ON ATYPICALITY AND THE DEPRESSIVE STATE.

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IT is perhaps not too fanciful an analogy to compare the expanse of psychiatric symptomatology to an expanse of sea scattered with a small and determinate number of islands.

These islands represent the typical cases of our psychiatric syndromes. To mention but a few: the anxiety hysteric with the bright smile and plethora of somatic dysfunction, the retarded melancholic, bearing all the guilt in the world on his shoulders, and the grimacing, hallucinated, well-established case of schizophrenia.

These cases are indeed the saving grace of the busy out-patient clinic, for dubiety is at a minimum, and the patient's physician can be advised in terms of a clear-cut diagnosis and almost certain prognosis.

Yet between these virtuous islands lie the channels of atypicality, replete with the whirls and eddies of uncertainty, carrying us first towards one island, and then sharply veering us towards another. It was perhaps inevitable that attempts should be made to group these islands. Mania and Melancholia in the unifying hands of Kraepelin readily became Manic-Depressive Psychosis. And indeed we must be grateful to him, although we may no longer *an seinem Feuer Süppchen kochen* for maintaining the concept of "disease entity" in an age which, under the stimulus of an adolescent Freudianism, might easily have become dominated by the doctrine of the *Einheitspsychose* to the detriment of our clinical and prognostic expediency.

Yet such groupings, almost as soon as formulated, split apart. For facts are formidable things, and symptoms are facts. A symptom is either present or absent, and although we may dispute its interpretation, its existence we may not dispute. Lewis (1), in his now almost classical paper on melancholia, did much to introduce us to a broader symptomatic conception of the depressive psychosis than was ever apparent within the rigidity of the Kraepelinian system.

Since 1934, when that paper was published, however, the advent of electrical shock therapy, although it has in no way altered the fundamentals of the situation, has given us the power of rapidly reversing the reaction, thus opening up a more extensive field of study. Indeed, the very availability and effectiveness of treatment have made many cases of mild depression seek earlier care, so that a shift in clinical emphasis has occurred away from the grosser types, which, in consequence, are becoming relatively less common. It is the purpose of this paper, therefore, to in some measure re-examine the

features of depression, and to relate them in particular to the problem of atypicality.

The Material.

This study is based upon 130 consecutive cases admitted to Cheadle Royal, all individually investigated by the author. All were regarded as basically depressive, and the majority, spontaneously or under treatment, achieved complete and persistent remission of symptoms. Where this was not so is indicated in the text.

Sixteen, or 12·3 per cent. of this group were regarded as *atypical* within the terms of the following definition—"that although the psychosis was regarded as basically depressive, it showed sufficiently bizarre features, or such symptomatic loading with features of another reaction type, as to make it difficult to fit strictly within the bounds of the generally accepted criteria of the Depressive Reaction."

The Significance of Age as a Criterion of Typicality.

The problem of age in regard to the depressive psychosis centres principally around the question whether depressions occurring in later life show enough qualitative differences to justify their inclusion in a special category of involutional melancholia. No discussion of the validity of this contention is proposed in this paper, but it will be briefly touched upon in dealing with symptomatology. In order, however, that the qualitative differences and similarities between the depressions of earlier and later life may be more clearly seen, the entire series has been divided into two groups, on the basis of *age at first attack*. Those in whom the first attack occurred at the age of 45 or below have been arbitrarily designated *manic-depressive*, and those in which it occurred above the age of 45, *involutional*. The series broke, fortuitously, into two even groups of 65 cases each. The distribution of the atypical cases between the two groups is shown in Table I.

Table I.

	Manic-depressive.	Involutional.
Total cases in group	65	65
Atypical cases in group	15 (23%)	1 (1·5%)

The Significance of Hereditary Predisposition as a Criterion of Typicality.

The significance of hereditary predisposition in mental disease is a difficult thing to assess with any degree of accuracy. There is probably no single factor in the patient's history which is more liable to distortion, either due to ignorance of the true facts, or their deliberate suppression. One gathers the impression (and it is only an impression) that the degree of eccentricity among the relatives of schizophrenics is higher than the incidence of positive mental disorder. This eccentricity in many cases seems almost to amount to an "abortive schizophrenia," and it is sometimes so definite that one has no

difficulty in deciding from which side of the family the illness is being transmitted. It is a factor, too, which because of its indefinite nature often escapes statistical evaluation.

The influence of heredity in the production of manic-depressive illness is, however, clearly established and recognized. It is particularly striking when one has access, for comparison, to the records of the present patient's relatives who have been in the same hospital anything up to fifty years previously.

Table II shows the distribution of mental disorder in the present series. Only positive factors appearing in the grandparents, parents, uncles, aunts and siblings were recorded, and only one factor was recorded in each case. When more than one factor was noted in the same history, a single factor was recorded in accordance with the priority indicated by the headings 1 to 8.

TABLE II.

	Typical (114).	Atypical (16).	Total (130).
1. Manic-depressive illness*	17	3	20
2. Suicide	5	1	6
3. Other psychoses: Nervous breakdown (unspecified) (5); In mental hospital (unspecified) (5); Psychosis, other than manic-depressive (specified) (2)	12	..	12
4. Psycho-neurosis	2	..	2
5. Personality deviation (marked)	3	1	4
6. Alcoholism	1	..	1
7. Epilepsy	1	..	1
8. Mental deficiency	3	..	3
Total	44 (38·5%)	5 (31·25%)	49 (38%)
Psychosis only (1, 2 and 3)	34 (30%)	4 (25%)	38 (29%)

* *Manic-depressive illness* includes manic excitements, depressions of early life, involutional melancholia, and alternating states.

