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Masked Depression and Depressive Equivalents

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Masked depression is one of the more common clinical ailments seen in western medicine and rivals overt depression in frequency. Indeed, it is the type of depression most often encountered by nonpsychiatric physicians. The subject of masked depression and depressive equivalents presents us with a paradox: In spite of the frequency of the syndrome, only a relative handful of clinicians have a meaningful awareness or understanding of it. The depressive affect and even many depressive syndromes may be so masked that a nonpsychiatric or even psychiatric physician may be unaware of the fact that a serious emotional disorder is at hand until a massive, full-blown depression erupts and dominates the clinical scene.

The term “depression,” in the minds of most laymen and physicians alike, usually refers only to a mood, which in psychiatric circles is more specifically labeled as sadness, melancholy, dejection, despair, despondency, or gloominess. If this overall mood pattern is not dominant in the clinical picture, the patient is not considered depressed. This view is universal among laymen. However, this narrow concept is also held by some physicians and even by psychiatrists. The masking veneer or facade may vary depending

upon many factors, including: (1) the culture, (2) age of patient, (3) socioeconomic and socio-philosophic background, (4) hereditary and congenital processes, and (5) ontogenic development.

While the masked depression syndrome, hidden behind a broad spectrum of masking processes, is broadly represented in all cultures, the relevant literature is very sparse and deals primarily with those syndromes that are essentially manifested clinically as psychosomatic disorders or hypochondriacal complaints referred to various organ systems. Masked depression has been referred to by a variety of labels, which in themselves have contributed to the confusion surrounding this syndrome. The various diagnostic labels include: (1) masked depression, (2) depression sine depression, (3) depressive equivalents, (4) affective equivalents, (5) borderline syndromes, and (6) hidden depression. In many instances, where the condition has not been detected by the physician, the term "missed depression" might be appropriate.

Concepts of Masked Depression and Depressive Equivalents

In western medicine, masked depressions are most commonly hidden behind psychosomatic disorders and hypochondriacal complaints. Less frequently the depressions may be hidden behind various behavioral patterns. If the clinician will look behind the presenting symptoms, a

depressive core will be evident, a core that in most instances eventually becomes overt if the patient is not treated. Therefore, this type of masking hides an active depression, which can be readily discerned by careful examination.

In other situations, a psychosomatic syndrome or hypochondriacal symptom may represent an aspect of a clinical spectrum that eventually may end in an overt depressive reaction. For example, individuals who demonstrate hypochondriacal symptoms early in life are prone to develop overt depressive reactions. Women who eventually develop postpartum or involutional depressions frequently have histories of significant hypochondriacal or phobic reactions earlier in life. This is not to say that all individuals who are hypochondriacal or phobic or who have psychosomatic disorders are destined to become depressed. However, individuals with a history of these clinical phenomena have a greater propensity to eventually develop overt depressions.

With this observation in mind, one should also note that the psychodynamic mechanisms associated with hypochondriasis, phobias, and psychosomatic disorders, as they occur in western culture, are similar to those that are observed in depressed patients. Therefore, hypochondriasis, psychosomatic disorders, and some acting-out behavioral patterns may be considered either as being masks of depression or depressive equivalents.

When these symptoms or syndromes are merely “covering up” an underlying depressive core, they should properly be considered as depressive masks. When these symptoms or syndromes occur in the absence of a clear-cut depressive core, and then years later manifest symptoms and signs of an underlying depression, they should be thought of as depressive equivalents.

In this second context, depressive equivalents may be viewed as part of a clinical spectrum having certain psychobiologic and psychodynamic origins with features in common. These symptoms or syndromes may be seen as separate entities or as steps in a continuum that may or may not manifest themselves as phenotypical, full-fledged, overt depressions. Many years might pass before an overt depressive reaction emerges.

These observations raise the question of differentiating between those patients who have hypochondriasis, phobic reactions, or who have psychosomatic syndromes without ever developing overt depressions, from those who manifest the same symptoms and syndromes and who have a marked propensity to become depressed. Genetic studies suggest that hereditary factors may play a role in some depressive equivalents. For example, the relatives of bipolar patients have a higher prevalence of hypertension, obesity, and thyroid dysfunction than do relatives of unipolar patients. In contrast to this observation, a higher incidence of chronic alcoholism and drug dependence has been noted in families of unipolar

patients.

From a genetic standpoint, depressive equivalents may be thought of in two ways: (1) as a different genetic subtype of affective disorder consistent with a model of heterogenic inheritance, or (2) as part of a continuum in a homogenic model of mood disturbances.

