadness,” “dejection,” “low spirits,” and “anguish” when the depression is normal or supposed to be normal. It is

obvious that all these emotional states are related, even if they vary in degree, and even if some are considered normal and others abnormal. It is obvious that it will be difficult to understand abnormal depression (or melancholia) if we do not know what normal depression (or sadness) is.

Although practically all human beings have at some time experienced depression, this emotional state is among the most difficult to describe and to analyze. It is a pervading feeling of unpleasantness accompanied by such somatic conditions as numbness, paresthesias of the skin, alterations of muscle tone, and decreases in respiration, pulsation, and perspiration. The head of the depressed person has the tendency to bend; the legs flex; the trunk tilts forward. The face assumes a special expression because of increased wrinkles and decreased mimic play. There is also retardation of movements, rigidity in thinking, and a general feeling of weakness. These characteristics vary in intensity, of course, from very mild to very pronounced, in accordance with the degree of the depression.

It is, however, at the mental rather than the somatic level that depression has more specific characteristics. Whereas anxiety is characterized by an expectancy of danger, depression is accompanied by a feeling that the dangerous event has already occurred, that the loss has already been sustained. For instance, a cherished love or a deep friendship has been destroyed, a loved person has died, a good position has been taken

away, a business venture has failed, an acceptable image of the self can no longer be maintained, an ideal has been dismissed. If the feeling is one of pure and profound depression and is not mixed with anxiety, there is also a more or less marked sense of despair, of unpleasant finality, as if the loss could not be remedied. The loss is deemed to have repercussions on the present as well as the future.

From these examples it is evident that, at least in conditions considered normal, depression follows other psychological processes, such as evaluations and appraisals. Cognitive processes, generally some ideas or clusters of ideas, have preceded depression.

Such considerations would make depression a uniquely human emotion, different from more primitive emotions, such as fear, rage, and some forms of anxiety that occur also in much lower animals. This point, of course, is debatable. Inasmuch as animals cannot verbalize their feelings, it is an open question whether or not the belief that animals become depressed is an anthropomorphization. A dog, for instance, may appear depressed when his master is away, but it is doubtful that this is either a feeling involving the future or a sense of loss that transcends the immediate discomfort. A feeling of deprivation rather than despair seems to be involved here. On the other hand, these uncomfortable feelings of deprivation, which even animals are capable of experiencing, may be the precursors of human depression.

Depression must have a significance and possibly a special function in the fabric of the psychological organism. If depression had only or predominantly negative survival value, species capable of experiencing it probably would not have procreated themselves in the course of evolution. Other emotions have survival value. Anxiety, for instance, is a warning of forthcoming danger.

What is the biological meaning of depression? Depression or anguish is mental pain, an experience to which the name pain is often given because of the similarity to physical pain. It is not implied here that depression is the only form of mental pain, but that it is the most typical, and that it is the evolutionary outcome at a human symbolic-interpersonal level of the biologic nociceptive pain.

Physical pain is a sensation which informs the conscious organism that a loss to the continuity of the proper functioning of the body has taken place. By being unpleasant, pain becomes a warning that something is wrong. It becomes a signal that a discontinuity of the integrity of the organism has occurred and may increase unless the animal removes the source of pain. Pain is thus a translation of an abnormal state of the organism into a subjective experience. In lower species, an attempt at removal of pain is made by withdrawal from the source of pain. In higher species, especially in man, a voluntary action generally attempts to remove the source of pain, so that the regenerative potentialities of the organism will permit healing. We may see

something similar in that form of mental pain, depression. The depression follows the appreciation of a loss of what we consider a normal and generally important ingredient of our psychological life.

For example, an individual hears the news of the unexpected death of a person he loved. After he has understood and almost instantaneously evaluated what that death means to him, he experiences shock, then sadness. For a few days, all thoughts connected with the deceased person will bring about a painful, almost unbearable feeling. Any group of thoughts even remotely connected with the dead person will elicit depression. The individual cannot adjust to the idea that the loved person does not live any more. And, since that person was so important to him, many of his thoughts or actions will be directly or indirectly connected with the dead person and therefore will elicit sad reactions.

Nevertheless, after a certain period of time, that individual adjusts to the idea that the person is dead. By being unpleasant, the depression seems to have a function—its own elimination. It will be removed only if the individual is forced to reorganize his thinking, to search for new ideas so that he can rearrange his life. He must rearrange especially those ideas that are connected with the departed, so that the departed will no longer be considered indispensable. Like pain, depression thus stimulates a change in order to be removed, but it is a psychological change, an ideational change, a

rearrangement of thoughts, and clusters of thoughts. Eventually, the actions of the individual, too, will alter as a consequence of this cognitive rearrangement.

Depression, however, is not always a normal emotion. Its importance in the field of psychiatry is probably second only to another emotion, anxiety. Depression is deemed abnormal when it is excessive relative to the antecedent event or events that have elicited it; when it is inappropriate in relation to its known cause or precipitating factor; when it is a substitution for a more appropriate emotion, for instance, when it takes the place of hostility or anxiety; or when it does not seem to have been caused by any antecedent factor of which the person is aware.

In abnormal depression, the process of cognitive change and reorganization, mentioned in relation to normal depression, fails. Another process occurs which brings about several degrees of pathology. The depression, rather than forcing a reorganization of ideas, slows down the thought processes. In this case, the psychological mechanism seems to have the purpose of decreasing the quantity of thoughts in order to decrease the quantity of suffering. At times, the slowing down of thought processes is so pronounced (as in the state of stupor) that only a few thoughts of a general or atmospheric quality are left; these are accompanied by an overpowering feeling of melancholy. Thus, the slowing down of thought processes is a self-

defeating mechanism. A vicious circle is produced which aggravates the condition. The decrease in motility, formed in the psychotic depressed, is secondary to the slowing down of thought processes, so that even the ideomotor activity, preceding movements and actions, is decreased.