Kraepelin, quoted by Henderson and Gillespie (2), gives the hereditary predisposition in manic-depressive psychosis as between 60 and 80 per cent. This figure is presumably exclusive of involutional cases. Yet the overall average of the figures given in the above table would suggest a hereditary predisposition nearer to 30 to 40 per cent., that is to say about half that estimated by Kraepelin. Table III shows the distribution of hereditary pointers in the manic-depressive and involutional groups of the typical series (i.e. *excluding* the *atypical* cases), and even this only increases the disposition in the manic-depressive group to 44 per cent. (32 per cent. psychosis only).

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TABLE III.

	Manic-depressive (50).	Involutional (64).
1. Manic-depressive illness	4	13
2. Suicide	4	1
3. Other psychoses	8	4
4. Psycho-neurosis	2	..
5. Personality deviation	2	1
6. Alcoholism	..	1
7. Epilepsy	..	1
8. Mental deficiency	2	1
Total	22 (44%)	22 (34%)
Psychosis only (1, 2 and 3)	16 (32%)	18 (29%)

The difference between Kraepelin's figures and those given above is probably explicable on the basis of the divergent nature of the case-material. Taking the figures of naval cases given by Curran and Mallinson (3), admittedly covering the younger age-group, but in which approximately the same criteria of estimation were used, 29 cases out of 88 gave a positive family history, or approximately 33 per cent. Whilst no great degree of validity is claimed for the above figures, particularly as the number of cases in the atypical series is so far below that in the typical, yet they do suggest that the atypical group has a slightly lesser tendency to be hereditarily predisposed.

THE SIGNIFICANCE OF SYMPTOMATOLOGY AS A CRITERION OF TYPICALITY,

Table IV shows the general distribution of symptoms over the entire series.

The cases were principally classified according to their content. Obviously, no hard and fast division could be made, and mixed features occurred, but were less common than might at first sight have been expected. The allocation to a particular group of any one case depended upon an estimation of the symptomatology of the case taken as a whole, and on what features appeared to predominate. It is now proposed to examine some of those features in greater detail, first in respect of the 114 cases regarded as *Typical*, and then in respect of the 16 regarded as *Atypical*.

THE TYPICAL GROUP.

(a) *Depressive features.*—These were in the main examples or variations of the symptoms which have become recognized as peculiar to the depressive reaction. A sense of failure, ideas of regret over incidents in the past, direct expressions of unworthiness and self-depreciation or indirect expressions by exaggerating the goodness and admirable qualities of others. Expression of guilt for adolescent sexual activities such as masturbation or pre-marital or extra-marital intercourse, exposure to or acquisition of venereal disease, homosexual or other manifestations of abnormal sexual conduct. Concern

TABLE IV.

Content.		Typical (114). Manic-depressive (50).	Typical (114). Involutional (64).	Atypical (16).
Predominantly	Depressive	36	51	6
	Somatic	8	12	..
	Phobic or obsessional	6	1	..
	Paranoid	..	..	9
	Schizoid	..	..	1
Anxiety*		43	64	15
Emotional overplay†		17	23	9
Retardation (marked objective)		15	7	..
With anxiety		10	7	..
With emotional overplay		3	..	..
Pathological overactivity—				
Immediately prior to present depressive attack		5	2	..
Recorded in the past		1	..	..
Other symptoms—				
Hallucinations; illusions		1	3	4
Depersonalization; derealization		2	7	1
Perplexity; confusion; clouding		..	1	6
Manneristic behaviour		..	..	9

* Anxiety—simple anxiety symptoms, mild or severe agitation, panic, tension, apprehension, screaming fits.

† Emotional overplay—tears, spasmodic or persistent fits of weeping.

over past minor delinquencies was common, and often blame was accepted for topical events associated with the life of the patient, but entirely unconnected with any possible personal causation. Thus, one patient accepted blame for the illness of an old lady residing in her house who had had to be transferred to hospital. Indeed, the depressive mood may seem to encyst itself around any event, however remote, in the patient's life, or however topical. The environment, too—and this is a point often insufficiently emphasized—may be a source of distress and dissatisfaction. One patient objected to her cat looking at her, and turned her relatives' photographs back to front on the mantelpiece. A change of house often provides a source of querulous comparison of its evils compared with the virtues of the old. The reaction, on the other hand, may be virtually devoid of content. In one case in the series little or no content could be estimated because the mere approach of the physician produced a persistent flood of tears and a dramatic display of sobbing. In another case the whole psychosis centred round a set of ill-fitting dentures associated with a hysterical dysphagia and much emotional overplay.

Cases associated with much emotional overplay, particularly if they appear to arise out of an unsatisfactory life-situation and show apparent responsiveness to intercurrent stimuli, such as a physician's visit, are in danger

of being classified as " reactive," " neurotic," or in more contemporary terms, " topical," with a consequent playing down of their seriousness. No greater mistake could be made. The first patient quoted above before admission to hospital made several determined and almost successful attempts at suicide.