Cultural and Economic Factors Influencing the Masks of Depression

It was found that depressive episodes that are masked by hypochondriasis and psychosomatic disorders are relatively uncommon in lower socioeconomic groups in the United States. For example, faciopsychomyalgia, more commonly described as atypical facial pain of psychogenic origin, is rarely seen among blacks or Puerto Ricans in lower socioeconomic levels. However, this syndrome is seen among blacks and Latinos who rise in the socioeconomic scheme and who become part of the more affluent aspect of our society.

Acting-out behavior represents the more common type of masking process among lower socioeconomic groups in western society. This parallels the observation that acting-out behavior represents the common masking process in agricultural societies. For example, in India, a developing Third World country, 85 percent of the people are engaged in agriculture. Psychosomatic disorders are relatively uncommon among the nonliterate

rural groups. In contrast to this observation, psychosomatic disorders and hypochondriasis are much more frequently seen among the better educated groups living in more industrialized, westernized centers such as Bombay or New Delhi.

In general, there is an evolutionary continuum of defensive confusion, anger, and acting-out from relatively frank and direct behavior in nonliterate cultures to increasing disguise and distortion in modern societies. Modern societies, with their greater sophistication, use deeper disguises and more personally damaging methods of coping with problems.

In keeping with this general observation, masked depressions occur in their least severe form in most nonliterate cultures. These milder ailments are more open to spontaneous remission or shamanistic and priestly ministrations. If, however, the nonliterate cultures were strongly influenced by the European conquerors, masked depressions of the more severe type are encountered.

Simple and open confusion is the most common masking pattern in primitive or nonliterate peoples. Among these groups, confusion may be seen as a cry for help that brings the nuclear or extended family group to seek the aid of a priest or shaman. In more modern societies, however, people are relatively reluctant to show such dependent attitudes.

Hostility is a mask of depression in all societies. The direction the hostility takes, however, depends on the degree of cultural sophistication the society has attained. In nonliterate cultures, hostility is usually directed toward groups of people. In western cultures, the chief target of hostility is usually the person who is the one closest to the hostile individual. The diffusion of the objects of hostility and anger noted in technologically more primitive cultures may be accounted for, at least in part, by the fact that nonliterate cultures have more diffuse patterns of authority in the form of an extended family system.

The diffusion of hostility differs among various nonliterate societies. Opler points out that among the Arctic Eskimos and the Ute Indians of Colorado and Utah, children are often adopted out of the nuclear family by relatives. This causes diffused object relations that are associated with a broad focus of hostility. In a similar fashion, when a Malaysian runs amok, there is a very diffuse portrayal of violent aggression toward anyone who crosses the path of the attacking individual. Opler also points out that acting-out among nonliterate peoples usually occurs in the presence of relatives or neighbors. In a similar fashion, Indonesian women who display the *latah* syndrome utter obscenities in the presence of friends and relatives.

Among more primitive peoples, acting-out may also be in the form of imitative or negativistic behaviors; this is what occurs in Arctic hysteria and

in the imu illness of the Ainu of the island of Hokkaido in Japan. A similar pattern may be seen as far south as Malaysia.

Periods of confusion, occurring either as masks of mild depressive states or as expressions of agitated euphoria, have been noted among African patients. The periods of agitated euphoria may be viewed as compensations for the underlying depressions. In general, patients in primitive societies who have masked depressions can readily be restored to "health" through the psychosocial interventions of a shaman or curing cultist when the ailment is in its early phases.

Acting-Out Behavior Masking Depression in Western Culture

Masked Depression in Children

The more primitive the culture the more direct and frank the clinical manifestations masking an underlying depression. In similar fashion, acting-out behavior, which is quite direct, is the most common type of depressive expression among children and, to a gradually decreasing extent, adolescents. Indeed, when viewed in this light, one can state that almost all depressions seen in childhood are masked depressions.

The literature dealing with childhood depression is quite limited. Mosse points out that childhood depressions are usually subsumed under the

classification of psychoneurotic disorders. She also points out that the classic and obvious symptoms of depression as they are known in adult life occur infrequently in childhood. Children who are depressed show a very diverse symptomatology. Therefore, the depressions of children and young adolescents may not be recognized at all, or are classified as minor aspects of other diagnostic entities.

The masking symptoms of depression, such as defiance, truancy, restlessness, boredom, antisocial acts, and so forth, which are so common among children and adolescents, are all too often not given appropriate attention by laymen and physicians alike. A study of suicidal behavior by children and adolescents indicates that months before their suicidal attempts almost half of them showed marked and definite behavioral changes that were not recognized as serious indications of depression by their parents or their teachers.

Mosse points out that in most child psychiatric studies no clear distinction is made between children and adolescents. She observes that both physically and psychologically there is a qualitative, and not just a quantitative, difference between childhood and adolescence and that this change affects the character of the psychopathology that is evidenced. This difference is most significant where depression is concerned.

