The "Target" Symptoms in the Treatment of Depressions

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THE RECENT PROGRESS in the pharmacological treatment of psychoses has forced a reconsideration of some of our concepts of psychopathology. The modification of psychotic symptoms by drugs raises the question of which symptoms are key and nuclear to the disease and which are secondary and constitute a superstructure. This paper attempts to re-examine the current nosology which classifies depressive states as being either psychic or somatic, reflecting the predominant influence of psychodynamic psychiatry.

In the light of developments in pharmacological therapy, some authors have already proposed different criteria for categorising the depressions. Lehmann[4] distinguishes the vigilant, asthenic, apathetic, catatonic and dysphoric states of depression. Cameron[1] proposes a typology of retarded depression, depression with anxiety, neurotic depression, depressive equivalents and depressions associated with other states such as senile dementia or schizophrenia. Investigations conducted by the writer suggest another scheme which appears to be more comprehensive in subsuming the clinical data.

As a point of departure, it can be conceptualized that in the depressive states there is a nuclear disorder, the exact parameters of which are as yet unknown, but which is clinically characterized by a primordial symptom. Around this primoridal symptom, other psychopathologic phenomena cluster representing such factors as the personality structure of the patient, his age, the environmental stress, the history and vulnerability of his vital organs, etc. As pointed out by Freyhan,[2] the clinical study of the effects of drugs would be advanced if the "targets" upon which the drugs acted were identified. The efficacy of a drug can be measured by its capacity to reduce, alter or eliminate these target symptoms which may be behavioral, somatic or experiential. To test the efficacy of imipramine in the treatment of depressive states, 58 patients were selected by Freyhan[2] to represent a sampling of target symptoms as well as diagnosis. With respect to diagnosis, the group included manic-depressives, depressive type; depressive reactions with psychosis, and involutional reactions with psychosis. The treatment with imipramine was found to be more effective with the manic-depressive group. Optimum effectiveness was found in 51.5 per cent of the cases, partial in 27.3 per cent, and failure in 21.2 per cent. There were less favorable results in the involutional subgroup which showed a failure in 33.3 per cent of the cases. Taking the group as a whole, the therapeutic effectiveness was better with female rather than male patients and was negatively correlated with advance in age and multiplicity of admissions.

Viewed from the standpoint of clinical experience, how can these results be explained? What is the key symptom in the diagnosis of depressions? Schneider[7] has observed that in the typical endogenous depression, the nuclear symp-

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tom is "vital sadness." This involves a reduction in the feeling of vitality and is differentiated from reactive grief which is a response to external stimulus. The phenomenological locus of the "vital sadness" is in the "corporeal ego." The state of sadness is projected into the soma, and in this sense we can speak of the vital depth of the depression. If a patient has a misfortune in the course of his depression, he can distinguish very well between the two sadnesses. He can be sad because his mother died, which is a qualitatively different feeling from the sadness of his illness. Freud recognized this distinction when he spoke of *Trauer und Melancholie.*

Since we are dealing with a "vital sadness," it is logical to think that the depression is responsive to somatic treatment. As Sargant[6] suggests, "Those who maintain that depression in the middle-aged is caused by breast frustration in infancy, are required to explain to us how depression can be cured by one or two convulsions."

From an extended catamnesis of 200 cases of depressions (endogenous and reactive) who were first seen 15 years ago in my service at the hospital, my collaborator Lerma found that the subsequent course in the majority of these cases indicated that we were dealing with a phasic disease. The "vital sadness" appeared to have been masked by situational factors which originally induced us to consider them to be reactive depressions. This component of "vital sadness" comingled with the neurotic and reactive components, perhaps explains why these cases were responsive to somatic treatment.

In an independent investigation, Roth[5] reported the following results in the treatment of depressions with ECT: 49 cases were symptom free, 12 were significantly improved, and 7 were slightly improved. For reactive depressions, these corresponding figures were 3, 9 and 9 respectively. His findings support the hypothesis that the greater the "vital depth" of the depression, the greater the responsivity to somatic treatment.

In reviewing our experience on the use of imipramine in the treatment of depressions, we can report the following responses: in a group of 125 patients diagnosed as depressives without specifying the type, successful therapy was reported for 51.20 per cent of the cases. However, if the group with "vital depression" is considered alone, then the remission rate jumps to 84.48 per cent. Of the 12 cases unresponsive to pharmacological therapy, 7 were responsive to electroshock alone or combined with imipramine.

The clinical evidence points clearly to the responsivity of "vital" types of depression to pharmacological treatment. There are however still some unresolved questions.

A. First, there is the question about the judgment of the presence or absence, and the degree of "vital depth" in the depression. According to Scheler's phenomenological stratification of feelings, there are three fundamental kinds of feelings: the psychic, the vital and the sensorial feelings. Essentially, the identification of the level of involvement must depend upon the report of the patient who says where his feelings emanate, or how he experiences his sadness. However, this is not an absolute source, because there are instances of "vital sadness" where the patient expresses his depression only at the psychodynamic

level. In general, the thought-content of the depressions is grouped around three radical ideas of existence: the guilt complex, hypochondria, and the poverty complex.

