THE EVOLUTION OF DEPRESSIVE SYMPTOMS IN ENDOGENOUS DEPRESSION

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ENDOGENOUS depression is a periodic illness which usually manifests itself without any apparent cause. It produces a lowering of mental and physical vitality, and it responds well to physical treatment. It has been described as genetically determined, but the illness is so common that there must be few families who have not been affected by it.

For some years now it has become more and more apparent that endogenous depression is a very common malady which is often overlooked. It is common not only in the consulting rooms of the family doctor, but also in the medical and surgical departments of any general hospital. Bailiss (1964) described its recognition as perhaps the most outstanding advance of recent years, involving all branches of medicine. It is in fact no longer the responsibility of the psychiatrist alone, but an important item in general medicine. Miller (1967) said that in his opinion endogenous depression was as near a clinical entity as almost any disease in internal medicine. He suggested that like the poor it was always with us, and he was inclined to think that few people could go through life without experiencing at least one depressive episode. He went on to say that the recognition of the depression by either patient or his physician was however another matter.

A College of General Practitioners report (1965) suggested that in any one year a single practice of 2,500 would have 12 cases of *severe* depression. Mild cases are however much more common. Fry's figures (1966) indicate that an average practice of that size would also have 110 cases of undiagnosed depression, of which six would attempt suicide. Before there was effective treatment for this common disease, its diagnosis was largely of academic interest, as little could be done to help the patient. Now that most cases can be treated successfully, usually by their family doctors, it is of considerable practical importance that it should be recognized.

With a disease of this kind it is very difficult to find an objective

measure of prevalence. The statistics of suicide for the country offer some guidance. Ratcliff (1962) found that with a treatment centre easily available and acceptable to the population, the local suicide rate fell. This has not happened in the country as a whole. In England and Wales the suicide rate is almost the same today as it was at the beginning of the century. The near static figures for suicide since the last war indicate one of two things. Either depressed patients are not seeking treatment, or if they do consult a doctor, their illness is not recognized. Both of these factors probably play a part.

The ineffective diagnosis of this common illness may perhaps be due to our ignorance of its natural history and the stages through which it develops. Over some 21 years in a single practice I have seen depressions come and go and come again, in some instances over several episodes. I have seen depression in its earliest stages as well as at the nadir. I have seen mild, severe, chronic, arrested, and recovered cases, and I have observed these patients over many years (Watts 1966). From what I have seen I have formed a hypothesis as to the way in which many cases of depression evolve, and I have drawn conclusions which explain why depression in a mild or early stage of the illness is so often disguised, thus making for difficulties in diagnosis.

The course of a depressive episode is represented diagrammatically in figure 1.

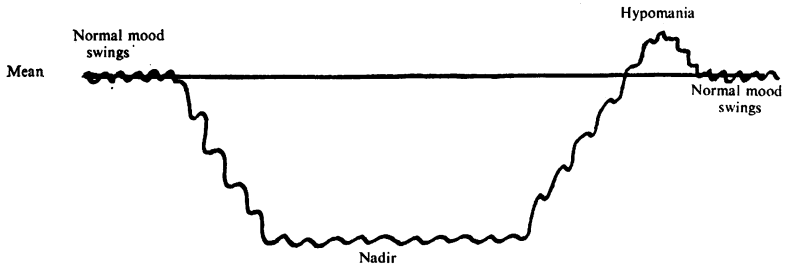

Figure 1

Schematic representations of a depressive episode

Energy diminution

The first symptom of depression is usually an inexplicable falling off of energy. The patient does not feel ill or depressed, but she finds things increasingly difficult to do, and she is slower at her work. One man who had had repeated depressions knew he was in for another bout, when after a day's work he could not summon up enough energy to go to the public house for his usual pint of ale. A usually active housewife found she viewed the stairs with appre-

hension and she became so exhausted that they were increasingly difficult to climb. Sleep becomes unrefreshing, and the patient can sleep the clock round only to feel more tired and weary in the morning than when she went to bed. Patients react to this feeling of exhaustion in one of two ways. Either they decide they have some physical disease, or they think that they are becoming neurotic.

Depression is due to some chemical unbalance in the hypothalamic region of the brain. Campbell (1950) pointed out that if at the same time the nearby autonomic centres were involved, the presentation would be that of a physical illness with somatic symptoms. The man who thinks that he has some physical disease rarely tells his doctor of his fears, he is usually too frightened to admit to them openly. If he is told there is nothing wrong with him he decides that his illness is even more difficult to diagnose and more sinister than he had first imagined, and he becomes even more anxious and, in time, the imaginary disease becomes something lethal. The doctor tries to reassure, but in the patient's mind, the cancer is growing and spreading relentlessly. Most doctors who have been in practice long enough can remember someone whom they had done their best to reassure, and who reacted by going home to commit suicide. These patients with hypochondriacal delusions are, of course, the end-stage of depression, but this state is usually preceded by weeks, months or even years of increasing anxiety. Very often the unfortunate patient is passed on from one hospital department to another, with each negative investigation making him more anxious and depressed.