It is most important to appreciate that suicidal attempts have been overlooked in children and adolescents due to the erroneous concept that they do not experience depression. In fact, it is only recently that the subject of childhood depression has been discussed at all. Some child psychiatrists contend that depression does not exist in children. Toolan points out that a popular book on child psychiatry, and several detailed monographs dealing with clinical and research aspects of depression, do not even mention childhood depression.

The scotoma that currently exists in regard to childhood depression parallels the blindness of some psychiatrists who denied the diagnosis "childhood schizophrenia" in the late 1940s and early 1950s. Psychiatrists and psychologists of that period were still fond of stating that children did not develop schizophrenia since schizophrenia could not appear until after puberty. This is no different from the ludicrous nineteenth-century belief that men could not be hysterics since hysteria was due to a "wandering uterus."

Spitz and Wolf described a severe type of developmental retardation in infants that was associated with deprivation reactions and depressive elements. They labeled this syndrome "anaclitic depression." This syndrome was noted in infants and small children who had been isolated from maternal care; it was most commonly seen in children raised in institutions. These children demonstrated physical, intellectual, and emotional retardation.

Initially, they protested actively, but finally became apathetic, showed decreased mental and physical activity, and rejected all adults.

Similar findings were observed in the Pavlov Institute in Leningrad in their studies of puppies. If puppies, at the time of the appearance of the "awareness reflex," receive electroshocks whenever they are fed, they will withdraw from their handlers, crawl to the back part of their cages, and even refuse all food. They lose weight and hair. No matter how the future environment is improved, these puppies do not recover. If the same experiment is performed with older puppies who had initially been treated in a very humane fashion, they too withdraw in this fashion. However, among this older group, if the environment is improved, the dogs will again begin to relate to people and the overall environment in a positive fashion.

Others have also described intellectual and social retardation in institutionalized children who were deprived of close ties with their mothers or maternal substitutes. John Bowlby described three stages that a child undergoes when separated from the mother: (1) protest, (2) despair, and (3) detachment. Often the stage of detachment is misinterpreted by a hospital staff as a sign that the child is beginning to adjust to his situation, whereas in reality it is evidence of a profound disturbance, which Bowlby labeled "mourning" and which Toolan described as "depression."

Among older children, sociopathic manifestations and acting out are more likely to mask depression. This may take the form of disobedience, temper tantrums, truancy, or running away. Several authors have noted that underlying depressions are responsible for so-called school phobias.

Some children will show equivalents of depression in the form of anorexia, colitis, and various other psychosomatic disorders; they may also display accident proneness and masochistic and destructive behavior. Hypochondriacal and psychosomatic disorders may take the form of headache, tics, choreiform movements, abdominal complaints, nausea and vomiting, and so forth. The parents of such patients not infrequently present a history of depression.

Meyers reports on a group of eighty-two childhood schizophrenics who had extensive residential and day-care treatment during their early school years. The biannual follow-ups revealed a strikingly low incidence of depressive response when the patients reached the ages of fifteen to twenty-six years. This absence of depression was even more impressive when one noted the degree of impairment in adaptation and the failures and defeats these schizophrenic individuals faced in their attempts to attain satisfying relationships with their environments. In contrast to this group, the emergence of depressive symptoms was greater in older children and in children with greater ego development and object relatedness. Meyers also

observed that in severely ill schizophrenic children the grief of the mourning reaction is usually shallow, if it occurs at all. Instead there is blandness, apathy, anger, or a variety of atypical responses.

Depression may also be masked among mentally retarded children who are very often aware of their deficiencies. This is particularly true among children who are only slightly to moderately retarded. These children are frequently rejected by their peers, by their siblings, and even by their parents. Often the depression that they evidence may be masked by irritability, rage outbursts, and destructive behavior. They tend to automatically fight authority figures, but if their rage is blocked by fear of adult punishment, it may be directed toward younger children, small animals, or inanimate objects. This type of masked depressive reaction is commonly misdiagnosed and mismanaged, especially in large institutions.

Masked Depression in Adolescents

Many of the depressive facades that were described for the older child are similar to those found in early adolescence. As the adolescent approaches young adult life, depressive episodes may become more overt and the masks will more closely resemble those seen in adult life. School phobia and underachievement in school may conceal underlying depressions in younger adolescents as well as those attending high school and even college. Among

the older group, depressions are frequently manifested by changing courses, failures to take final examinations, dropping out of school, or changing from fulltime to part-time schooling. The threat of graduation, laden as it is with the fears of unknown responsibilities, is often associated with depressive reactions masked by acting-out behavior or hypochondriacal and psychosomatic disorders.

