TREATMENT OF DEPRESSIONS

By

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IT seems to me proper to stress from the beginning that there are various types of depressions. Often they are ill-defined, while at other times they fit into the clinical entities of manic-depressive reactions or later-life (involutional) groups. In addition, psychoneurotic depressions are also recognized. However, the essential nature of all these types of depressions is still poorly understood. Treatment therefore cannot be based on an aetiological concept or be specific for depression, but must be based on the psychopathological data.

In our current thinking we include in psychopathology the inseparably linked aspect of the overt and the covert. The overt data are directly obtainable and demonstrable and include symptoms and dynamic factors. The covert data include dynamic factors which cannot be recognized directly or may not even be demonstrable. Psychotherapy must be guided by current and past psychopathologic findings and the technical procedures must be adjusted to the psychopathological changes. When I proposed the concept of dynamic psychotherapy, I used the adjective "dynamic" because it emphasizes the moving force which is inherent in psychopathology and the active aspect of the therapeutic procedure. This concept demands that in treatment one pay attention to all factors which have a *dynamic* significance in the psychopathological reactions and in the healthy functioning of a person. These factors may be physiological, psychological, social or cultural. Their therapeutic significance depends on the constellation in relation to other factors, the period in the person's life during which they occur and the degree of their flexibility.

Clinical experience demonstrates the success with convulsive therapy in the middle and late-life depressions and in the depressions of the manic-depressive group. The results, however, are unsatisfactory in psychoneurotic and psychodynamically-determined depressions. It is also fully recognized that permanent results are often poor. Recurrences of the depressive illnesses result in prolonged incapacitations and painful experiences and frequently end in early death by suicide. At present the only hope for better-lasting results lies with psychotherapy, which may produce a healthier life adjustment and prevent recurrences. In the future, when a better understanding of possible physiological factors becomes available, physiological treatment may add to or replace some of the psychotherapeutic aspects which I am discussing.

Thus far, the results of the various analytic therapies have not been too encouraging, although in some patients valuable assets become established and psychological understanding permits the avoidance, or a better toleration, of the stresses of life. It has been stressed for many years that it is difficult to obtain a sufficiently far-reaching psychological understanding which would permit good results, because intense exacerbations of the depression with great suffering or suicidal danger prevent active therapeutic progress. Usually, after the depression has cleared, although the patient may participate therapeutically it is very difficult to reach him sufficiently.

Before outlining our method, I should like to mention that Freud referred to Griesinger's statement of 1875 that in the content of a psychosis the patient's

hidden dynamic factors become obvious. Freud related them very correctly to the same factors which he demonstrated in dreams.

In dynamic psychotherapy one must accept that there will be a constant change of theories with the progress of psychiatry and medicine in a constantly changing culture. It is important that the psychiatrist be aware of these influences and assume a critical attitude which will prevent him from seeking goals which are too limited or too far-reaching.

It is essential that one study the individual and his development in the world in which he lives. The significance of the dynamic events of childhood can often be recognized in the psychopathological manifestations of later life. It is therefore desirable that one investigate such dynamic factors which may relate to childhood in patients who are over 50 years of age as well as in the younger age groups. However, how much material should be elicited depends on the total psychopathological constellation.

Emotions may produce clinically and therapeutically disturbing symptoms. In people with cerebral arteriosclerosis for instance, anxiety may lead to an organic type of thinking disorder which may persist, but usually in one's therapeutic approach one succeeds in alleviating interfering anxiety. In depressions it is especially important that one should obtain the meaning of the emotions and establish their psychopathological influence and expression.

The therapeutic technique may vary, but usually an active form in several therapeutic sessions a week in which interpretations are used sparsely is the choice. Much repetition may prove to be undesirable and decentralization and desensitization may be effective tools. One must also emphasize usable assets and the need to tolerate that which cannot be changed within oneself or in the environment. The patient must learn to recognize that striving for certain life goals may lead to emotional difficulties because of an unchangeable discrepancy between his inadequacies and his desired goals.