When the depression becomes overwhelming, it seems to possess the whole psyche, to leave no room for ideas or thinking. The patient reduces his thinking to a minimum. He becomes aware only of the overpowering feeling of depression. As a matter of fact, if we ask the patient why he is depressed, he may say that he does not know. In patients who have recurring depressions, severe or even moderate in intensity, often the ideas or thoughts that have triggered off the depression become almost immediately submerged by the depression. They become unconscious, and the patient is not able to say why he is depressed. Some patients say things like the following: “I woke up this morning, and I was immediately overpowered by an intense feeling of depression.” In these cases, the depression has, among others, the function that repression has in other psychiatric conditions. Perhaps, it is a special type of repression; the cognitive part is repressed, but the painful feeling is very intensely experienced at the level of consciousness.

Another type of defense that the individual may resort to in the presence of depressive thoughts is the escape into action and fugitive thoughts. This defense is available in typical manic-depressive patients, who,

although they do not have clear-cut manic episodes, go through periods of hyperactivity. This defense, which is not as frequent as the deep depression just described, is the formal counterpart of the outer-directed, hypomanic-like, or merely cyclothymic personality. This defense may be so effective as to prevent the occurrence of the psychosis throughout the life of the patient. Thoughts must be very fugitive, must be changed very rapidly, because any constellation of organized thoughts about practically any topic sooner or later brings about the depression. Pleasant thoughts are searched for; actions that may replace ideas are sought.

The patient resorts to this defense either in order to prevent the depression or in order to escape from the depression (as when he slips from the melancholic into the manic state).

At times, he succeeds in using this defense in an acceptable, or at least tolerable way, retaining, or even increasing, normal abilities. The ability to recall masses of detail, shown by some hypomanic patients when reporting their experiences, may be useful if channeled into activities that require accurate descriptions. Often, however, the wealth of details is useless and irritating. The escape into words, into social symbolism, and into observation of reality almost to a photographic level is obvious.

The following are some excerpts from a woman's conversation during a

hypomanic interval: (She has had three previous psychotic depressions.)

"The telephone rang; it was the doctor who treated my husband, Dr. B. He told me that I should go to see him right away. I put on my spring coat. It must have been spring, as I remember, because I wore the spring coat. The doctor lived a few blocks away in an apartment in the Hotel Plaza. I went there, took the elevator. They lived at the fourth floor, fourth or fifth. I don't think it makes much difference. I rang the bell. The wife came to open the door. She is such a short woman, and her husband, the doctor, is so tall "

These details were, of course, useless and irrelevant to the goal of the conversation. Logicalness, however, was retained. Similar behavior may be tolerated. Often, however, when the looming depression is very intense, the patient must resort to more pronounced manic mechanisms.

The foregoing exposition may create the impression that the manic pleasure consists only in the escape from depression, in the removal of the negative. Not every pleasure, however, is the removal of the negative, or a decrease in the tension that produced pain; it is my impression that the manic does not try only to escape from the pain of depression but to gain by extending or enlarging his contacts with the world. Such contacts must remain superficial, however, if depressing connections are to be avoided. A further consideration is the fact that pain elicits in the organism a reaction of

moving away from the source. At the level of human depression, no movement or moving away is visible, because the moving away is only from depressive thoughts (unless, as we have seen before, the depression is very intense). In pleasure, there is not only a moving away from the source of pain but also a *moving toward* the object which will confer pleasure. And the increased motility of the manic must be considered as an attempt to *move toward* the source of pleasure.

The manic mechanisms, however, fail on account of their pathologic proportions. In order to avoid unpleasant constellations, thoughts must be so rapid that they cannot be organized or, therefore, capable of achieving rewarding actions. The pleasant ideas cannot be sustained and eventually leave the patient with the realization that they are futile. When the manic fervor is exhausted or cannot be sustained any longer, depression ensues or returns.

It is still not clear why some patients are able to avail themselves of the manic defenses and others are not. Perhaps constitutional, cultural, and dynamic factors play roles that cannot yet be ascertained. Studying the literature, however, one gets the impression that in so-called primitive cultures the manic attacks are much more numerous than the depressions.

The incidence of manic attacks is much lower than that of depressions,

and many writers today feel that one cannot classify as manic-depressive the many patients who undergo depressions but never have a manic attack.

More conservative psychiatrists, however, tend to retain the manic-depressive syndrome as a unit, a position that can be justified on the grounds that our understanding of its partial manifestations is increased by our acceptance of its unitary concept.

The Study of Affective Psychoses from the Point of View of Sociocultural Psychiatry

Affective psychoses offer a special field of inquiry for social and cultural psychiatry because of two clinical variations that seem correlated to changes in the sociocultural environment.

The first variation consists of a marked decrease in recent times in the incidence of typical manic-depressive psychosis. The second variation is represented by the increasing frequency of the claiming type of depression, and the relative decrease of the traditional self-blaming type. We shall consider these two phenomena separately.

The decline in frequency of typical manic-depressive psychosis is reflected also by a decline of interest among psychiatrists in the condition. Whereas at the time of Kraepelin this psychosis received an amount of

consideration equal, or almost equal, to that of dementia praecox, a relative but progressive disinterest has gradually been evident in the last few decades. Books and articles continue to be written, but schizophrenia appears much more often in the literature, particularly in the United States.

Practicing psychiatrists justify their decrease of interest with the statement that they encounter this disorder much less frequently. The statistics seem to support this observation, made at a clinical level. In 1928, in New York, there were ten first hospital admissions of manic-depressive patients per 100,000 inhabitants; in 1947, this incidence decreased to 3.7 per 100,000. The percentage of first admissions of manic-depressive psychosis in 1928 was 13.5 percent of all admissions; in 1947, the percentage was reduced to 3.8. Similar statistical trends are obtained in most of the other states. The statistics point out a definite decrease of this psychosis, but their interpretation is difficult because, as in all cases of psychiatric vital statistics, there are many variables involved. Beliak offers three possible explanations: (1) an actual lessening of the relative frequency of this disease; (2) greater toleration by the healthy population of milder cases of manic-depressive psychosis; and (3) changing diagnostic trends.

To these three hypotheses a fourth can be added. New therapeutic methods administered at the beginning of the illness produce such improvement or recovery that the patients do not need to be hospitalized.