Among adolescents one often encounters masks of depression in the form of pervasive boredom, restlessness, frantic seeking of new activities, and a reluctance to be alone. The bored teenager often complains that he or she is tired. This type of adolescent may manifest an alternation between complaints of fatigue and evidence of almost inexhaustible energy.

Complaints of feeling empty, isolated, or alienated, so often described by adolescents, may also be indicative of underlying depression. He may describe himself as being unworthy and unlovable. The depressed adolescent often evinces a paradoxic combination of resentment toward his parents coupled with overdependence upon them.

The post-World War II period, particularly the past decade and a half, has been characterized by a decreased psychosocial threshold to psychologic or physical pain and frustration. This pattern has been enhanced by a multibillion-dollar advertising industry that preaches *ad nauseam* of one's

birthright to wallow in material, physical, and emotional pleasure while expending little or no effort. Among older adolescents the compulsive use of drugs and sexual acting-out has become progressively more common as masks of depression. Sexual acting-out may be seen as seeking a significant other person in an attempt to relieve feelings of aloneness and alienation. At times, a depressive propensity may be aggravated by marked guilt feelings associated with this sexual behavior. Teenage pregnancies, which have increased in frequency at an astounding rate, too often compound the problem.

Chwast has pointed out that depressive reactions may be masked under the guise of delinquent behavior among adolescents from lower socioeconomic backgrounds. Among these adolescent offenders, evidences of depression are commonly hidden behind sociopathic behavior patterns in a fashion also seen among adult criminals. Chwast found that in a total sample of 121 delinquents, more than 75 percent appeared at least somewhat depressed, with almost 50 percent being substantially or severely depressed. Delinquent girls were usually more depressed than delinquent boys.

Among some delinquents the sociopathic acting-out served to ward off decompensating, schizophrenic defensive mechanisms. With regard to others, Chwast felt that fighting and destructive behavior should be seen as an attempt to combat depressive manifestations that threaten to become overt.

To some of these individuals, the gang was a search for "significant other persons" in an attempt to compensate for a void in meaningful attachments. A separation from the gang may cause some culturally deprived persons to have feelings of inadequacy and hopelessness and to show even overt depression.

Automobile accidents and direct suicidal attempts are the two commonest causes of death among college students. Many of these adolescents and young adults had exhibited masked or overt depressions. Herschfeld and Behan expressed the opinion that failures in academic or social performance, which were considered "unacceptable disabilities," were converted into "acceptable disabilities" in the form of automobile accidents.

Behavioral Masks of Depression Among Adults

In the vast majority of instances, masks of depression in adults take the form of hypochondriasis and psychosomatic disorders. But depression is also frequently masked by multivariant forms of acting-out. Drug dependency is one of the more common acting-out behavioral masks of depression in adults. While public attention has been focused upon problems that are secondary to narcotics addiction, which is so commonly associated with major crime in large cities, the excessive use of alcohol remains the most commonly encountered type of drug abuse.

Chronic alcoholism frequently serves to mask depression. Feelings of

hopelessness, rejection, or overwhelming retroflex rage may appear precipitately following an alcoholic debauched When the mask slips, that is, when the alcoholic sobers up, massive guilt and profound depressive feelings are uncovered. Suicidal acts have followed failures in sexual performance, a problem commonly associated with alcoholism.

Marijuana, a wide spectrum of hallucinogenic agents, cocaine, amphetamines, barbiturates, antianxiety agents, neuroleptics, antidepressant drugs, and so forth, are available on the streets of American cities in vast quantities. Psychedelic drugs are often taken to mask underlying depressive syndromes. It is well known that weeks may pass before a covertly depressed patient who has been “on a trip” suddenly manifests overt depression.

Narcotics addiction may sometimes be seen as an attempt to cope with an underlying endogenous depression. Some of the suicidal attempts made when addicts are taken off narcotics may be ascribed to the emergence of massive depressive reactions that had been masked by the addiction. Individuals dependent on amphetamines and other stimulant drugs commonly have a depressive core. Precipitous depressive reactions very often result following rapid withdrawal of amphetamines from chronic users. While amphetamines are dispensed frequently to depressed patients, they usually serve only to mask the depression if it is profound enough.

Barbiturate habituation is a massive problem. There is an overproduction of barbiturates in this country, with the excess finding its way onto the streets where it is dealt with as a highly profitable, marketable product. Adolescents and adults from lower socioeconomic groups buy their barbiturates from "street pharmacists." In addition, there are literally tens of thousands of iatrogenically created barbiturate habituates. These drugs may mask underlying depressions for long periods of time, depressions that may rapidly become overt when the drugs are withdrawn.