The use of chlorpromazine has proved to be most beneficial in the treatment of depression because it alleviates intense anxiety, tension, resentment, anger, and transient sexual unrest. Through this decrease of the strength of the emotions, many thinking difficulties and depressive phenomena disappear and the patient is able to proceed with the dynamic analysis which may lead to an understanding of his personality and the factors which contributed to the illness and how these factors can be modified or changed. It is interesting to note the change in the subjective experience of depression without the above-mentioned secondary emotions. In these cases progress is rarely hampered by acute suicidal danger, but we think it essential that all these patients be considered potentially suicidal. This point is important because the usual signs which indicate to us decrease in suicidal danger in the depressed patients are hidden by the chlorpromazine.

I wish to outline briefly the treatment as we carry it out:

In depressions where intense emotions interfere with dynamic analysis, chlorpromazine is administered orally where there is intense anxiety and agitation in the amount of 400 to 800 mg. a day. In most cases 200 mg. a day are sufficient. Chlorpromazine is considered indicated if dynamic analysis is not possible in the acute phase of the depression. At the same time the patient receives the generally accepted psychotherapeutic aid in the form of a suitable routine in which work and appropriate recreation are balanced according to the patient's needs. Attention is paid to the physical needs, which include sleep, food, alcoholic beverages, smoking and drugs. Re-education is undertaken with regard to the faulty actions and behaviour, based on an understanding of the various dynamic

factors. Reassurance, based on signs of actual improvement, is utilized. Under the influence of chlorpromazine, which alleviates anxiety, guilt and resentment, and modifies agitation reactions, an attempt is made to analyse the patient's life development and learn the factors which played a role in the illness, as well as the assets which can be used in a constructive way. Termination of the chlorpromazine phase of treatment is indicated when the dynamic analysis has been completed satisfactorily. This evaluation depends upon the physician's judgment and experience. After termination, it occurs occasionally that a renewed phase of analysis under the influence of chlorpromazine might be indicated. If, after the essential psychotherapeutic goals have been reached, the depression has not improved greatly and apparently not close to recovery, the illness is terminated with electrically induced convulsions. This latter treatment has been necessary in the majority of depressions of middle and late life. Usually 5 to 7 convulsions, administered twice a week, were sufficient. In psychoneurotic depressions, dynamic analysis may proceed for a long period of time without chlorpromazine and may then occasionally be terminated by convulsions.

The final phase of psychotherapy is the dynamic formulation, which includes physical, psychological, social and cultural factors, and the attempt to consider the future life of the patient with the necessary adaptations. During the whole treatment, much attention is paid to the relationship with other members of the family who often may need a great deal of psychotherapeutic support if no actual aid.

The results have been most encouraging and seem to be superior to the termination of depressions by convulsive therapy without intensive psychotherapy. Recurrences have been infrequent. The danger is that the inexperienced psychiatrist will reach too soon for chlorpromazine without first determining whether this drug is actually indicated in the treatment of the depressed patient and to what purpose.

To summarize—the treatment of depressions must be guided by the psychopathological findings, and modified by the changes in the clinical picture. The goals of therapy should be primarily oriented to life adjustment—the patient developing self-reliance with an ability to adapt to inadequacies in himself which cannot be changed and to obstacles in the outer world which he cannot remove or overcome. Chlorpromazine may be a valuable aid in carrying out intensive psychotherapy while the patient is still deeply depressed. In this phase he can be reached more readily and the dynamic factors can be better recognized and investigated than in the convalescent phase of the depression. The organization of the patient's life during the illness, with desirable occupation, recreation and socialization is important and a valuable aid to a dynamically oriented psychotherapy. Convulsive therapy is of value in the termination of a slowly improving depression, especially in the ageing group and less in psychoneurotic depressions. With recognition of overt and covert psychopathological findings, with constant evaluation of psychological and physiological needs, with an appreciation of the family's reaction and of environmental and cultural factors the treatment of depression of any kind demands therapeutic activity, with stress on the psychotherapeutic aspects.

DISCUSSION

By **Prof. E. Stengel,** *Sheffield*

There must be few among us who did not know Professor Diethelm's work and who have not learned a great deal from his writings. He is one of the

distinguished psychiatrists of Swiss origin who have made such an impact on American psychiatry. As far as our discipline is concerned, the Mayflower set out from the shores of the Lake of Zurich.

