PROGNOSIS IN INVOLUTIONAL DEPRESSION

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DEPRESSIVE states occurring in the involutional period are among the most common syndromes encountered in psychiatric practice. Since the introduction of electroshock therapy, this has been the treatment of choice for these conditions. Unfortunately not every patient who is treated remains in good health, and every mental hospital has a certain number of chronic involutional depressions who remain refractory to further electroshock therapy.

This paper is devoted to a study of two groups of female patients suffering from involutional depressions who failed to benefit from electroshock therapy. In the first group of 39 patients the investigation was limited to the routine clinical examination customary in mental hospital practice. The second group consists of 8 patients who were studied intensively during their treatment by group psychotherapy conducted by two of the authors. The material produced by members of this second group provided the authors with an unusual opportunity of gaining insight into the psychological factors operating in the perpetuation of the illness. It seems reasonable to suppose that these factors are equally decisive for patients of the first group, but the methodology of the routine approach precludes the emergence of such information. It is just this information which is important in estimating the prognosis in involutional depression whether treated by electroshock therapy or not. The psychoanalytic theories of melancholia (Freud, 1917; Abraham, 1924) were used by the authors to further their insight into the prognosis of involutional depressions. Such insights are employed by many psychiatrists in their selection of patients for electroshock therapy, but a review of the literature reveals that little has been written on this aspect of the subject during the past decade.

The work is presented in three sections. The first is devoted to those patients examined by routine methods; the second deals with the information obtained from those studied during group therapy and the third section comprises a discussion. The patients have been studied with the aim of discovering, if possible, any factors which have contributed to the unfavourable outcome. It is hoped that the elucidation of these variables may assist in selecting cases for shock therapy with greater precision than has been possible previously.

CURRENT VIEWS ON PROGNOSIS

Many authorities have laid down criteria governing the outcome for involutional depressives who undergo electroshock therapy and they have

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specified the conditions which predispose to a poor result. Kalinowsky (1948) believes that in patients who fail to benefit paranoid trends are frequently encountered. He has noted that these patients have a poor emotional response, and neither a feeling of guilt nor a deep sense of hopelessness or self-condemnation. He remarks that they are more inclined to be resentful and to blame their unhappiness on others. Often such patients display hysterical or hypochondriacal tendencies.

Noyes (1948) states that "the more nearly the general manifestations of the disease approach those usually seen in the depressive phase of manic-depressive psychosis the better the prognosis. The greater the deterioration of personal habits, the more grotesque the delusions or the hypochondriacal ideas, the greater the occurrence of hallucinations, the more marked the poverty of thought and the tendency to aversion, the worse the prognosis." Henderson and Gillespie (1948) express views which are very similar to those of Noyes. Emphasis is laid on the preservation of the patient's affect and his capacity to make contact with the examiner. Hypochondria, excessive timidity and paranoid trends are of poor prognostic significance. Horowitz (1948) has observed that occasionally he had encountered a type of involutional melancholic who gave a history of a typical agitated, depressed state which had been present for six months to one year with an accompanying hypochondriasis. Treatment was rarely of any value.

The impression gained from reading such views is that prognosis tends to be based predominantly on the symptoms of which the patient complains and the impression which he makes upon his relatives and upon the examiner.

The Clinical Material—Group I

In this section of the paper an account is given of thirty-nine female patients suffering from involutional depression who had not responded to electroshock therapy. As stated in the introduction, these cases were investigated by routine clinical methods. Prognosis was estimated by a survey of environmental factors and of symptomatic state. The findings of this investigation are as follows. The average age of onset was just over 54 years, with variations in individual cases, between 38 and 75 years. The average age now is over 61 years, with limits of 46 and 78 years, and the average duration of illness, just over seven years. The number of electric shocks administered varied between 3 and 62, with an average per patient of approximately 15, administered at various times during the illness. Of the thirty-nine patients, twelve are married, eighteen are single and nine are widows.