Anger and rage are among the most commonly observed masks of depression. Spiegel has stated that "the role of the equivalence of anger needs to be understood by both the patient and the therapist; and when anger or rage is dominant, the therapist should consider a relationship to depression." This is a very cogent observation. Patients with masked depression are almost without exception extremely angry individuals. The rage could either be overt or covert; in most instances, it is overt. Covert anger is more difficult to manage from a therapeutic standpoint. Covert anger arises from severe childhood trauma. It is most commonly seen in patients who have been abandoned emotionally by their parents. It also occurs when parents are so hostile, domineering, critical, and sadistic that the patient, as a child, became terrified by the aggressive, punitive atmosphere. Attempts by the child to protest were usually met with overwhelming and crushing punishment. These patients, in general, are unable to react with appropriate anger in later life,

even when it is justified.

Most patients with masked depressions are overtly hostile. In this type of patient, in contrast to the patient who had developed covert rage, the domineering, critical parent did not *completely* destroy the child's compensatory rage capacities or block the patient from expressing anger. This excessive anger is a compensatory mechanism that tends to dominate the patient's personality.

In the definitive treatment of patients with masked depressions, a pointed effort is made to unfold gradually the full degree of the patient's unconscious hostility. This anger is strongly guilt-linked.

Many of the patients are afraid of the intense degree of their latent anger, which is often tied to unconscious, symbolic, murderous fantasies. Many depressed patients, particularly those with covert anger, must be taught how to express anger and must be made aware of the fact that anger can be a normal, healthy reaction to certain types of stress.

The apparent states of remission in depressed suicidal patients are the most serious and at times the most complicated type of masked depression. They may occur in patients who have a history of suicidal ideas or who have made suicidal attempts but in whom the drive for self-destruction appears to have been ameliorated. Too frequently, the psychiatrist or psychotherapist

who treats a suicidal patient may be so relieved to record some improvement that he or she may overestimate its true degree.

The availability of multiple therapies (including electroshock, psychotropic drugs, and some psychotherapies) that may be effective for various types of depressed and suicidal patients gives some psychiatrists a false sense of security simply because they use these techniques. The suicidal impulses may be merely blunted or masked by various psychotropic drugs or with electroshock therapy, particularly if the frequency or number of treatments is inadequate.

Psychotropic drugs also may result in a similar premature relaxing of clinical vigilance. Some suicidal patients may demonstrate an apparent remarkable remission following the administration of tranquilizers or antidepressant drugs. At times this apparent change may be purely a tenuous placebo reaction with the suicidal drive being only superficially masked. Any relaxation of clinical precautions during the early phase of treatment of suicidal patients, no matter what technique is used, may result in a self-destructive act.

Masked Depression in Old Age

Among geriatric patients an organic mental reaction may mask an underlying depression. Patients who demonstrate fluctuations in the intensity

of an organic mental syndrome require particularly close scrutiny. Organically confused patients commonly show a decrease in the intensity of a depression and even of suicidal impulses. However, as they gain insight into the nature or severity of their problem, a depressive reaction leading at times to a suicidal act may occur. Among geriatric patients, depression may also be masked behind hypochondriacal symptoms and psychosomatic disorders. Marked irritability, obsessive thinking, or a gross increase in psychomotor activity may also serve as masking processes.

There is an unfortunate tendency among both physicians and laymen to attribute all changes in elderly people to organic illnesses. Not infrequently, symptoms such as listlessness, anorexia, and insomnia may be manifestations of an underlying depressive reaction.

Hypochondriasis and Psychosomatic Disorders Masking Depression

In the vast majority of instances among adults in highly industrialized western countries, masks of depression assume the form of hypochondriasis and psychosomatic disorders. While this type of depressive syndrome rivals overt depressions in frequency, it is insufficiently appreciated by psychiatrists and non-psychiatrists alike, at times with tragic consequences. Physicians without formal psychiatric training are prone to treat a patient's "physical complaints" without probing to see whether the affect associated with the

symptoms is secondary to a true physical deficit or whether it is a psychological expression mimicking an organic disorder. This clinical scotoma often results in patients being exposed to unnecessary and even inappropriate treatment over long periods of time.

It is likely that from one-third to two-thirds of patients past age forty who are seen by general practitioners and even specialists have masked depressions with the depressive syndromes masked by hypochondriacal or psychosomatic disorders. These patients, particularly those in the late middle and older age groups, are extremely prevalent in hospital clinics; they also occupy a sizable proportion of general hospital beds. Unfortunately, they are usually subjected to a multitude of laboratory examinations and too often are exposed to a variety of organic treatments, even surgery.