Several of the patients expressed the belief that they were influencing other patients. This rarely amounted to more than a vague feeling of adversely affecting them in some way, and in only three cases did it attain grandiose proportions. One patient stated he was doomed and a terrible scourge on the place, and expected to be thrown out. Another felt she was responsible for the nurses going sick, and stated that all the other patients had become worse since she was admitted. A third stated she had cancer and had infected all her friends, and was indeed responsible for all the cancer in the world.

Nihilistic delusions, especially of poverty, were perhaps the most characteristic feature of the involutional series, but again occurred in only a small proportion of that series (10 per cent.). The most characteristic feature of the younger group was the frequency with which they felt they were letting people down, husband, wife, family, or friends. One patient considered she was " deserting " her husband by coming into hospital for treatment, and two women with apparent sterility were mainly preoccupied by the way in which they were letting their husbands down by being unable to have children.

(b) *Somatic features*.—By far the commonest complaint consisted of pain or sensations referred to the head. This varied from frank headache, either frontal or occipital, to " disturbed feelings," buzzing sensations (not invariably associated with arteriosclerosis), pressure feelings on the skull, and a sensation of the head being enclosed in tight bands. Two patients referred to the sensation of numbness or " deadness " on the vertex. In only one case was it severe, and it was then associated with marked feelings of derealization and tended to be persistent.

Visual disturbances were common, but rarely amounted to more than a dimming or blurring of vision. Frank hysterical amblyopia was not noted in the series. One patient, however, complained of diplopia. This appeared a very unusual symptom not noted before or since. It was associated in this case with many other complaints and delusions of a somatic nature in a markedly hypochondriacal personality. It had appeared as a prominent symptom in each of the three major recorded depressive attacks which the patient had sustained over a period of 24 years.

Cardio-vascular symptoms consisted mainly of palpitation, sub-sternal pain and pseudo-anginal attacks, one patient complaining of his veins swelling as though they would burst.

Gastric symptoms were pain and peculiar sensations referred to the abdomen and stomach. Nausea was frequent, but in only one case was it associated with actual attacks of vomiting. Weakness and fatigue, sensations of vibration in the throat, loss of feeling in the arms, tingling sensations in the fingers, urinary dysfunction, cough and pain in the chest were all complained of. The more characteristic depressive beliefs of having acquired venereal disease or cancer and of undue preoccupation with the bowels were all in evidence. Gross hysterical features were noted in only 3 cases, all in the involutional

group: the case of hysterical dysphagia, already mentioned, one retarded melancholic who developed a hysterical monoplegia of the left arm, and one acutely agitated and confused patient with a hysterical paresis of both legs. These symptoms all cleared with the depression under treatment.

In the younger age-group one patient complained of being unable to breathe properly because she had become ultra-conscious of her breathing and required to "think out" each breath. This proved to be based on identification with her mother, who at that time was suffering from severe cardiac asthma, and whose illness was given as a principal reactive factor in the patient's history. This symptom, too, cleared satisfactorily with the depression under treatment.

(c) *Phobic and obsessional features.*—The association of compulsive features and depression is one of considerable interest, and has received some attention in the past. It is also generally recognized as being an association which is not uncommon, and for this reason, such cases as appeared in this series have been included in the typical rather than in the atypical group. The significance of the more purely phobic aspects, however, seems to have received little or no attention. Seven cases in this series (6 manic-depressive and 1 involutional) were regarded as predominantly phobic or obsessional in content. As these cases are of some interest, their principal features will now be briefly summarized.

CASE 1.—A recurrent retarded depressive state. The content of the patient's thought was entirely taken up with his preoccupation with several phobias the fear of heights, the wake of ships, and open razors. The wake of ships was associated with once seeing a man commit suicide by throwing himself overboard. The fear of razors was associated with once being shaved by a drunken barber. These fears were accompanied by brilliant visual images of almost hallucinatory intensity, and faded into the background with the depression under treatment.

CASE 2.—A meticulous, over-conscientious, neurotic personality, with a marked over-attachment to a tyrannical and psychopathic mother. She developed a retarded depression, in which the whole content centred around fears of what would happen to her parents if she died.

CASE 3.—Content of this case was almost entirely taken up with morbid thoughts associated with ideas of death, and she had vivid visual images of what she described as her own funeral.

CASE 4.—A notably depressive background was associated with a fear of pregnancy, coloured with obsessional doubts as to whether she was pregnant or not. The removal of the depressive element with treatment left the phobia of pregnancy relatively unaltered.

CASE 5.—A neurotic personality whose history revealed numerous phobias in childhood, of such things as moths and church. Over the last thirty years she had sustained several attacks of acute agitated depression with a predominantly phobic content, all apparently precipitated by some association with death. The death of a friend in the war, the unexpected death of a relative, seeing a man die suddenly in the street, and the death of a pet animal. During the attacks she became acutely afraid of going outside, going downstairs, and developed fears (not complaints) of bodily disease, for which she sought continual reassurance the effect of E.C.T. (and a more than average amount was given) was disappointing, for although it produced some improvement in the depressive element, the phobias tended to persist, and ultimately only became quiescent after the treatment had ceased for some time.

The last two cases are cases of depression associated with established obsessional neurosis.