One thinks here in particular of electric shock treatment, which is capable of rapidly ending a manic-depressive attack. But this hypothesis will not withstand close examination. The first reports on electric shock by Cerletti and Bini appeared in 1938. Electric shock was introduced into the United States in 1939 but did not receive wide application, especially in private offices with non-hospitalized patients, until 1942-1943. The statistics indicate, on the other hand, that the decline in first admissions of manic-depressive psychoses started in 1928. What I have said in reference to electric shock treatment could be reported with even more emphasis about antidepressant drug therapy or lithium therapy in manic cases, which were introduced long after a marked decrease in affective psychosis had taken place.

There are some factors that tend to weaken Beliak's third hypothesis, that changing diagnostic trends are completely responsible for this decrease. It is correct that many patients with a mixed symptomatology today are classified not as manic-depressives but as cases of reactive depression, senile depression, schizophrenia, obsessive-compulsive psychoneurosis, etc. The pertinent question here is, Why are we reluctant to make the diagnosis of manic-depressive psychosis?

It can be argued justifiably that this reluctance is not merely caprice but is determined by the fact that in many cases today the manic-depressive

features play only a secondary role, whereas in the past they played the predominant one. We have already mentioned that an increase has recently been noticed of cases in which depression follows a typical initial schizophrenic symptomatology. In these cases, obviously, preference is given to the initial, and much more marked, symptomatology. Moreover, often schizophrenic residues are detectable in these cases even when the depressive features prevail.

Relevant information has been gathered in other parts of the world. Gold found a relatively larger incidence of manic-depressive than schizophrenic psychoses in the lands of the Mediterranean basin, as well as in Ireland. He reported that in Oriental countries, especially where Hinduism and Buddhism prevail, manic-depressive psychosis again becomes much less common, but in the Fiji Islands manic-depressive patients are numerous. He wrote further that, whereas in India the incidence of manic-depressive psychosis is low and that of schizophrenia higher, the reverse is true for the Indians who have emigrated to Fiji. While I was visiting mental hospitals in Italy immediately after World War II, I had the impression that classical or pure manic-depressive patients were more numerous there than in the United States. The official statistics in Italy corroborated this clinical impression. In 1949, in the United States, the rate of admissions was 4.7 for manic-depressive psychosis and 16.1 for schizophrenia; in Italy, it was 10.0 for manic-depressive psychosis and 8.2 for schizophrenia.[10] Italian

psychiatrists, however, state that since the late 1940s, in Italy, too, manic-depressive psychosis has decreased in number, especially the manic type, approximately by now as much as in the United States.

Another important point to consider concerning diagnostic trends is whether the differentiation of such categories as "involutional paranoid state" and "involutional melancholia" is responsible for the statistical differences. In other words, patients previously diagnosed as manic-depressive may now be diagnosed as suffering from the involutional syndromes. Here, again, it is difficult to evaluate all the factors. Previously, involutional patients might have been diagnosed as paranoid conditions, paraphrenia, etc. It is only in the case of pure involutional melancholia that competition with the diagnosis of manic-depressive psychosis exists. It is doubtful whether the cases of pure involutional melancholia, if added to the official figures of manic-depressive psychosis, would reverse the apparent decline or explain the great difference existing today, between the rate of first admissions of schizophrenia and that of manic-depressive psychosis. Again, the trend is demonstrated sharply by the statistics. Beliak reports that, of first admissions to New York State hospitals for the year ending March 1947, 27.7 percent were diagnosed as dementia praecox, 7.0 percent as involutional psychosis, and 3.8 percent as manic-depressive psychosis. (Involutional and manic-depressive combined were 10.8 percent.)

The second hypothesis of Beliak, that the healthy population has more tolerance for milder cases, is difficult to accept. Beliak states that the "full-of-pep-and-energy" salesman type of person is now an accepted type. He is correct, but, in spite of some similarities, this person corresponds not to the cyclothymic hypomanic who is liable to become manic-depressive, but rather to the "marketing personality" of Fromm and the "other-directed" person of Riesman.

These observations and considerations seem to lead to the conclusion offered by Beliak's first hypothesis that the decline in the number of manic-depressive patients is real rather than apparent. Statistics further indicate that if the same trends continue in the United States, manic-depressive psychosis may disappear entirely or reappear later in a near or distant future. Although this decline is not universal, it seems to affect many countries, especially Western countries, but not with the same speed.

It seems apparent that a clear understanding of the reasons for this decline can lead to conclusions relevant to the fields of mental hygiene in particular, and of psychiatry in general. In order to understand this, we must resort to social psychiatry, that discipline which, as Rennie has defined it, "is concerned not only with facts of prevalence and incidence . . . [but] searches more deeply into the possible significance of social and cultural factors in the etiology and dynamics of mental disorder."

There may be a relation between what Riesman calls the "inner-directed" personality and culture, and manic-depressive psychosis. When this type of personality and culture tend to disappear, this psychosis tends also to disappear.

Riesman explains the establishment of the inner-directed society as the result of demographic and political changes. At certain times in history, a rapid growth of population determines a diminution of material goods and a psychology of scarcity. Although this type of society has existed several times in history, we are particularly concerned with the recurrence which had its beginning at the time of the Renaissance and the Reformation. As Fromm noted, at that time the security that the individual enjoyed in the Middle Ages by virtue of membership in his closed-class system was lost, and he was left alone on his own effort. The religious doctrines of Luther and, indirectly, Calvin, gave the individual the feeling that everything depended on his own efforts. Deeply felt concepts of responsibility, duty, guilt, and punishment, which, up to that time had been confined to a few religious men, acquired general acceptance and tremendous significance and came to color every manifestation of life. This type of culture, which originated during the Renaissance and developed during the Reformation, sooner or later permeated all Western countries; only recently has it faced replacement by another type of culture, the "other-directed." In some countries, such as the United States, this replacement is taking place at a rapid rate; in others, it is

taking place more slowly.