In most instances, it is only after many months or even years of examinations and multiple treatments that a psychiatric consultation is requested. By the time the patient is seen by a psychiatrist, the depressions are usually of severe proportions. This observation is documented by the fact that more than 40 percent of the patients with masked depressions have suicidal ideas or drives by the time they are first seen by a psychiatrist.

The masked depression syndrome poses a sharp challenge to all physicians, psychiatrists and non-psychiatrists. A number of clinical

possibilities may occur:

1. The masked depression syndrome may occur in patients without any organic processes. On the other hand, the patient may have a masked depression superimposed upon a true organic deficit. This second situation may pose a significant diagnostic problem.

2. Too often a minor organic illness is magnified by the psychogenic overlay, and it may be misdiagnosed as being a major organic disorder. In such a situation, the physician exaggerates the importance of the organic component and fails to recognize the psychogenic aspect of the problem. This usually leads to months and years of repeated studies and organic treatments. Most of these patients develop a massive iatrogenic overlay that further complicates diagnosis and treatment.

3. In other instances, a patient may have a major organic lesion with hypochondriacal or psychosomatic complaints superimposed. If the physician or therapist becomes preoccupied with the psychogenic aspects of the problem and fails to recognize the severity of the organic lesions, serious consequences may follow.

Clinical Characteristics

Sex and Age Distribution

One study of 336 patients who had depressions masked by hypochondriasis or psychosomatic disorders reported that 246, or 73.2 percent, were women. This represents a female:male ratio of 2.7:1. However, in a different study of 198 patients who had a type of masked depression known as "faciopsychomyalgia" (more commonly known as "atypical facial pain of psychogenic origin"), it was found that 86 percent were women. This is an 11:1 female:male ratio.

The age distribution is also very characteristic. Two hundred and ninety-five (87.8 percent) of 336 patients with masked depressions were between thirty-six and sixty-four years of age at the onset of illness. One may state, therefore, that the syndrome in which depression is masked by hypochondriasis or psychosomatic disorders is primarily an ailment of middle-aged females.

It is unusual for these patients to be seen by a neuropsychiatrist early in the course of the illness. For example, 65 percent of the 336 patients were seen only after two or more years had passed from the time of onset of symptoms to the initial consultation. More than 30 percent had been ill for five or more years prior to being correctly diagnosed.

Initial Examination

A number of general characteristics can be noted during the initial

examination. Patients present their history in a very wordy, forceful manner; the term "logorrhea" would be appropriate in many instances. The descriptions are replete with medical jargon gleaned from the many physicians or dentists who had examined and treated these patients. Quite often the patients consult medical texts and bring this "knowledge" to the examination.

The clinical descriptions are vague and do not represent classic descriptions of specific organic processes. At best, they are suggestive of a more unusual organic process. In addition, patients with masked depressions are far more handicapped in their vocational and social performance than are patients with true organic illnesses. These clinical descriptions, together with a tendency to exaggerate the suffering experienced, are further colored by iatrogenic factors that are secondary to prior multiple somatic examinations and treatments.

These patients come with a fixed concept that their ailment is due to a serious organic disorder. They demonstrate marked hostility toward the psychiatrist if the diagnosis of a psychogenic process is made early in the examination.

The initial phase of the history is directed primarily to ruling out a primary organic cause for the patient's complaints. Nevertheless, even the few

clinical characteristics already described should warn the examining physician of the likelihood that the patient's ailments, at least in part, represent a significant psychogenic overlay, which necessitates intensive psychiatric evaluation.

The patients have a marked emotional and economic investment in their illnesses. There is a strong secondary gain mechanism behind their symptoms. Sufficient time must be allotted for the patients to expound upon their ailments, to relate the exquisite details of their symptoms, and to demonstrate their "knowledge of medicine."

The pointedness of the psychiatrist's investigations may be slowly broadened after the patient's confidence has been won. With gentle interrogation one can gradually compose a psychiatric scenario that is applicable for almost all of the patients. Patients routinely describe an agitated state, with restlessness, floor pacing, and marked feelings of anxiety. Insomnia, anorexia, persistent fatigue (especially in the morning), difficulty with concentration, loss of interest in vocational and social activities, and "feeling low" are also typical complaints. Routine personal habits become major chores. Frequently, the patients state that they are "losing their minds" and point to a "poor memory" as justification for this opinion.

Although the patients constantly refer to their "serious physical

illnesses," one can gradually obtain statements indicating that they are moderately or severely depressed. Inevitably, this admission is accompanied by the disclaimer, "I would be fine if only I was free of my physical illnesses."

Once the patient admits to being depressed, one can readily elicit the presence of feelings of hopelessness. This admission can usually be brought out by questions such as, "Do you ever feel as though you will never get better?" A question that brings a positive response in almost half of the patients is "Do you ever feel as though you would like to go to bed and not awaken the next morning?" The usual response is "If I have to suffer like this, life isn't worthwhile."