CASE 6.—An excessively tidy woman addicted to washing rituals of moderate intensity, directed against faecal contamination. She visited a dying senile relative

and was shocked to see the bedclothes soiled with faeces. After the death of the relative, whose effects she had inherited, she became excessively worried about faecal contamination of this property and developed excessive rituals of washing, with a depressive state and some emotional overplay.

CASE 7.—A man married to a woman older than himself. His rituals and ruminations were associated with fire—cigarettes and matches—and he indulged in obsessional precautions about turning off the gas. After the death of his wife he went through a period of elation to an extent which caused comment by his friends, and in which the obsessional compulsions were less insistent. This was followed by an attack of depression in which the obsessive features altered. Some turned into phobias projected into the past of more obviously depressive emphasis (e.g. he began to wonder if he had harmed some of his childhood friends), associated with more typically depressive ideas such as wondering whether his brain was diseased.

In only one other case in the series were obsessional features prominent. This patient was obsessionally preoccupied with words and their derivation. These words would come into his head and he would link them with obscene associations, then being afflicted with a compulsion to say the words aloud. In this case also there was misinterpretation of a paranoid illusionary variety in that he heard the wireless accusing him of a number of misdeeds such as sexual perversion, violence and murder. The depressive element in this case, however, appeared dominant, and the pre-psychotic personality, although meticulous and obsessional in type, showed no actual symptoms of a florid obsessional neurosis. Treatment removed the depression and other symptoms.

This patient would correspond to the type mentioned by Stengel (4), in his recent observations on the relations between depression and obsessive-compulsive symptoms, where patients with marked obsessional personality features, but not actually suffering from an obsessional neurosis, develop severe obsessional features in the course of their depressions only—a type which, he points out, is often diagnosed as a recurrent or cyclical obsessional neurosis. One would merely point out in passing the significance of this observation in connection with states referred to as " recurrent paranoia."

In attributing to depression an unmasking and aggravating effect on latent obsessional symptoms, one could carry this viewpoint to its logical conclusion by ascribing to depression an exaggerating effect on all the attitudes and attributes of the personality, so that the appearance of hypochondriacal, paranoid, phobic, obsessional and hysterical symptoms may be expected during the course of a depression in the appropriate personality.

This would present us with a so-called " dynamic " relationship of relative simplicity. Yet it is hardly possible to extract the depressive element from the totality of the psychic situation unless one is willing to give it an independence, perhaps even a physiological independence, outwith that situation. To do so would be to strike at the very roots of psychic causality, upon which any system of psycho-dynamics must inevitably be based. If the concepts of psycho-dynamics are to remain as useful in the future as they have been in the past, their mechanisms must be regarded as interdependent in a logical and not merely incidental way. This, of course, does not make it impossible to accept the view of a physiological concomitant of the depressive state, of which view the rational psychiatrist in this modern age must, Janus-faced, be ever aware.

It means simply that one must regard the psyche as a more or less fluid equilibrium, reacting to a total situation in which the depression, if it appears, is given purpose and meaning. Thus, Stengel notes that there are obsessional neurotics who are subject to recurrent depressions, but rejects the explanation that these depressions are the natural reaction to an exacerbation of the obsessional illness. Yet cases can be cited in which the presence of strong external factors may succeed in upsetting the delicate dynamic equilibrium of the obsessional system with the logical appearance of depression.

Two cases (not included in the series, as they were seen elsewhere) may be quoted in this respect: A young married woman of markedly obsessional personality, excessively house-proud, within a few weeks of having her first baby developed a depression with much weeping and emotional overplay. The baby formed a disruptive element in the obsessional system, making the obsessional rituals less easy to carry out. She was much preoccupied with cleaning rituals and avoidance of faecal contamination, and admitted that from the first she found handling the baby's excreta distasteful to her, in spite of her attempt to overcome it. The second case was of a nurse who, before her marriage, was associated with infant welfare work. In this case the patient had twins. Of a markedly obsessional personality, she accepted the rituals of infant welfare work with the rigid conscientiousness which would be expected of such a personality, until she had to put them into practice in the case of her twins. The impossibility of carrying out this task to her satisfaction led to a depression of the same type with much emotional overplay. Indeed, one can hardly think of a more closed or vicious circle than is illustrated by these two cases.

Imagine for a moment an experimental situation in which, as part of that situation, an obsessional neurotic is forcibly prevented from carrying out customary rituals. Surely this would lead to intensely aggressive behaviour directed towards the frustrating object? In the cases quoted above the frustrating object is at one and the same time the loved object, and hatred directed against the loved object is the very essence of obsessional ambivalence. The unconscious hatred directed against the child would lead to a reinforcement of the defensive rituals which are *ab initio* the very protection against such hatred. The frustrating effect of the child, however, remains, and although in actuality perhaps no greater in degree, would have the effect of an intensified challenge to the intensified defensive rituals. This in turn would lead to an increase in the unconscious hatred directed against the child, with the development first of an anxiety situation. Thus a position would soon be reached in which the intensification of the defensive rituals might no longer be able to keep at bay the unconscious hatred against the child, which would come dangerously near to full conscious expression. As conscious hatred against the loved object is in this case intolerable, the depressive position soon intervenes in which it finds conscious expression against the patient herself, in an overwhelming sense of guilt, and in which the obsessional mechanisms, as they are now no longer necessary, fade into the background.