In the "inner-directed" society, the parent is duty-bound and much concerned with the care of the newborn child. It is this duty-bound care and the ensuing burdening of the child with responsibilities and the sense of duty and guilt that may permit the child to develop the strong introjective tendencies that play such a prominent role in the development of manic-depressive psychoses.

The similarities between the pattern of life of the manic-depressive patient and the typical "inner-directed" person are apparent.

1. Very early in the life of the child, the parent is duty-bound and gives such tremendous care to the child as to determine in the latter strong introjective tendencies.

2. A drastic change will occur later when the child is burdened with responsibility. This change will produce the trauma of the paradise lost.

3. The individual feels responsible for any possible loss. He reacts by becoming compliant, working hard, and harboring strong feelings of guilt. Life becomes a purgatory. (At this point many manic-depressive patients deviate from the "inner-directed" personality, as they develop instead an excessively dependent or a hypomanic-like outer-directed personality.)

4. This tremendously burdened life leads to depressive trends, or to

> inactivity which leads to guilt feelings, or as a reaction, to activity which appears futile. These negative states and feelings are misinterpreted as proof of one's unworthiness, and reactivate the expectancy of losing the paradise again, this time forever. A vicious circle is thus formed.

Other social studies point out a relation which is more than coincidental between manic-depressive psychosis and "inner-directed" society. The research by Eaton and Weil on the Hutterites may throw additional weight behind this hypothesis, although these authors do not speak of "inner-directed" society. The Hutterites are a group of people of German ancestry who settled in the Dakotas, Montana, and the prairie provinces of Canada. Their life is very much concerned with religion, and their birth rate is very high, the average family having ten children. This type of society seems to be a typically "inner-directed" one. In a population of 8,542 people, Eaton and Weil found only nine persons who some time in their life had been suffering from schizophrenia and thirty-nine who had been suffering from manic-depressive psychosis. In other words, among the Hutterites, manic-depressive psychosis was 4.33 times more frequent than schizophrenia, whereas in the general population of the United States the incidence of schizophrenia by far exceeded that of manic-depressive psychosis.

The "inner-directed" society actually offers a high degree of security to the individual, for it leaves his fate in his own hands rather than in the control

of mysterious, omnipotent, and unpredictable forces. Thus, obviously, I do not mean to suggest that the "inner-directed" culture is "the cause of" manic-depressive psychosis; rather, I speculate that this type of culture tends, in certain cases, to elicit family configurations and interpersonal conflicts that are generally those that lead to manic-depressive psychosis. What is supported here is a psychosocial or biosocial position similar to that expounded by Opler and by Lemkau and his collaborators.

Additional cultural factors either add to or detract from the importance of the structure of the society in the formation of various disease entities. Immigration to a foreign country, with consequent problems of maladjustment, seems to elicit a propensity toward this as well as other psychiatric disorders. Some additional explanation for the various incidences of manic-depressive psychosis may be found in epidemiologic studies.

In 1939, Faris and Dunham published a study, *Mental Disorders in Urban Areas,* in which they found that while schizophrenia is prevalent in the central areas of the cities of Chicago and Providence—that is, in areas of social disorganization (where delinquency, crime, prostitution, and drug addiction are also frequent)—and gradually declines in number toward the outskirts of the city, no definite pattern of distribution was found for the cases of manic-depressive psychosis.

The contrast between the ecological distribution of manic-depressive psychosis and schizophrenia was so marked that Faris and Dunham saw in it another proof of the distinct nature of the two disorders. Faris and Dunham believed that precipitating factors probably have a more important causal relation to manic-depressive psychosis than to other disorders. We have seen that precipitating factors are undoubtedly important in manic-depressive psychosis. On the other hand, it is my impression that manic-depressive psychosis is not necessarily connected with a milieu that offers "extremely intimate and intense social contacts," but rather with a structural, well-organized "inner-directed" milieu, removed from the disorganization or relative looseness of organization that we find either in some "other-directed" societies or, for entirely different reasons, in low economic or socially unstable elements of the population.

A difference in the occurrence of the two major psychoses is also illustrated by the size of the communities involved. The highest proportion of manic-depressives comes from cities of 100,000 to 200,000 population and from rural areas, whereas the largest proportion of schizophrenic cases comes from metropolitan or urban areas.

Other studies seen to point out that the economic level of the manic-depressive tends to be higher than that of the schizophrenic. It is debatable, however, whether the low economic condition of the latter is related to the

effect of, rather than to the etiology of, the disorder. Manic-depressives are affected by their condition later in life and less seriously.

In sum, there is much presumptive evidence that ecological, cultural, and social factors are important in either engendering or at least predisposing to manic-depressive psychosis.

We have observed in relation to affective psychoses the increase of the claiming type depression and the decrease of the self-blaming type. Of course, what we have discussed in reference to the decline of manic-depressive psychosis applies in particular to the self-blaming type. It cannot be necessarily repeated for the claiming type. A person who tends to rely on others for autonomous gratification is also a person who may be "other-directed," a person who since early childhood has resorted to the external environment for most kinds of stimulation and has been less prone to internalize or conceive distant values and goals. In my book, *The Will To Be Human,* I describe how the most pronounced forms of this type of personality are not just "'other-directed." They are immediacy-directed. Inasmuch as they cannot be in touch with any sustaining inner life, I consider them as suffering from a special type of alienation not previously described. They search excessive external stimulation; they do not even conform, they respond. They are at the mercy of the environment. When they feel deprived, they become depressed, especially if early in life they had undergone traumas that had

sensitized them to losses.

Choice of Therapy

The treatment of affective psychoses should be considered under four headings: (1) psychotherapy; (2) hospitalization; (3) drug therapy; (4) shock therapy. A discussion of the last three will be confined to a few general remarks, since they are discussed extensively in Volume 5 of this Handbook. Here we will consider primarily the psychotherapeutic approach.