One study found that more than two-thirds of the patients expressed feelings of hopelessness. Even more startling was the observation that 44.5 percent had suicidal preoccupations or drives. This is evidence of the fact that depression masked by hypochondriasis or psychosomatic disorders is usually of severe proportions by the time the patient is referred for neuropsychiatric consultation. It is crucial that the intensity and imminency of these suicidal ideas be studied carefully. A number of patients examined by the author for the first time were actively contemplating suicide.

If the psychiatric or nonpsychiatric physician is patient and gentle in the history taking, a close correlation between the onset of the patient's

symptoms and her or his emotional traumas can often be discerned. This requires a step-by-step account of the patient's life situation prior to, during, and following the onset of the "somatic" symptoms. In some instances, specific environmental traumas cannot be documented. However, even if this is the case, careful evaluation will elicit the fact that the patients had been under chronic and severe stress with which they had difficulty coping.

Personality Patterns

The patients' personality patterns are rather consistent. They are typically aggressive, perfectionist, and highly intelligent individuals who have a need to dominate their environment. Characteristically, they are rigid and inflexible in their management of everyday life. In addition, they are overbearing and verbally critical of most people. These attitudes frequently alienate those around them. It can be stated that their compulsive need to dominate their surroundings is an attempt to compensate for feelings of self-derogation and inadequacy.

Although many of these patients, most of whom are women, are leaders in their communities and claim many close friendships, most of the so-called friends are usually just working acquaintances. By the time the patients are seen in initial psychiatric consultation, they are quite seclusive and are unable to function effectively vocationally, socially, or sexually. They usually express

fears of being alone, strong guilt feelings related to their inability to function, and confess to a lack of sexual desires. A marked feeling of worthlessness is a characteristic clinical observation.

Family History

The family histories are also quite characteristic. Usually one or both parents are described as being very aggressive and perfectionistic. One study reported that 82 percent of these patients described their mothers as the dominant individual in the home. The mother was often characterized as being an "attentive martyr," while the father was a rather passive, dependent personality dominated by the mother. Frequently, the patient's mother was hypochondriacal, phobic, or had a history of psychosomatic disorders. In many instances, the description of the mother indicated that she had referential trends. Characteristically, there is a history of a running conflict between the patient and his or her mother; this relationship universally generated marked guilt feelings in the patient.

From a psychodynamic standpoint these patients develop feelings of inadequacy and worthlessness beginning in early childhood. This is in response to the parents' real or imagined rejection. These feelings grow in crescendo fashion and color the patient's vocational and social relationships through the years. They are plagued by the anticipation that parental

surrogates and peers might have the same negative image that they have of themselves.

These patients spend their lives compensating for feelings of inadequacy by a high level of performance. There is a constant struggle for self-recognition. They usually are highly critical of others (in scapegoat fashion) in an attempt to deny their own feelings of inadequacy.

There is often a history of overreacting to even mild physical illnesses. The physical ailments are a threat to the patient's constant attempts to compensate for her feelings of inadequacy. Furthermore, if one or both of the parents had been hypochondriacal, the patient tends to mimic the parents' particular hypochondriacal complaints.

Treatment

The treatment of choice for patients with masked depressions, when the underlying depression is severe, is a combination of antidepressant drug therapy and appropriately designed, psychoanalytically oriented psychotherapy.

The results of treatment depend upon a number of factors, including: duration of illness, amount and nature of prior medical treatment (prior drug therapies and surgical procedures), and the organ system involved. Patients

with problems associated with the head and face, mammary glands, or genitourinary system are more difficult to treat for reasons that are not entirely clear at this time.

Considered as a group, more than 75 percent of those patients in whom the depression is masked by hypochondriacal complaints or psychosomatic disorders obtain excellent results if the illness is of less than one year's duration ("excellent" meaning that their symptoms disappear, the level of psychomotor activity becomes appropriate, and they are able to function vocationally and socially with pride and pleasure). Approximately 50 percent of those patients who have been ill for less than two years and who do not have strong iatrogenic overlay secondary to surgical procedures obtain excellent or good results during the initial period of therapy.

When a patient has been ill for more than two years, particularly if he or she is plagued by marked iatrogenic complications resulting from prior drug or mechanical therapies, it is difficult to predict how successful the combined therapeutic technique will be. Overall, approximately one-third of such patients obtain excellent or good results from combined therapy. While one cannot be so certain of the results that will be obtained in more chronic patients, excellent individual responses have been obtained in some who have been ill for as long as twenty-five to thirty years.

Bibliography

Agras, S. “The Relationship of School Problems to Childhood Depression,” *American Journal of Psychiatry,* 116 (1959): 533-536.