It is significant that in both cases the depression was possessed of the same quality, a weepy state with much emotional overplay and practically devoid

of content—a condition suggestive of Stengel's "masochistic orgy," but probably as near to a "pure" depression as it is possible to go.

Thus, between the purely obsessional position and the purely depressive, a series of stages may intervene. There may be a stage of partial reinforcement. This would explain the appearance of more formal obsessional symptoms in the obsessional personality with depression; and the intensification of obsessional rituals in the frankly obsessional, associated with an element of depression which often does not appear to predominate (Case 6). From a stage of partial reinforcement a more completely depressive position may be reached in which the obsessional content becomes more obviously replaced by a depressive content (Case 7). The final stage would be that of descent to a "pure" depression virtually devoid of content (i.e. devoid of rationalizations and elaborations). These conclusions must be regarded as largely tentative, and they cannot be elaborated further at this stage, although it is hoped to do so in a future communication. In the five obsessional states quoted in this section a clear-cut external situation was present in them all, and all it is desired to emphasize at this point is that factors in the external situation should not be entirely ignored in presenting a truly dynamic view of the relationship between obsession and depression.

(d) *Paranoid features.*—As Lewis (1) has pointed out, paranoid beliefs are not uncommon as part of a depressive illness. They vary from simple referential delusions obviously based upon guilt feelings, to more marked delusions of a persecutory nature in which the accompanying attitude is less one of resignation as one of hostility and resentment. The list given below shows the gradation in type of the paranoid beliefs throughout the typical series. Most of the beliefs were of the simple referential type, as cases which showed prominent paranoid beliefs had by definition fallen within the atypical group.

1. "People were looking at her strangely, talking about her, and criticizing her."

2. "Her appearance had deteriorated and people were laughing at it and talking about it." (This patient was markedly narcissistic.)

3. "She was being shunned by everyone because it was known that she had been her fiancé's mistress."

4. "People were talking about his strained relationship with his wife, and discussing his homosexual tendencies."

5. "His friends were talking about him."

6. "People were making a fool of him."

7. "She was going to be done away with."

8. "A mockery was being made of him, and he was being represented on the screen."

9. "He was to be prosecuted because his accounts were wrong."

10. "The police were going to take him to prison because he struck his sister."

11. "He was being watched by the pension people." (Believed he had accepted a pension under false pretences.)

12. "People were laughing at her and spying on her."

13. " People thought he was a spy and police agent."

14. " His removal to hospital had been organized by the state police."

15. " People were following him, and he was to be taken away and tortured. He was under arrest and in prison."

16. " His foreman was against him."

17. " Her family were against her."

18. " The window cleaner had stolen a wheel-barrow, and the people next-door were guilty of wrong-doing." (Associated with marked agitation.)

19. " A doctor (who had taken off a sample of blood) had injected poison into his system. As the doctor had been a Jew, he was now a Jew-hater. There was an organized conspiracy to remove him to hospital." (Agitation.)

20. " The Nazis were after him." (Agitation.)

21. " His guts were being strangled in the night; he was dead and was going to be taken away by embalmers. The embalmers were persecuting him." (Agitation.)

The problem of practical importance is to decide how much significance should be placed on the appearance of paranoid beliefs in the course of an apparently depressive illness. Obviously if too great a relevance is placed on the superficial symptomatology of a psychosis, without reference to the underlying affective state, whether the symptomatology be obsessional, phobic, paranoid, or schizoid, then the way is open to prognostic uncertainties of no small magnitude.

This is a point which cannot be too strongly emphasized, because it is felt that routine diagnosis is still too often a matter of being impressed by what is obvious in the content without its being related to the underlying emotional state. Thus bizarrerie is " schizophrenic " whether, indeed, schizophrenia is present or not.

Yet it is not always easy to nullify the paranoid element. A patient who appeared to be suffering from a typical " melancholic " depression was heard to remark that " she was illegitimate and had been brought to hospital in the Royal Car, and the King had been talking to her." This statement seemed to bear a grandiose quality verging on the paraphrenic. It was only some days later, when she was heard asking whether she was fit to be a patient in this " Royal hospital," that it was realized that her previous statement had been one of extreme humility, and the " Royal " car was the hospital car and the " King " the Medical Superintendent. In the second case the patient felt that people were looking at him, and his friends shunning him because of an alteration in his facial appearance which made him ugly and ape-like. Yet in this case there was undoubted depression, showing a characteristic diurnal variation in intensity, with a pyknic build and an active energetic pre-psychotic, personality. The " paranoid " feature here was regarded as largely self-depreciative and in harmony with the emotional state.

A depressive reaction with a paranoid content does not appear to be a precursor of a true paranoid state, certainly not a common one. Paranoid states often have an associated depressive element. Yet the distinction is almost always clear-cut, and there is usually no difficulty in deciding when the paranoid element is dominant.