In discussing the treatment of depressions Professor Diethelm has consistently refused to be impressed by authority and by preconceived ideas. He has looked afresh at what to many may appear old and unrewarding problems, and his presentation today has been singularly free from dogmatism. He made it, first of all, clear that in view of our ignorance about the aetiology of depression, treatment cannot be based on an aetiological concept but only on psychopathological data. This is a salutary reminder at a time when treatment of depression is so frequently coloured either by preconceptions about aetiology, organic or psychological, or else by therapeutic nihilism.

Professor Diethelm's observations about the limitations of electro-convulsive therapy are of special interest. The striking immediate effect of this treatment in many cases of depression has tended to obscure its limitations. Professor Diethelm's insistence on a combination of electro-convulsive treatment with psychotherapy is in keeping with his concept of psychodynamics, which embraces the effects of both physical and psychological treatment. I have been impressed by the fact that a course of electro-convulsive treatment often fails to have a satisfactory result in depressions when given early, while it may have a dramatic effect a few months later. It seems that long-standing depressions have what I would call a "refractory period", i.e. one in which the symptoms fail to respond to physical therapy. Obviously, a knowledge of this period would be of great value for the timing of treatment. I wonder whether there is not also a refractory period with regard to psychotherapy.

Professor Diethelm's observations on the role of anxiety in depressions and its effects on thinking, and his reference to the changing meaning of emotional disturbances are of great importance. Depression is all too often regarded as a simple and stereotyped condition. Another feature which is often taken for granted is the lack of sexual libido. Professor Diethelm has reminded us that sexual unrest is not infrequent.

Many psychotherapists have fought shy of the treatment of depressions, probably because it is for the therapist the most difficult mental disorder to tolerate and because frequently there is a "spontaneous" remission. Although we know nothing about the mechanism of the latter, not even whether it really is quite spontaneous, its frequency has nevertheless had a demoralizing effect on the psychotherapist's zeal. Professor Diethelm has not been influenced by these prejudices. He not only has told us that he has found psychotherapy useful but has also given us a clear picture of the kind of psychotherapy he has employed.

In the psychotherapy of depressions one soon comes up against the excessive sense of guilt, especially in the so-called endogenous depressions. The problem whether the profound guilt feelings so typical of these conditions are related to an emergence of pathological aggression which forms part of the illness, or whether they can be related to previously latent aggression, is still unsolved. This question is nevertheless of great importance in the psychotherapy of depressions. I gather that Professor Diethelm would discourage therapists from analysing these guilt feelings too actively during the depressive state, because such a procedure may deepen the depression and increase the suicidal risk.

Another example of Professor Diethelm's independence of majority opinion, which in clinical psychiatry has often proved mistaken, is his report on the effect of chlorpromazine in the treatment of depressions. Far from taking

it for granted that chlorpromazine, which has sometimes been known to cause depression, is therefore contraindicated in the treatment of depressive states, he has found this drug very helpful in certain cases. He has thus forced us to look again at this clinical problem, which too many of us have been inclined to regard as closed. In reconsidering this question we shall have to note the judicious and discriminating way in which he uses chlorpromazine, and its combination with psychotherapy and electro-convulsive treatment. The importance of a complete dynamic formulation considering all aetiological factors has been duly emphasized by Professor Diethelm.

The fact that chlorpromazine should be able on the one hand to produce depression as well as modify it, while also liable to produce a Parkinsonian syndrome, is of particular interest to me; for in 1937* I observed a recurrent syndrome consisting of typical depressive and Parkinsonian symptoms in patients with lesions of the brain stem. At the time I pointed out that this combination of symptoms was suggestive of certain types of depression being related to dysfunction of the brain stem. The fact that chlorpromazine and other tranquillizers have proved capable of producing both depressions and Parkinsonism seems to bear out this hypothesis.

These are only a few comments on Professor Diethelm's address which has been full of stimulating and important observations.

* Stengel, E., *Archiv. f. Psychiatrie*, 1937, **106**, 726.

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