Nine of the patients became ill without a known determining event. Of the remaining thirty, half became depressed immediately after the deaths of persons emotionally very important to them, such as parents, husbands, siblings or companions, or after a physical illness of the patient herself, such as influenza. The illness of the other half of the remainder was associated in its onset with the death of a close person, the loss of such a person by departure, or the threat of such loss by illness, or on physical illness of the patient, but these precipitants though existing cannot be averred with certainty. Thus possible precipitating factors are known in thirty out of thirty-nine cases.

Among the patients under review are five who suffered permanent mental incapacity from physical causes. These have been included intentionally since the effect of such incapacity is towards a lessening of emotional security and a diminution in the power to maintain necessary emotional attachments. The five cases suffer respectively from deafness, cerebral arteriosclerosis, subnormal intelligence (? birth injury), failing heart, and mild myxoedema. In a sense, these

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conditions might be described as possible precipitants of the depressive illness.

The criteria of case selection have not been rigid and the authors feel that the inclusion of five patients in the series who have had a previous single depressive illness between the ages of 23 and 33 in no way invalidates the conclusions. Not only do the present illnesses of these people closely resemble the patterns of illness of many of the others who have had no known previous depression, but, in addition, it would be unjustifiable to assume that, because the history of a previous attack is not recorded nor admitted, it did not in fact occur. Thus the authors feel that the homogeneity of the group is unaffected by the inclusion of these cases.

Thirty are hospital in-patients, nine are living outside the hospital. Twenty-seven have been ill for between one and twenty-two years, with an average of eight years, and have shown little or no response to electroshock therapy. The remaining twelve have been subject to relapses and it is clear from the histories that of these the majority have not really been well between exacerbations. The average time since the onset in the latter group is 5½ years.

As expected, various symptoms of depressive illness were shown by these patients, not only from case to case, but also by individual cases from time to time. They have therefore been classified with regard to the predominant type of symptom group apparent on consideration of the illness as a whole, and the descriptive terms used do not necessarily refer to the condition of the patient at the present time. Six categories were used (hypochondriacal, paranoid, retarded, deluded and hallucinated, agitated, with preserved affect). Those predominantly hypochondriacal, paranoid, retarded, and exhibiting fantastic delusions and hallucinations constituted, respectively 2, 3, 4, and 5 cases out of the 39. Twelve showed agitation as a predominant feature, and the remaining thirteen, though usually tense and anxious, had sufficient preservation of affect to allow reasonably good contact to be made with them. Their symptoms included anxiety, lack of confidence, difficulty in concentrating, poor sleep, headache, feelings of dullness, and irritability. It is significant to note that though the average time spent in hospital by the cases in this last group was less than a third of the time spent by the cases in the group described as predominantly agitated yet they had on average a slightly greater number of electrical shock treatments. In this connection it is worth adding that the total duration of hospitalization seems to vary directly with the number of electroshocks to which patients are subjected. Among the thirty-nine cases the average time of hospitalization for those who received up to twelve shocks (twenty-two cases) was two years five months, while those who had over twelve electroshocks (seventeen cases) were in hospital an average of three years five months.

A brief description of six cases typical of the group as a whole follows:

Case 1 (No. 10).—Single woman admitted 1949 at the age of 47 and in hospital since apart from two months unsuccessful trial at home in 1950. She never knew her parents and has no blood relations. Always self-effacing, hard-working, she had lived with a workmate for twenty years before the death of the latter just before onset of patient's illness. Her only interests were in her work at a thread mill and in her friend whom she tended faithfully and with self-sacrifice during her periodic illnesses. After friend's death, patient was dull, depressed, despairing, anxious and slightly self-reproachful. While in hospital, she has had six courses of electroshock therapy, totalling thirty-five shocks—each course followed by some improvement, then relapse. Has now become attached to another patient with similar symptoms, whom she admits stands in her mind for her dead friend. Patient often very worried by the fear that her new friend will die in the night and indeed frequently goes to her room in the mornings to enquire whether she is still alive. In the ward, patient is hard-working, self-effacing and friendly and only occasionally too depressed to be allowed ground parole or passes into the city. Contact is good and affect preserved.