(e) *Miscellaneous symptoms.*—Apart from the illusions and visual images in connection with the phobic and obsessional features, only two examples of actual hallucinations were found in the typical series, both in the involutional group. One patient heard voices which he attributed to the departed spirits of his ancestors telling him to pull himself together morally—a clearly self-accusatory phenomenon. While in another case, a voice repeating over and over again, "What shall we do? What shall we do?" was an obvious expression of the patient's agitation and distress. Feelings of depersonalization and derealization, although not restricted to the involutional series, were most commonly associated with it. Feelings of depersonalization were of two types. Expressions of having changed in some way, of feeling different, of complete loss of feeling, or inability to feel, of being a different person, were common. The more bizarre and less usual type was difficult to dissociate from what were virtually gross somatic delusions, e.g. :

"His heart had burst open and the blood was rushing to his head and giving him pain."

"His stomach was an empty cask, devoid of feeling."

"He was half in and half out of the ward, and the food he was eating was passing through all the other patients first."

"His body had ceased to function below the neck."

Feelings of derealization were, on the whole, very much less prominent, but when they did occur, had a quite characteristic quality.

"Everything was dull and bleak, and the world had lost its colour."

"The world was in four sections in contradistinction to each other."

"The beauty had fallen away from the world like petals from a flower."

(f) *Anxiety.*—In discussing anxiety in relation to the depressive state it is not proposed to revive the acrimonious arguments of "psychosis" *versus* "psycho-neurosis" which flourished in the nineteen-thirties. Such distinctions have frankly lost significance under the modern therapeutic urge, which is less concerned with allocating to the case a rigid diagnostic label than in estimating the total reaction, in an endeavour to assess which form of treatment is likely to be most beneficial, whether it be psycho-therapeutic or physical. To revert to the analogy of the introduction, it is not that the "islands" have become less important, but that they have become land-marks as well as landing-stages.

Anxiety in one form or another, either objective or subjective, is almost universally associated with depression, as can be clearly seen from Table IV. It is for this reason that the tendency to sub-classify depressions on the basis of anxiety is to be deprecated. Lewis (5), in a more recent account of depression, regards it as being of two types, melancholia and agitated depression, each type having a minor form, the minor form of melancholia being simple or neurasthenic depression, and that of agitated depression being anxiety state. Munro (6) would retain the older categories of manic depressive depression and involutional melancholia, while adding a further group of anxiety depressions.

Such classifications may be a matter of clinical convenience, but as it is obvious that any classification is bound to be unsatisfactory, it would seem

better to speak simply of the depressive state or depressive reaction, while using such generally accepted terms as " agitated depression," " retarded depression," etc., in particular cases as implying shorthand descriptions rather than specific sub-types.

Of the 7 cases in the typical series in which anxiety was not recorded, 5 were associated with marked retardation almost amounting to stupor. In the other 2 the depression was associated with a marked degree of apathy, and both showed little effective or sustained response to treatment. They appeared to be acquiring all the characteristics of chronicity.

(g) *Retardation.*—Retardation was only recorded in this series if it was marked and objective. As seen from Table IV, it was more often than not associated with definite anxiety and even with emotional overplay in the form of tears or fits of weeping. The " characteristic " and often perpetuated picture of the severely retarded melancholic as dry-eyed and without objective anxiety clearly does not fit in with these facts. Further, 7 cases occurring after the age of 45 showed definite retardation. No history of a previous attack of depression could be obtained in any of them. This illustrates the difficulty of assigning special characteristics to depressions occurring at the involutional period of life—at least sufficiently standardized to enable them to be regarded as separate entities.

Retardation appears not only to imply a depth of reaction, but a particular quality of reaction apparently closely allied to endogenicity. This is indicated by Table V.

TABLE V.—*Relation of Hereditary Pointers to Retardation. Typical Series*—114 *Cases.*

		Positive family history.		
		No.	Psychosis only.	Total.
Retarded	.	22	8 (36%)	10 (45·5%)
Unretarded	.	92	26 (28%)	34 (37%)

THE ATYPICAL GROUP.

(a) *Paranoid features.*—In this group they assumed a more persecutory character, often associated with definite ideas of influence. Heightened suspicion and perplexity went hand in hand with an alteration in external reality, in which undue significance was given to events and objects in the patient's surroundings. The different quality of the features can be seen by comparing the list given below with that given under paranoid features in the typical series. The paranoid features, too, in this group, appeared to occupy a considerable portion of the total content of the reaction rather than being merely incidental.

1. His work-fellows were trying to gas him, and since he had come into hospital gas was being pumped into his bed. The workmen had stabbed him in the back with a syringe, causing spots and pain.

2. He was being accused of having venereal disease, and if he went to the

pictures he found this fact being related on the screen. He also found references to it in the newspapers. Society was against him, and people were accusing him of wrong-doing.

3. The Boys' Brigade were being paraded outside the window to spy on her. The nurses and doctors were trying to poison her, and figures of men were being kept in the ward to frighten the patients.

4. She was being hypnotized through cigarettes, and the objects in her room were being altered in a peculiar way. Her clothing was being destroyed, and an attempt was being made forcibly to separate her from her husband.

5. People were acting towards her in a strange way, and names and signs on the road had been altered.

6. He was being influenced by electricity.

7. "They" were laughing at her.