Hospitalization must be considered especially when there is danger of suicide. However, we must realize that a suicidal risk exists in practically every patient suffering from a psychotic form of depression. It is up to the psychiatrist to determine whether the risk is great, moderate, or minimal, and there are no infallible methods to make such distinction. If the danger is deemed great and the patient cannot be under proper surveillance at home, hospitalization becomes necessary. Often it is more difficult to convince the relatives than the patient that he should be hospitalized. The depressed patient, perhaps in a masochistic spirit, at times is ready to enter the hospital, whereas the relatives would prefer to send him on vacation. It is more difficult to hospitalize a manic, as he himself prefers to take trips and to escape into actions. When the risk is moderate or minimal, the decision is more difficult. At times the risk is worth taking in view of the fact that long

psychotherapy is not possible in the hospital (with some exceptions), and that the possibility of suicide is not completely eliminated even in a hospital setting. Moreover, in some cases a certain amount of risk remains for an indefinite but prolonged period of time, because the patient does not benefit from any type of therapy; he would thus have to be hospitalized for an indefinite period of time with great damage to his self-image and increased feeling of hopelessness. All these possibilities, of course, should be discussed openly with the members of the family. The responsibility for the decision must be made in a spirit of collaboration and possible unanimity among patient, family, and therapist.

Drug therapy at times diminishes the risk of suicide, but in my experience is not sufficient in most cases to cure affective psychoses even from the manifest symptomatology. Lithium therapy, however, often produces good results in manic attacks.

Electric shock therapy is very efficient in terminating many (but not all) acute and subacute attacks of severe depression. At times, merely a few electric shock treatments are sufficient to produce a temporary recovery from a depression. A manic attack may require a longer course, and the result is more uncertain than the one obtained with lithium.

In my opinion, these physical therapies do not change the basic

personality of the patient. The fundamental problems remain unsolved, although they may be forgotten or poorly integrated because of the effects of electric shock treatment. Drug therapy makes the patient less sensitive to his depression or elation; but the potentiality for affective disorders remains, once the therapy is discontinued.

Psychotherapy, if successful, will prove to be the best type of treatment, because it will change the psychological prerequisites for the disorder. On the other hand, psychotherapy, too, has many disadvantages: (1) in extremely severe cases, where the patient is in stupor or near stupor, it may be difficult to establish contact or to elicit an atmosphere of participation necessary for the treatment; (2) the risk of suicide is often great and the patient cannot be allowed to go to the therapist (unless, of course, psychotherapy is given in a hospital setting or the patient is accompanied by a reliable person).

Psychotherapy should be instituted also in (1) patients whose acute attacks have ended spontaneously; (2) patients who have received convulsive treatment, as soon as the organic effects of the treatment, such as forgetfulness, mild confusion, etc., have decreased in intensity.

Psychotherapy

Psychotherapy of affective psychoses is still in the pioneer stage. It is true that depression has been treated with psychotherapy for a long time, but

generally in cases which had not reached the psychotic level. It is also true that unlike schizophrenia, psychotic depression has been treated psychoanalytically relatively early in the history of psychoanalysis. However, these cases have been very few and have as a rule been treated in the intervals during the attacks of depression. Manic attacks have been treated with uncertain results by psychoanalytic and existentialist therapists.

The intensity of the depression should not deter the therapist from making psychotherapeutic attempts. Certainly, it is difficult to make contact with a depressed person but not impossible.

Contrary to what happens in schizophrenia, where the psychosis is a consequence to a failure of cosmic magnitude, involving as a rule the relation with the whole interpersonal world, the failure of the depressed patient is experienced mainly or exclusively in relation to what we have previously designated as the dominant other. It is one of the first tasks of the therapist to detect and study the failure of this relation.

We have seen that the dominant other is generally a person, most often the spouse, less often the mother, a person to whom the patient is romantically attached, an adult child, a sister, the father. We have also seen that the dominant other at times is not a person but a group of persons, like the family as a whole, the firm where he works, or an organization to which

he belongs. This changed relation with the dominant other produces or precipitates a sense of loss, which triggers off the depression. The dominant other, who used to nourish the patient with approval, love, guidance, or hope, is no longer there, either because he has died, dissolved, or is seen by the patient in a different light.

When the therapist enters the life of a very depressed person and proves his genuine desire to help, to reach, to nourish, to offer certainty or at least hope, he will often be accepted, but only as a *dominant third.* Immediate relief may be obtained, because the patient sees in the therapist a new and reliable love-object. Although the establishment of this type of relatedness may be helpful to the subsequent therapy, it cannot be considered a real cure; as a matter of fact, it may be followed by another attack of depression when the patient realizes the limitation of this type of therapeutic situation.

The therapist must be not a *dominant third,* but a *significant third*—a third person, in addition to the patient and the dominant other, a third person with a forceful, sincere, and unambiguous type of personality, who wants to help the patient without making threatening demands.

In the case of a predominantly self-blaming type of depression, the relation with the dominant other has to be studied, especially in some aspects described in previous sections of this chapter. The dominant other quite

often, because of repressed hostility or because of perfectionistic, ultra-moralistic, or obsessive-compulsive attitudes, unwittingly increases the patient's feeling of guilt, duty, and denial of himself. Such sentences as "You are too sick to do the housework now," or, "For many years you took care of me; now I take care of you" increase the guilt feeling of the patient. With the permission of the patient, in some cases it is important to discuss with the dominant other several environmental changes and the climate of the relationship, in order to relieve as much as possible the patient's feeling of unbearable yoke, guilt, responsibility, unaccomplishment, loss.

On the other hand, we must clarify to the patient that he did not know how to live for himself. He never listened to himself, he was never able to assert himself, but cared only about obtaining the approval, affection, love, admiration, or care of the dominant other.

As we have already mentioned, the dominant other is not necessarily a person, but in some cases may be the whole family or a special group or organization. The patient must be guided by the significant third on how to live for whatever meaning he wants to give to his life, and not just in order to obtain the gratifying psychological supply from the dominant other.