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Case 2 (No. 13).—Single woman admitted 1942 at the age of 58 and either in hospital or under constant surveillance as a member of the domestic staff since then. She was hard-working, self-effacing, and seems to have had no interests outside her work as a seamstress with the exception of a man of her own age to whom she was engaged between the ages of 30 and 38, during which time she indulged in mutual masturbation with him before he terminated their relationship. She was depressed for the first time when she was 47, for six months. From the age of 48 for ten years she and her ex-fiancé revived their old practices. When he broke off the liaison again, the patient became depressed, anxious, tearful, full of various somatic complaints, demanding attention and reassurance, and fearful of passing on "contagion". This state has continued with partial remissions since that time, some following short courses of electroshock therapy of which she has had 27 shocks in all, and some spontaneous. She is one of those described as having preservation of affect.

Case 3 (No. 16).—A widow admitted in 1946 at the age of 58 and continuously in hospital since then. She had no previous mental illness but is described as having been spoilt and over-protected all her life. Parents lived with her after her marriage, and both died when she was 52. Her husband was away from home in the forces from then till 1945 and patient became ill after his sudden death in 1946. She quickly became fearful, agitated, depressed, with nihilistic ideas, and negativism. Despite two courses of electroshock therapy, totalling 12 shocks, she remains tense, avers she is blind or dead. She has no useful activity, and is in constant agitation and fear. She is classed as "predominantly agitated".

Case 4 (No. 27).—A single woman admitted in 1951 at the age of 49 and in hospital since then apart from a few months' unsuccessful trial at home. She was shy and reserved and clearly attached to and dominated by an overpowering and rather unkind mother in whom she alone of the family could see no fault. She had a previous attack of mild depression for a year when she was 23, but was not then in a hospital. The present illness seems to have been precipitated by the illness of her mother, whose life was at the time described as being in danger, and patient became depressed, anxious, self-reproachful, irritable, sleepless, and had nihilistic ideas, saying "I will never die, I will live for years for my sins". She has had 5 courses of electroshock therapy, a total of 30 shocks, with partial remission followed by relapse after each course. She is tense and fearful and food intake has to be carefully watched. She is classed as predominantly agitated.

Case 5 (No. 31).—A married woman admitted in 1952 at the age of 54 and discharged from hospital after seven months. As a child she was jealous of a younger sister and married at twenty to get away from home. Husband is suspicious and possessive; patient is rigid and over-particular. Five years before admission gradually increasing symptoms of insomnia, tension, irritability, lack of concentration, and depression. Three courses of electroshock therapy in hospital with little permanent effect, a total of 21 shocks. Afraid to go home, family unsympathetic, patient tense and apprehensive on discharge. Classified as having preservation of affect.

Case 6 (No. 34).—A married woman admitted to hospital in 1951 at the age of 50 and not yet discharged. Childhood unhappy, mother died and father abandoned the children when she was a child; brought up by an aunt who gave more affection to her own children. Patient has no children of her own and has been on poor terms with her husband for years. Illness began two years ago following a hysterectomy and the death of her mother-in-law whom she disliked. Symptoms were of insomnia, lassitude, anxiety, headaches and weeping. She showed paranoid features, blaming all around her for her misery, with considerable expression of resentment against her relatives. Improved only very briefly after one course of 8 shocks of electroshock therapy. Classed as depression with predominantly paranoid symptoms.

Attempts to base prognosis solely on symptomatology are confusing and misleading. Nevertheless, at present, such criteria seem to be decisive in estimating prognosis with or without electroconvulsive therapy. This approach runs counter to the conceptions of patient-environment interaction proposed by Adolf Meyer 30 years ago, and now generally accepted. Meyer consistently advocated that symptoms and syndromes are the expression of the patient's attempt to adjust to life situations which are beyond his capacity. The symptoms are not to be overestimated but to be seen against the background of the patient's organic and psychological equipment in its dynamic relationship with environmental stresses. Meyer (1922) stated: "The best facts still are the data of observation of behaviour and mentation, i.e. the facts we can observe from the beginnings of the disorders. But even there it is best not to lay too much stress on the formal facts but to work from the start with the dynamic as well as the