(b) *Schizoid features.*—True schizophrenic behaviour or thought was only prominent in two cases, and in only one did it reach such proportions as to make the diagnosis of a depressive state in doubt. This patient was of pyknic build, had a positive history of manic-depressive disorder in one parent, and was normally (if one may say so) a somnambulist. He passed through a period of acute depression with clear-cut ideas of guilt and suicidal tendencies, to arrive at a detached and mildly disorded state (he tied padlocks and keys to his shoes), in which Divine commands came into his head instructing him to go on journeys. The whole condition cleared with complete insight under electroplexy. In the second case the patient expressed the belief that her thoughts were coming from the wireless.

(c) *Manneristic behaviour.*—The patients in this group showed every form of disordered behaviour, restlessness, grimacing, talkativeness, repetition of stereotyped or obscene phrases, gesticulation in a dramatic and theatrical manner, adoption of peculiar and grotesque postures, speaking in an affected, childish or pedantic voice, rearranging objects and clothing, mutism, resistiveness, negativism, and aggressive behaviour, contradicting forcibly statements made to them (often apologized for afterwards, when well), laughing and weeping in turns, singing, whistling and over-breathing. All associated with a marked depressive element in which tears, regret and a hopeless outlook could readily be detected.

(d) *Depersonalization and derealization.*—This was only prominent in one case, and attained considerable proportions, the patient believing she was an abnormal person, a monster created by God, and indestructible, so that she would never die, but was, in addition, full of disease for which there was no cure. The hospital was cut off from the outside world and the people in it were not able to leave, and if they did so, they only left in their minds, their bodies remaining behind.

(e) *Hallucinations and illusions.*—Two patients had hallucinations of smell for odours coming from their own bodies. One stated he was giving out an odour obnoxious to his friends, and another complained of the smell of blood on her hands. Two of the patients were in a restless state, and afflicted with extensive visual and auditory hallucinations. One heard a voice repeating the same phrases over and over again, and saw faces with no body attached. This

patient also had visual images of some intensity associated with her thoughts! thus, if she thought of a telephone a persistent image of one would appear.

The second patient heard people crying for help, and heard his wife's voice coming from odd corners of the room. He also saw people staring at him through the window, and believed he could read people's thoughts and summon spirits.

It may therefore be seen that the criteria on which the atypicality of this group was mainly judged consisted of markedly paranoid features with a persecutory quality, heightened suspicion, perplexity and ideas of influence, grotesque and manneristic behaviour, and a marked hallucinatory activity. Truly schizophrenic features, such as basic thought disorder, were practically non-existent. It is important that this should be recognized, however, as these cases might have been classified as "schizophrenic" or "paranoid," on the basis of the bizarre quality of the ideas of depersonalization and derealization, the erratic behaviour, the hallucinations and paranoid features, the depressive element being readily obscured by the prominence of the superficial symptomatology. The apparent similarity between these states and such delineated series as the "Schizophreniform" of Langfeldt (7) and "Schizo-affective" of Kasanin (8) is too obvious to require elaboration. These states also showed marked episodicity with complete remission of symptoms between attacks, and no apparent tendency to dementia. Some were seen after having sustained repeated attacks over a period of as long as twenty years. Nine members of the group had had attacks prior to the one studied, and of these one had 1, four 2, two 5, and two 6 previous attacks.

The Significance of Personality as a Criterion of Typicality.

The problem of personality is by far the most difficult factor to analyse in relation to mental disorder. No mere listing of traits would provide an adequate study, for the personality, whatever its constituents may be, is essentially the integrated psyche in action. It is only desired, therefore, to draw attention to some general features which appeared to arise from the study of the cases in this series.

There appeared little justification for the view noted, particularly among analytical writers (9), that there is a unitary "depressive personality." The personalities in this series, once detached from the complicating features of the depression, showed considerable variability so that no possibility of success could be claimed for any attempt to force them all into the same mould. It is true, however, that if one is prepared to ignore the more individual features of the personality pattern, and concentrate only on what might be termed the "field of action" of the personality, certain striking features emerge. These are detailed in Table VI.

The restricted personality was the commonest manifestation, and was more in evidence in the involutional than in the manic-depressive series. It was characterized by much conscientiousness, a reserved ultra-sensitive disposition, the whole expressing itself within a narrow field of interest. This type of personality has been regarded as "inhibited," but this is scarcely an adequate

TABLE VI.

Personality type.	Manic-depressive (50).	Involutional (64).	Atypical (16).
Restricted	23 (46%)	53 (83%)	7 (44%)
Active	8 (16%)	4 (6%)	2 (12%)
Inactive	2 (4%)	3 (5%)	..
Neurotic	17 (34%)	4 (6%)	7 (44%)

description. Within the narrow field the activity may be extensive, but directed towards a few over-valued ends and ideals, or to the maintenance of certain exaggerated standards. It is the failure to attain such ideals, often beyond their inherent capacity, or their unadaptability to the fluctuating demands of external reality, that lead, in these individuals, to a breakdown with depression. Naturally the contrast between what it has been desired to achieve, and what has actually been achieved, make the involutional period of life a particularly vulnerable one for such personalities. But as what has actually been achieved is often of an above-average standard, these individuals appear to be, and indeed are, social assets. There is, therefore, some justification for the aphorism that depression is an illness of " valuable people." The personality is rigid, however, and devoid of much of the resilience necessary to meet the everyday ebb and flow of life. In some respects it might be regarded as " obsessional," but to term it so is probably carrying it a stage too far.