If the therapist succeeds in making some indentations in the patient's psyche, several developments may occur. The patient may become less

depressed, but angry either at the dominant other or the therapist, whom he would like to transform into a dominant third. The anger and hostility toward the dominant other (most frequently the spouse), is at times out of proportion. Once repressed or unconscious ideations come to the surface, the dominant other may be seen as a tyrant, a domineering person who has subjugated the patient. At this point, the therapist has a difficult task in clarifying the issues involved. At times, the dominant other has been really over-demanding and even domineering, taking advantage of the placating, compliant qualities of the patient. Often, however, it is the patient himself who, by being unable to assert himself and by complying excessively, has allowed certain patterns of life to develop and persist. Now, when he wants to change these patterns, he attributes the responsibility for them to the dominant other. No real recovery is possible unless the patient understands the role that he himself has played in creating the climate and pattern of submissiveness.

We have so far referred to the patient as “he” and we shall continue to do so. However, we must remind the reader that almost two-thirds of these patients are women, and if the language required referring to the most common sex involved, we would use the pronoun “she.” Perhaps, society will change and the so-called woman’s liberation movement will alter the cultural climate or at least the frequency of certain developments. At the present time, the prevailing patriarchal character of our society makes it easier for a

woman to assume the attitude of dependency on a male dominant other, or even on a female dominant other. By tradition, many more women than men have overtly or in subtle ways been trained to depend on others for support, approval, appreciation. Some of them actually live a vicarious life.

The fact that society and culture have facilitated these developments does not exonerate the female patient from recognizing the role she has played. By omission or commission, the patient has, so to say, allowed the dominant other to assume that specific position in her life. Many husbands, certainly helped by the prevailing patriarchal character of society, are not even aware of having played the role of dominant other. When they come to such realization, they may try to deny certain facts, are busy in defending themselves as if they had been accused, and may require psychotherapy (or family therapy together with the patient). The same remarks can be made, although less frequently, for dominant others, other than husbands.

The realization of these factors on the part of the patient does not yet relieve the depression, although in most cases it diminishes it. Generally, the patient continues to be depressed because he broods (1) over what he did not have; (2) has a feeling of self-betrayal (by accommodating to the dominant other, he has not been true to himself); (3) has some sort of realization that many gratifications he desired in life had to be given up; (4) has a feeling of hopelessness about remedying or retrieving what he has lost, the

opportunities he did not grasp.

As mentioned earlier, ideas of this type are not kept in consciousness for a long time. The ensuing depression covers up these cognitive components. The therapist must train the patient to catch himself in the act of having these ideas, or in an attitude in which he expects to be or to become depressed. If he becomes aware of these ideas and of expecting to be consequently depressed, he may stop the depression from occurring, or at least from reaching the previous intensity. Then, he must, of course, discuss with the therapist these depression-prone cognitive components. If the patient understands that he had a role in this dynamic complex, he will abandon a state of helplessness and hopelessness. In the present and in the future, he may act differently and learn to assert himself and to obtain what is really meaningful to him and gratifying. Any feeling of loss or disappointment is no longer translated into self-accusation and/or guilt.

Obviously, he must, with the help of the therapist, change his ways of living and interrelating with the dominant other. The patient cannot devote his life to the dominant other or live vicariously through him. On the other hand, the patient may be afraid of going overboard, of being too hostile and angry at the dominant other. However, this stage will be also outgrown when the dominant other will be recognized to be not as the patient consciously or unconsciously used to see him in recent years, but as the early childhood

situation has made the patient envision him. In other words, the trauma over the alleged or real loss of love, sustained in childhood, and the mechanisms adopted in the attempt to re-obtain this love or its equivalents (admiration, approval, affection, care), have led to a series of events where the patient had to create or to choose as a mate a person who would fit the role of dominant other. The patient has also misperceived some attributes of the dominant other, in order to see him in that role. When the patient will no longer be concerned with the dominant other, in his recent role, and will concentrate on his childhood's situation, treatment will be at an advanced stage. However, even then, the patient may become easily depressed since depression has become his fundamental mode of living. Depressive thoughts should not be allowed to expand into a general mood of depression, but must retain their discrete quality and content, which have to be analyzed. The patient must learn that because of this pattern of depression even innocent thoughts at times have the power of eliciting a depression. Little disappointments or losses that lead the patient to self-accusation, guilt, or severe depression are actually symbolic of an earlier, greater disappointment, or of lifelong disappointment. But, now, the early losses or the recurring losses are no longer likely to be repeated, because the patient is learning to assert and fulfill himself.

It is not possible to eliminate historically the original trauma of childhood, but it is possible to change the pattern by which the patient tried

to remedy or undo the original trauma. Finally, the original traumas and these patterns will lose their significance and the compulsive qualities that caused their persistence or recurrence.

The handling of irrational guilt feeling is still important in the self-blaming cases of depression, even at advanced stages of treatment. The pattern that the patient has learned, throughout many years of life, is the following: guilt feeling —> atoning —> attempted redemption. Guilt about what? Originally, of course, the child attributed to himself the responsibility for the traumatic loss. He was naughty, terrible, evil. By atoning (that is, by placating, obeying, working hard, doing his duty, denying himself, by wanting peace at any cost), he felt he could obtain the love, approval, or admiration that he desired. But if he did not get it, he felt guilt again for not having done enough, for not having atoned enough. The cycle thus repeated itself. Since this pattern has become so ingrained in him, the patient will often change other psychological mechanisms into this guilt complex, for instance, anxiety into guilt feeling. For example, the patient does not go to church on Sunday or does not accompany her child to grammar school. Now, the patient has something to feel guilty about. As painful as the guilt feeling is, the patient is aware that the possibility of suffering and thus of redeeming himself is in his power, whereas with anxiety he is at a loss; he does not know what to do about it.

The obsessive-compulsive symptoms that complicate a minority of cases of severe depression are attempts to channel guilt feelings and find measures to relieve them, so that the lost love or approval will be re-acquired. Actually, they aggravate the situation instead of solving it. For instance, the patient may have the obsession of thinking about something profane or sacrilegious, or about the coming death of a relative, and he feels guilty about having such thoughts. Similarly, compulsions may obligate the patient to perform actions condemned by the ritual of his religion, and again he feels guilty.