Bowlby, J. “Childhood Mourning and Its Implications for Psychiatry,” *American Journal of Psychiatry,* 118 (i960): 481-498.

Campbell, J. D. "Manic-Depressive Disease in Children," *Journal of the American Medical Association,* 158 (1955): 154-158.

Caruthers, J. C. “The African Mind in Health and Disease,” *World Health Organization Monograph H17.* Geneva: World Health Organization, 1953.

Chwast, J. “Depressive Reactions as Manifested Among Adolescent Delinquents”, *American Journal of Psychotherapy,* 21 (1967): 574-584.

Glaser, K. “Masked Depression in Children and Adolescents,” *American Journal of Psychotherapy,* 21 (1967): 565-574.

Goldfarb, W. “Effects of Psychological Deprivation in Infancy and Subsequent Stimulation.” *American Journal of Psychiatry,* 102 (1946): 18-22.

Herschfeld, A. H., and Behan, R. C. “The Accident Process, III. Disability: Acceptable and Unacceptable,” *Journal of the American Medical Association,* 197 (1966): 125-128.

Lesse, S. “Current Clinical and Research Trends in Soviet Psychiatry,” *American Journal of Psychiatry,* 114 (1958): 1018-1022.

----. “Psychotherapy Plus Drugs in Severe Depressions: Technique”, *Comprehensive Psychiatry,* 7 (1966): 224-231.

----. “Apparent Remissions in Depressed Suicidal Patients,” *Journal of Nervous and Mental Disorders,* 144 (1967): 291-296.

----. “Hypochondriasis and Psychosomatic Disorders Masking Depression,” *American Journal of*

Psychotherapy, 21 (1967): 607-620.

----. "Masked Depression: A Diagnostic and Therapeutic Problem," *Diseases of the Nervous System,* 29 (1968): 169-173.

----. "The Multivariant Masks of Depression," *American Journal of Psychiatry,* 1246 (Suppl.) (1968): 35-39.

----. "Atypical Facial Pain of Psychogenic Origin: A Masked Depressive Syndrome," in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 302-317.

----. "Depression Masked by Acting-Out Behavior Patterns," *American Journal of Psychotherapy,* 28 (1974): 352-361.

----. "Hypochondriasis and Psychosomatic Disorders Masking Depression," in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 53-74.

----. "Psychotherapy in Combination with Antidepressant Drugs in Patients with Severe Masked Depressions," *American Journal of Psychotherapy,* 31 (1977): 185-203.

----. "Psychotherapy in Combination with Antidepressant Drugs in Severely Depressed Patients: Twenty-Year Evaluation," *American Journal of Psychotherapy,* 32 (1978): 48-73.

Mattison, A., Seese, L. R., and Hawkins, J. W. "Suicidal Behavior as a Child Psychiatry Emergency," *Archives of General Psychiatry,* 20 (1969): 100-109.

Mendelwicz, J. "A Genetic Contribution Toward an Understanding of Affective Equivalents," in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 41-52.

Meyers, D. I. "The Question of Depressive Equivalents in Childhood Schizophrenia," 29. in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 165-173.

Mosse, H. "The Psychotherapeutic Management of Children with Masked Depression," in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 174-201.

----. Culture and Social Psychiatry. New York: Aldine-Atherton, 1967.

----. “The Social and Cultural Nature of Mental Illness and Its Treatment,” in Lesse, S., ed., An Evaluation of the Results of the Psychotherapies. Springfield, Ill.: Charles C Thomas, 1968, pp. 280-291.

Opler, M. K. “Cultural Variations of Depression: Past and Present,” in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974, pp. 24-40.

Schmideberg, M. “The Psychological Treatment of Adult Criminals,” *Probation,* 25 (!946): 45-53.

Spiegel, R. “Anger and Acting Out: Masks of Depression,” *American Journal of Psychotherapy,* 21 (1967): 597-606.

Spitz, R., and Wolf, K. M. “Anaclitic Depressions: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood,” in Eissler, R. S., et al, eds., *The Psychoanalytic Study of the Child.* New York: International Universities Press, 1946, p. 373.

Toolan, J. M. “Suicide and Suicidal Attempts in Children and Adolescents,” *American Journal of Psychiatry,* 118 (1962): 719-724.

----. “Masked Depression in Children and Adolescents,” in Lesse, S., ed., *Masked Depression.* New York: Jason Aronson, 1974. PP-141-164.

Winokur, G., and Pitts, F. N. “Affective Disorder: VI. A Family History Study of Prevalence, Sex Differences and Possible Genetic Factors,” *Journal of Psychiatric Research,* 3 (1965): 113-118.