The instinctual energy has become diverted into the narrow channels of certain personal ideals, and in so far as their attainment is socially useful, and in that they show little evidence of reaction-formations of a truly obsessional type, it is probably wiser to refer to the personality as simple restricted.

The active group consisted of bright go-ahead energetic individuals in whom mood swings were not much in evidence, and whose life seemed to consist of a mild hypomanic attack punctuated by episodes of usually severe, but often infrequent, depression.

The inactive group was made up of a melancholy, brooding, self-pitying, lugubrious personality type, relatively infrequently encountered over the entire series. These two latter groups were obviously the most closely related of all to the manic-depressive constitutional tendency.

The neurotic group was entirely heterogeneous, consisting of neurotic, obsessional, psychopathic, inadequate, and poorly integrated personalities. As might be expected, they made up a high proportion of the personalities in the atypical series, and as such personalities under stress are more liable to breakdown earlier in life, they also formed a not inconsiderable fraction of the manic-depressive group.

It is fully recognized that the analysis of the personality given above has many imperfections, but it is only intended to convey a general and not intimate, or even particularly accurate, picture. In assessing the personality for allocation to a particular group, however, it was decided to ignore what Fox (10) has termed the " thymopathic factor "(manic-depressive constitutional tendency). From a study of this series it seemed to possess a somewhat elusive quality, it being more often possible to say when it was present than when it was not. It seemed to run through certain of the cases like a thin red line, and because

of its dramatic qualities, especially in alternating states, it tended to obscure the basic features of the individual personalities which, when dissociated from it, and from the complicating features of the depression or excitement, showed considerable variability.

The Clinical and Etiological Significance of Depression and its Relation to Atypicality.

The problem which this paper has been mainly designed to present is to what extent it is justifiable to introduce the concept of atypicality into a consideration of the depressive state. Melancholia is a field in which many claims have been staked in the past, claims built mainly upon half-truths. the relationship between excitement and depression involved in the concept of manic-depressive psychosis, for example. Fox found only 21 per cent. of his 400 cases had had an excitement, or history of excitement, and the figure in the present series would be much less. The relationship of body physique to depression is also true, but only up to a point, and the manic-depressive constitutional tendency is certainly a factor, but little more.

It would seem, therefore, that we have turned full circle from the classical concept of melancholia, through that of manic-depressive psychosis, to that of the depressive state, with the concept broadening from the symptomatic point of view. Thus in the typical series we have not only to account for depressive and somatic features, anxiety, retardation, personality and reality disturbance, but also for illusions, hallucinations, hysterical, paranoid, obsessional and phobic symptoms. Further, if the atypical series are regarded as valid, manneristic and grotesque behaviour, vivid hallucinatory states, marked persecutory and even schizoid features, have to be added.

Such bizarre reactions were included in the category of depressive states on the following grounds :

1. The prevailing affect was persistent and essentially " depressive," or, if it could not be so clearly defined, at least, " unpleasant."

2. The states were self-limiting, or responded to electroplexy, with complete remission of symptoms, and absence of residual dementia.

It can be seen, therefore, that we have gone little beyond the concept of the depressive state formulated by Lewis (1), except perhaps to include some rather more atypical cases than were given in his series. The cynical may feel that we have gone little beyond the prognostic-diagnostic criteria of Kraepelin, " If it gets better it is depression ; if it doesn't, it is schizophrenia, paranoia, or what you will." Yet, regardless of its superficial symptomatology, there is something fundamental about the depressive state, just as there is something fundamental about true process symptoms in schizophrenia. We know now that, although a depressive reaction is liable to occur in a particular type of personality, it is not the prerogative of that type, so we need not be surprised if the superficial symptomatology of the reaction varies towards the limits of the atypical members in this series.

Is it necessary to emphasize that the depressive state, or depressive reaction, implies more than depression ? That it implies persistence and self-limitation,

for example. It would appear to be necessary to do so. Good (11) would have us believe that there are two types of depression, melancholic and schizophrenic. Depression appearing in diverse clinical states, such as G.P.I. or schizophrenia, cannot be regarded as unusual if one regards depression as a normal psychological phenomenon. But can there be any logical basis for the view that depression differs in quality, when it appears in different pathological states, or indeed differs in any other way than in extensity or intensity, or both ?

Its extensity or intensity being dependent upon the circumstances under which it is arising and on the nature of the pathological processes at work. Good would see these processes as stages in a basic insanity, an *Einheitspsychose*, leading to a state of complete ego disintegration.

Yet as equally convincing an argument could be produced for a basic organic pathology if one took only cognizance of the relatively limited number of changes that are possible in tissue cells. Surely, however, the patterns are important ? They not only show the quality inherent in the basic material, but provide the key to the nature of the causal factors.

Jefferson (12), in his recent Lister Oration, stated that he suspected that discussion of mind-brain relations would always be premature. One suspects the same may be true of the *Einheitspsychose*.

Summary.

1. The clinical features of depression have been re-examined in the light of 130 cases.

2. It is suggested that the broader symptomatic view, propounded by Lewis requires emphasis and extension.

3. It is further suggested that the more atypical features arise mainly in poorly integrated or eccentric personalities who break down early in life and tend to be slightly less hereditarily predisposed.

4. A critique of depression as a " symptom " and as a " reaction " is given.

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