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descriptive data. The consequence has been that, for a long time, I have not been as much interested in the question: Is the case one of dementia praecox or manic-depressive insanity? as in the question: What combination of facts and factors does the patient present? What are the reaction groups and the factors at work? What are the facts I have to reckon and work with? What are the assets? What is the group tendency of the reactions, and the individual prognosis?" *and* "But under no circumstances do we consider the mere formal material adequate for a prognostic forecast without a survey of all the dynamic or causal factors and a thorough trial of the responsiveness of the patient to a distributive analytical and reconstructive study."

Malamud, Sands and Malamud (1941) undertook a study of prognosis in involutional melancholia. They followed a number of patients, who were ill before the introduction of the shock therapies for some years, and their paper records their observations. They drew the following conclusions: "The development of the psychosis (involutional psychosis) depends upon a variety of factors which tend to render an adjustment to the involution more difficult. Chief among these are (*a*) special types of personality organization lacking in plasticity and restricted in interests. (*b*) Conditioning experiences which enhance these weaknesses. (*c*) Precipitating factors in the form of catastrophic occurrences which threaten the sense of security or the continued possession of subjects of strong attachment. The following factors were found to be of importance in the consideration of criteria of prognosis—Age, intellectual level, adequacy of adult sexual and family adjustment . . ." Malamud, Sands and Malamud laid special emphasis on the influence of certain precipitating factors as prognostic criteria. They state "Economic stress can be remedied, worry over children or other relatives may prove unfounded or exaggerated, but the death of a loved one or the loss of a house to which one is attached has the stamp of inevitability".

In the six patients described above who are typical of the whole group, many of the prognostic factors mentioned by Malamud and Sands are apparent. The frequent occurrence of adverse external circumstance pre-supposes that external factors ("socio-psychiatric") are of major importance not only in the precipitation of the illness but in its perpetuation. This does not explain the frequent observation that some patients recover in the face of adverse external circumstances; that some patients break down at the climax of their career; and that others fail to improve or relapse when the environment is apparently beneficial. In a subsequent section of the paper, material will be advanced which supports the view of those who hold that an internal (psychological) factor is often the decisive one in determining the outcome of the disease.

The Clinical Material—Group II

This group is composed of eight patients, five of whom are still under treatment. In these patients the average age at onset was approximately 54 with variations in individual cases, between 39 and 62. The average age now is 57 with limits between 40 and 63. The average duration of illness is three years. The number of electroshocks received varied between five and twenty with an average per patient of approximately twelve. Of the eight patients, four are married, one is single and three are widows. In six instances, the patients became ill after an important emotional stress such as death of husband, serious illness of near relatives, etc. Only two fell ill without any apparent determining event. One patient was predominantly paranoid in her attitude. Three were predominantly agitated. All, except one, were able to enter into emotional contact with an examiner. Only one patient was very hypochondriacal. All were very

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depressed, tension and anxiety of varying degrees being common accompaniments. The illness has been continuous in six patients and episodic in two. At present, five of the patients are in hospital.

The outstanding characteristics of the group were their intolerance of aggression and their marked reaction to loss. In dealing with the former, two main defence mechanisms were used—"turning against the self" and projection, whereas with the latter denial was the most usual reaction. Wherever the possibility of loss arose, unconscious conflicts over aggression could be discerned. For example the absence of one of the therapists or of a member produced signs of deepening depression within the group. On such occasions patients appeared to be seeking for memories to show that they had been responsible for the absence of the missing person. Associations always led to thoughts of death and memories of the loss of spouses, parents, siblings, etc. Dreams were reported in which the death occurred of a person still living. For example one patient was tormented by a recurrent dream of great clarity in which she received a telegram informing her of her father's death. In her waking hours she spoke of him with the highest esteem and affection. After her father's death recently she dreamt that the husbands of her three best friends had died. Both this patient and one other who sustained actual loss by death while under treatment reacted with denial. The symptomatology of the former changed to a mild hypomania. In one instance of psychical loss resulting from the indifference of her sons, a patient became acutely depersonalized.