Weitbrecht[8] has isolated a group of depressions in which "guilt delusions" rather than "vital sadness" is the primary symptom. In these cases, the apparent absence of a mood disorder is so striking that one can speak of a depression-without-a-depression (*depressio sine depressione*). However, phenomenological investigation does eventually reveal a "vital ground" from which the delusions emanate.

There are depressions involving primary delusions of guilt that respond to physical therapy (ECT or imipramine). Yet, this responsivity is not found in other cases with guilt delusions. What accounts for this difference? Analysis of the structure of these symptoms of guilt reveals that a change occurs in which the "vital ground" is transformed to what can be called a "psychodynamic superstructure." An analogy is the predelirious mood of the schizophrenic which is transformed into a paranoid structure. Phenomenological investigation needs to explore much more in this field to clarify the relation between the psychodynamic and the "vital" level.

The "vital depth" is found to be less embedded in other depressive states, such as the endo-reactive depression of Weitbrecht and in some neurotic depressions. In the lectures on depressive states organized by the University of Buenos Aires, the psychiatrists who favored a psychodynamic viewpoint, gave recognition to the efficacy of pharmacotherapy in the neurotic depressives.

B. Why is therapeutic action lacking in those patients where the presence of the "vital sadness" is clear? The following factors may militate against effective action.

1) The archtype of depression is essentially phasic, and the course of the depression may remit even without therapy. This is to say that there is a certain period of readiness for treatment. In the majority of cases falling into the category of archtype depressives, the patients respond immediately to the treatment. The following case history is undoubtedly a familiar experience to most psychiatrists: A female patient with depression left the clinic after two months because she felt the treatment was ineffective and her condition had remained unchanged. She went to another clinic where she received the same drug in the same dosage. This time the depressive phase of her illness remitted.

I suggested at the International Congress of Psychiatry in Paris in 1950 this period of readiness of depressive states to treatment with electroshock. I have talked on other occasions about the change of a phase of melancholia to a manic phase in patients under treatment with imipramine. I do not believe that the result is due directly to the drug, but to a spontaneous change of the cyclothymic phase. Imipramine is not a euphoria inducing drug, but acts as a "muffler." Its action is analogous to the effect of chlorpromazine and reserpine derivatives in the treatment of schizophrenics. The delusions disappear because the disorder at the depth of the mood from which they emerge is toned down. The effect of imipramine on depressive states, muffles the oscillations of "vital sadness." However, the oscillation of the mood of the schizophrenic, which

may be termed "schizophoria," is different from the oscillation of the mood of the cycloid structure, and therefore, imipramine is not effective as a therapeutic agent in schizophrenia. The pseudo-schizophrenic is more directly connected with the cyclothymic disorder and may respond to imipramine.

2) Another problem is the relation of the drug to the physical constitution of the patient. Imipramine has a secondary influence on the vegetative functions which can obstruct or even annul the therapeutic action.

Kuhn[3] has pointed out the difference between the sympathicotonic and vagotonic effects in drugs. There are times when it is necessary to terminate the use of a drug because of the patient's unfavorable reaction to its side-effects.

We have encountered some cases of "vital disorders" which did not respond to imipramine, and where the patients developed uncomfortable side-effects when the dosage was increased. We have found that electroshock treatment can sometimes alter the tolerance to the drug, and that smaller dosages are required for remission.

For prognostic purposes, we have developed a modified version of Funkenstein's test to predict the tolerance for imipramine. A full minute was used for the intravenous injection of 50 mg. of acetylcholine; (B. P. levels were determined before) and at intervals of 3, 5, 8, 10 and 20 minutes after injection. Our findings suggest that imipramine is better tolerated by patients with sympathicotonic or fast vagotonic responses. A major drop in arterial tension without recovery at the final reading, characteristic for marked vagotonus, indicates a poor tolerance for imipramine.

From my point of view, the criterion of imipramine-effect is related to the clinical changes in behavior. We have found that we can at times alter the tolerance and the effects of a given drug, by the concurrent use of another drug which modifies the vegetative tone.

C. Depressive equivalents sometimes respond to imipramine thus demonstrating their relationship to the depressive symptom complex. If the existence of "vital sadness" is detected, either through the description of the patient or through a knowledge of the phasic course of the illness then recourse to imipramine is indicated. The drug is also valuable for purely psychosomatic disorders.

Summary

Clinical experience with imipramine (Tofranil) demonstrates its therapeutic effectiveness on the nuclear symptom of depression, the "vital sadness." This sadness is somatotropic or somatogenic, thus differing from normal sadness. The more this "vital sadness" manifests itself in the clinical picture, the better are the therapeutic results. Therapeutic responses varied accordingly from 51.20 per cent to 80.48 per cent in pure cases.

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