The patient who thinks that he is getting neurotic may be in an even more difficult situation. He feels that he should be able to pull himself together, a thesis which is often reinforced by well-meaning but misguided relations. He tends to be ashamed of himself for letting himself go, and he hesitates to see his family physician, in case he is going to make a fool of himself. Such patients are very sensitive, and they are easily put off by unsympathetic handling. Once rebuffed, their own diagnosis of neurosis is confirmed. The doctor cannot help them, they must help themselves, and they tend to avoid medical contacts at all costs. On the other hand, with minimal encouragement they are only too willing to accept long and expensive psychotherapy, a drug to which they readily become addicted. The conviction that they need a personal analysis may in the end assume the proportions of a delusion. 'Ego disintegration' can seem real and be as dangerous as any other depressive delusion and it can end in suicide. In an autobiographic study, York (1966) vividly described the sufferings of a psychotherapy addict who needed ECT and all the supportive treatment that is necessary for a severe depression. Whether the fear is that of physical illness or neurosis, the patient

becomes very anxious, and anxiety is the second phase in a developing depression.

The phase of anxiety

Primary anxiety is a normal physiological response to a threatening situation. It is a relic of the fight-flight reaction to fear, a reflex that was essential to the survival of our primitive ancestors. Primary anxiety can usually be alleviated if the basic cause can be uncovered or removed. In other words it readily responds to simple psychotherapy which involves listening, reassuring, explaining and interpreting. The young woman with a globus syndrome due to hearing a friend's mother has died of a throat cancer, can be reassured after a thorough and complete physical examination, and the uncovering of the basic cause of the fear. If however the cancer phobia is caused by depression, it will not respond at all to this type of treatment, but it will respond to antidepressant drugs. In this case the anxiety is secondary anxiety, due to depression, and the symptom is often more obvious than the depression itself. All too frequently a patient with anxiety symptoms of this kind, is assumed to be suffering from a neurosis, and he is likely to be given tranquillizers and psychotherapy which have little or no effect on the basic depression. Depression and anxiety often occur in the same patient. Anxiety can cause depression and *vice versa.* It is important to determine which emotion is primary. Much confused thinking on this subject arises because many doctors cannot appreciate that there is any real difference between physiological anxiety, which is a healthy alerting response to some danger signal, and the secondary anxiety of depression which is an inhibiting and irrational type of fear. In patients who exhibit both anxiety and depression, the clinical skill of a physician is needed to sort out the dominant factor. The patient with an anxiety state who is depressed will in all probability respond to psychotherapy like any other case of anxiety. On the other hand when the basic condition is one of depression with an overlay of anxiety, such treatment is usually a futile waste of time. It is not generally appreciated how often endogenous depression is a potent and frequent cause of anxiety.

Anxiety, often an early symptom of depression, may also occur in moderate or severe cases. The agitated depression is the extreme example of this phenomenon. Even severely depressed patients are sometimes missed, because the attention of the doctor is distracted by the obvious anxiety of the patient. A case of puerperal suicide was recently described (1967 *Lancet* **1**, 326) in which a doctor told the coroner that with the approach of the child's birth, the patient had suffered from extreme anxiety, and this anxiety had continued intermittently over the five days after the child's birth, culminating in maternal suicide. There was no suggestion of any depression.

If the basic depression can be overlooked in a case like this, it is not surprising it is often missed in mild cases.

Horizontal lines on the depressive diagram can be used to illustrate the various stages of depression. At first there is a fall off of energy, which later causes the patient to be assailed by a form of anxiety which is psychotherapy resistant.