During therapy, it will be possible to show the patient how he tends to translate anxiety into guilt and depression. Finally, he will learn to face anxiety rather than to reproduce the sequence that will lead to the depression. He will also recognize the cognitive components that lead to anxiety. If the therapeutic climate established with the therapist is a sound one, the patient will realize that he can manifest and consequently share his anxiety with the therapist. His anxiety, that is, his negative attitude toward what is uncertain or what is about to come, will progressively change into hope, that is, into a positive attitude toward what is uncertain or what is about to come.

The therapist will eventually learn to handle little relapses, to understand and explain little psychological vicious circles that are formed or

stumbling blocks that are encountered and tend to re-establish a mood of depression. For instance, the patient may become depressed over the fact that he may so easily become depressed; any little disappointment triggers off the state of sadness or guilt. Again, he has to be reminded that the little disappointment is symbolic of a bigger one. Another difficulty consists of the fact that some clusters of thought seem harmless to the therapist and are allowed to recur; actually, they lead to depression because of the particular connections that they have only in the patient's frame of reference. Eventually, however, the emotional pitch of the therapist will become more and more attuned to that of the patient.

At times, we encounter patients who do not seem to have had the relation with a dominant other that we have described. It is true that the patient has experienced mild disappointments, like broken friendships, but they hardly seem traumatic loss situations. If we analyze these patients carefully, we discover that once in their life a dominant other existed, and that these little disappointments are symbolic. In a few cases, however, the dominant other has not been a person, not even a group of persons or an organization, but an ideology, an ideal, a grandiose aspiration about oneself and the world. The patient has lived for this ideological dominant other, which eventually has proved to be false, unworthy of a lifetime sacrifice, or unrealizable. Whereas the stable person, the artist, or the philosophically inclined individual may accept the impossibility of realizing certain goals, and

understand it in terms of the human limitations, the severely depressed person may interpret it again as proof of his defeat, guilt, unworthiness of himself, or of life in general. Again, a great deal of explanation and sharing of anxiety is necessary on the part of the significant third.

The treatment of the claiming type of depression is also difficult. Before starting treatment, the patient has become more and more demanding on the dominant other, the more deprived he felt. Any unfulfilled demand was experienced as a wound, a loss, and increased the depression. When treatment starts, the patient wants to find in the therapist a substitute for the dominant other who has failed. To the extent that the patient's demands are plausible or realistic, the therapist should try to go along with these requests and satisfy some of the needs for affection, consideration, companionship. Even clinging and nagging have to be accepted.

Kolb, English, and Cohen et al. emphasized this excessive clinging as one of the main problems encountered in intensive psychotherapy with manic-depressives. Some patients do not want to leave at the end of the hour; they claim to suddenly remember many things they must say, plead for help, and attempt to make the therapist feel guilty if they are not improving. As Kolb described, these patients have learned proper or apparently suitable social manners, and, with pleading and tenacity, they are often capable of eliciting in the therapist the reaction they want.

Occasionally, we have to prolong the session for a few minutes, as at the last minute the patient feels the urge to make new demands or to ask "one more question." The recommended attitude may seem a too indulgent one, but, especially at the beginning of treatment, we cannot expect the patient to give up mechanisms he has used for a long time.

Many patients, especially at the beginning of the session, are not able to verbalize freely, and should not be requested to explain their feelings in detail or to go into a long series of associations. On the contrary, the therapist should take the initiative and speak freely to them, even about unrelated subjects. As a patient of Thompson's said, the words of the analyst are often experienced as gifts of love by the depressed person. Following the suggestions made in Spiegel's studies,' the therapist will soon learn to communicate with the depressed, at times even in spite of his lack of imagery and the poverty of his verbalizations. It is in the feeling itself, rather than in verbal symbols, that he often expresses himself.

When this immediate craving for being given acceptance is somewhat satisfied, the claiming depression will considerably diminish, but not disappear. However, now the depression will no longer be in the form of a sustained mood, but will appear in isolated, discrete fits. At this stage, it will be relatively easy to guide the patient to recognize that the fit of depression comes as a result of the following conscious or unconscious sequence of

thoughts or of their symbolic equivalents: “I am not getting what I should —> I am deprived —> I am in a miserable state.” The patient is guided to stop at the first stage of this sequence, because these words mean, “I would like to go back to the bliss of babyhood. I do not want to be a person in my own right, with self-determination.” Can the person substitute this recurring idea and aim for another one, for instance, “What ways, other than aggressive expectation and dependency, are at my disposal in order to get what I want?” In other words, the patient is guided to reorganize his ways of thinking, so that the usual clusters of thoughts will not recur and will not reproduce the old sequence. The psychological horizon will enlarge and new patterns of living will be sought. However, the patient will be able to do so only if the new relationship with the therapist has decreased his feeling of deprivation and his suffering, so that the old pathogenic sequence will not reproduce itself automatically and with such tenacity. Excursions into paths of self-reliance will be made more and more frequently by the patient. At the same time, gradual limitations are imposed on the demands made on the therapist. Once the fits of depression have disappeared, the treatment will continue along traditional lines. The patient will learn to recognize his basic patterns of living that had led him to the depression, and the special characteristics of his early interpersonal relationships that led to the organization of such patterns. Such characteristics as superficiality, insensitivity, marked extroversion covered by depression, recurrence of clichés, infantile attitudes, such as “love me like a

baby," will be recognized as defense mechanisms and disappear.

At an advanced stage of treatment with any type of depression, therapy should consist in going over again and again the life patterns the patient has adopted and in explaining how his present dealings with current life situations are often in accordance with the old psychogenetic patterns. Sooner or later, the patient, who has understood by now the psychodynamics of his life history, learns to avoid the old mechanisms, as he recognizes in them pseudo-solutions and vicious circles. In some patients, the old mechanisms will tend to recur even after they have been completely understood. As a matter of fact, even discussion of them will evoke strong emotional reactions that are not congruous with the gained insight but are the usual affective components of the original symptoms. For, even after the patient has understood the meanings of his symptoms and behavior patterns, he has more familiarity with the old patterns.

It must, for example, be pointed out constantly to the patient that he should learn to ask himself what he wants, what he really wishes. Quite often, his attempted answer will be only a pseudo-answer. He may say, "I wish first of all for peace; I wish for the happiness of my children." He must learn—and relearn—that peace at any cost implies satisfying others before oneself, and that even the happiness of children, although a natural wish of every parent, is not a wish predominantly related to the individual himself.