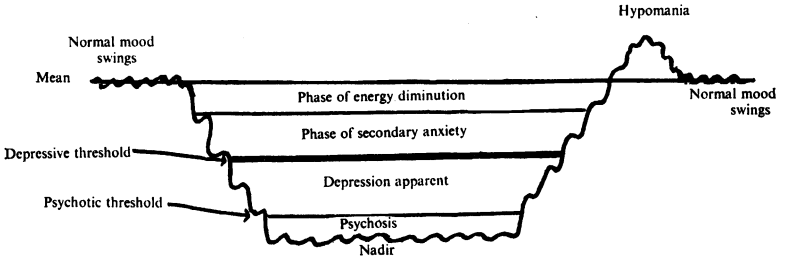

Figure 2
The stages of depression

During these early phases a strange paradox may exist in that, although the patient is suffering from endogenous depression, he or she is not depressed. Some cases of periodic anxiety are in fact a mild form of endogenous depression which has not sunk below the depressive threshold. If the illness lasts long enough or becomes severe enough, a depressive threshold is passed, and then obvious depressive symptoms emerge. One woman who had had many episodes told me she was always anxious for weeks before she became depressed. The patient who slept too much, now cannot sleep at all. The patient who was vaguely ashamed because he felt that he was becoming neurotic, now has profound feelings of unworthiness. Mild worries about health become morbid delusions. The sick person becomes low spirited and can see no future. It should be noted that only in the lowest stratum of all does the psychosis become obvious, and for every patient in that extreme state of depression, there are probably a dozen milder cases, most of whom will respond well to antidepressant drugs if they are given in adequate doses over a long enough period.

The swing of affect

In no other illness is the swing of affect more conspicuous than with endogenous depression. The mood may be diurnal, vary from day to day or even from hour to hour. This symptom in the early stages of depression can be very disconcerting to the patient. When he feels ill he may decide to consult his doctor next day, but when the morrow dawns he feels so much better he decides not to see him after all. In any case how can he describe his symptoms which have now

gone? These mood changes put him into a state of indecision, and the idea that he is neurotic becomes reinforced in his own mind. This symptom of mood change is largely responsible for many early and mild depressed patients keeping away from the doctor. When the patient is down he feels too exhausted and ill to go to the surgery. When he feels better he tries to persuade himself that he is going to be all right and doesn't need medical advice.

Arrested depression

Most depressive illnesses run a self-limiting course, and even without treatment, in a matter of months or even years, the patient recovers. Treatment can cut the period of illness drastically. Ideally, the patient returns to his normal state of mind. Some patients improve very considerably, they are so grateful for the improvement they are content to live their lives below their norm, in a state of arrested depression. This type of reaction is depicted in the following diagram.

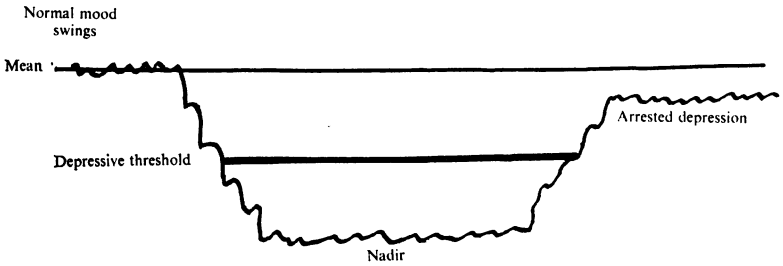

Figure 3
Arrested depression

Some such patients are intelligent enough to realize that their recovery is incomplete, and vocal enough to insist on further treatment. If the patient has been treated by drugs, a few electroconvulsive shocks will usually complete the cure. If ECT has been used, drugs may be necessary for a few months to get the patient to the top. In a few cases the drug may be needed permanently to keep the patient well. A man who had had two depressive episodes which had been treated with ECT was given an MAOI drug for his third depression. The improvement was quite spectacular, far better than after ECT. Some years later his wife, quite unprompted, disclosed that he had been a completely different man on the drug. She said that the past few years had been the happiest of their married life. In former episodes, ECT had picked him up from the nadir, but he had never completely returned to normal. The drug had this desirable effect; it might even have pushed him into a kind of mild and productive hypomania. One of the difficulties of the hospital

psychiatrist is to be sure that the patient has made a complete recovery. It can be easier for the family doctor who knows the normal bearing and character of the patient to make this important assessment.

Endogenous depression is a disease of considerable importance in every branch of medicine. It should be recognized by physicians and surgeons in hospital practice. While it is realized that many depressed patients do not seek medical advice, the general practitioner who is so often the doctor of first contact is in the best position to recognize the patients who do come at his office. Not only is this a common complaint, but it lasts for a long time. Few consultation sessions must pass without one, two or more cases being seen. Of these 80–90 per cent can be treated by him alone. With adequate dosage of drugs over a long period of time most recover completely. There is still a great deal we do not know about this common and very complicated disease, but we can do far more for our patients today than was possible ten years ago.

Summary

It is suggested that the first symptom of endogenous depression is a falling off of energy. This causes the patient to be anxious, and either he thinks that he is neurotic, or that he has some obscure and perhaps deadly disease. These reactions are readily mistaken for anxiety neuroses or organic diseases. Anxiety as an expression of depression is often overlooked. It has a different feel from physiological anxiety, from which it should be differentiated. It is psychotherapy resistant, but it usually responds to antidepressant treatment. Depressed patients do not always make a complete recovery, and some are content to live in a state of arrested depression, if this is accepted as satisfactory recovery by the doctor. This type of case is described, and the importance of adequate treatment is emphasized.

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