In other words, the patient must learn to listen to himself and to reduce the overpowering role of the Thou. At the same time, he must make a voluntary effort to develop inner resources. In the attempt to imitate others, or even to surpass others in proficiency and technique, the patient has never relied on himself. He cannot be alone (unless he is depressed), and alone he cannot do anything that gives him satisfaction; he must work for the benefit of others or take flight into common actions. He must learn that he, too, may have artistic talent, and if he has the capacity to search for it, he may find it. Creative upsurges in apparently uncreative conventional manic-depressive personalities are a good prognostic sign. Transient and short feelings of depression will be tolerated at this point, indicating, as Zetzel puts it, a measure of the ego strength.

As we have already mentioned, the therapist must be alert to spot early signs of depressions, at times precipitated even by trivial disappointments or even by chance associations of ideas. As Jacobson and Kolb emphasize, the recurring depression must immediately be related by the therapist to its precipitating cause. Dream interpretations are very useful.

What is advocated here is in a certain way a psychotherapeutic approach that will attempt to reproduce the healthy formal mechanisms which constitute a normal reaction to depression and loss—reconstructions of thought constellations, rather than the self-perpetuating depression or the

manic flight.

Orthodox psychoanalytic procedure, with the use of the couch and free associations, is not indicated in manic-depressive psychosis even during the interval periods. Many failures in treatment of these patients were due to the adoption of the classical psychoanalytic technique. Many therapists feel today that the retarded or hyperactive patients generally should be treated with less frequent sessions— from one to three a week. Many patients, especially elderly ones, seem to do well with one session a week. The therapist must play a relatively active role, not one that conveys to the patient the feeling that he is being pushed or under pressure, nor one in which the passivity of the therapist is too much in contrast with the natural extroversion of the patient. Whenever the therapist feels that he has succeeded in reaching some conclusions or in understanding the feelings of the patient, he should verbalize them freely. Often, the patient prefers to keep quiet, not because he is unable to put things together, as in the case of the neurotic or the schizophrenic, but because he feels guilty or ashamed to express his feelings of rage, hostility, and, paradoxically, even of guilt and depression.

The treatment of hypomanic patients is far more difficult, as the flight of ideas prevents any significant contact. Here, an opposite procedure is to be followed. The patient is asked to cut out details, so that irritation and rage are purposely engendered, or he is reminded that he must talk about certain

subjects (the subjects that are liable to induce depression). A conversion to a mild depression is therapeutically desirable. In many cases, however, it will not be possible to induce mild depression exclusively with active intervention of the therapist, and chlorpromazine (Thorazine) must be resorted to. This drug, either by decreasing the intensity of the manic or hypomanic state or by eliciting a mild depression, can be a valuable adjunct to psychotherapy.

Needless to say, not every therapist is suitable to treat manic-depressive patients. Some therapists who have been quite competent in treating psychoneurotic or schizophrenic patients have been utterly unsuccessful with manic-depressive patients, especially of the manic-hypomanic type. The verbose, circumstantial talk, or the photographic reproductions of past experiences with no signs of originality, the lack of any fantasy or of symbolic material, may tire the therapist. The immediate recognition of these characteristics as defense measures, and of their variation in accordance with the transference situation, can help the therapist in his trying efforts.

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Notes

1 In this chapter is included the study of the disorders which, according to the official nomenclature of the American Psychiatric Association, are called:

296 Major affective disorders: 1 Manic-depressive illness, manic; 2 depressed; 3 circular; 8 other.

298.0 Psychotic depressive reaction.

Involutional Melancholia will be discussed in Chapter 30.

2 According to Cameron,19 earlier authors grasped the intermittently manic and depressed character of the psychosis: Bonet in 1684, Schacht in 1747, and Herschel in 1768 (all quoted by Cameron).

3 This point of view has been sharply criticized by Spitz,72 who has found infantile depressions (which he calls anaclitic) only in pathological conditions and determined by the fact that the mother was removed from the child between the sixth and eighth months for an approximate period of three months.

Several of Klein's conceptions seem only adult personifications of the infantile psyche. Although these conceptions are thought-provoking, there is nothing to indicate that they relate to the processes or activities of the infant's cerebrum.

4 See Chapter 41, Volume One, for a succinct, comprehensive presentation of the existentialist approach. See also Kahn.

5 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. At the present time, the prevalent opinion of people who have worked for many years in the same hospital is that some patients who once presented what appeared to be a typical manic-depressive symptomatology later disclose a typical schizophrenic symptomatology. This point of view, of course, does not exclude the possibility of wrong diagnoses being made in some cases, especially during the first psychotic attack.

6 I have observed this displacement by a sibling to be an important factor also in the psychodynamics of milder depressions, which cannot be classified as cases of manic-depressive psychosis.

7 Some statistical works seem to indicate that the first-born child is more liable to manic-depressive psychosis. Of course, the first-born is more liable to be displaced. Berman,13 in a study of 100 manic-depressives, found that forty-eight were first-born, fifteen second, ten each third and fourth, and seventeen fifth or later. Pollock and coworkers61 found that 39.7 percent were first-born and 29.7 percent were second-born. Malzberg54 and Katz41 could not find any relationship between birth order and manic-depressive psychosis.

8 It is not implied here that the feeling of depression removes the feeling of anxiety. Some anxiety, at times even to a pronounced degree, is retained by every melancholic patient, in connection with additional possible losses, but depression is the general feeling.

9 For further discussion of suicide, see Chapter 33 of this volume.

10 Italian statistics were kindly provided by Professor Francesco Bonfiglio of Rome. To be exact, first admissions of schizophrenics in Italy totaled 3,541 in the year 1947, 3,780 in the year 1948, and 3,854 in 1949. First admissions of manic-depressive totaled 4,298 in 1947, 4,562 in 1948, and 4,791 in 1949. The rate of admission per 100,000 represents the annual average of the triennial period 1947-1949.