The aggressive conflict associated with loss invariably resulted in bitter self-recrimination. As the patients learned to tolerate their inner hatred it was observed that the amount of self-criticism diminished and the capacity to be critical increased. Associated with this was a revival of repressed memories where aggressive wishes had been directed against spouses, parents, siblings, etc., who had subsequently died. For example, one patient had the greatest difficulty in being angry with another group member. When she was eventually able to show these feelings she recalled a painful rivalry situation with a sister whose death was the precipitating factor in her depressive illness. One patient stated that the reason for remaining in hospital was her fear of venting her anger on her aged parents. This event, if followed by their death, would have been a repetition of the situation following her husband's death.

Hatred is not only a threat to others but also to themselves. They constantly attempt to maintain "good" relationships, but this is imperilled by the projective defence mechanism. This results in all people eventually becoming hostile and critical. They unconsciously attempt to placate these "hostile" people by adopting a passive attitude. This is one cause of the dependency which is so apparent with these patients. This dependence is forever creating anxiety. They consciously recognize their emotional vulnerability. From the early days of the group the patients apprehensively awaited the termination of the treatment, "the doctors may at any time be promoted and sent to other hospitals". The approach of the holidays intensified these fears and just before the group closed for a period these topics were a constant theme. Another anxiety was that they might be dismissed by the therapists for being too demanding. They wondered how anyone could put up with their constant complaints and demands.

Without doubt the patients' needs from others are enormous and consequently the pressure to remain on good terms is enhanced so that these demands will be met. Their previous experiences of rejection when attempting to satisfy such needs are an ever present warning against showing what the other person (e.g. the therapists) may regard as unacceptable. They dread rejection and

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frequently after an outburst in the group they express fear lest they be not allowed to return. For example, one patient, now living at home, criticized one of the therapists and stated afterwards that she was sure that if she repeated this behaviour she would be brought back to hospital, forbidden the group and given electroshock therapy which she dreaded.

An account of two patients is given below to illustrate in more detail some of the points already mentioned.

Case 1.—Mrs. A.—Age 62 years.—At the time of admission to hospital, this patient was markedly agitated. From time to time she screamed and said that some terrible fate was going to befall her. She spoke fluently with pressure behind her words. Fear, anxiety and depression dominated her thoughts and she believed she was dying of some incurable physical disease. Constantly, she sought reassurance from the staff. Her physical examination revealed only severe bilateral varicose ulceration of the legs.

The following is a résumé of the history obtained from her husband. She was of Highland stock and was one of a large family. Her childhood as far as he knew was a happy one. She was a good scholar, taking an arts degree and then training as a teacher. They were married when she was 28 years of age. The marriage was a happy one and they have three sons. The two elder ones are married and live away from home. The youngest is still at home. Her father died, aged 72, cause unknown to the informant. In 1944, the patient found her mother, who had been living with her, dead in bed one morning and was most upset afterwards. In 1945, she had a nervous illness and was admitted to a mental hospital. The husband described this as a persecution complex. She thought he wanted to be rid of her so that he could live with another woman. In 1948, she had electroshock therapy and was allowed home soon after. They were quite happy until April, 1952, when, travelling to visit her son, she was involved in a train smash and was detained in hospital for three weeks with bruises and abrasions. When she left hospital, she went to her son's house. There she became upset and was removed to an observation ward. A few weeks later she was transferred to another nearer home, where she continued to be noisy and excited, and was given 6 electroshocks. She went home, but 3 days later, as she was again agitated and screaming, she was brought to hospital in the state already described.

In hospital she settled, but when a month later she attempted to go home for the week-end she again relapsed and came back very agitated and upset. Soon afterwards, she left the hospital but had to return ten days later. She was agitated, shaking and stuttering. Her son said that she had been well until two days before her admission. By the afternoon of admission she was very upset, clinging to her husband and son asking them if she was going to die. She herself stated that she had relapsed because her son had had a few drinks and then had had an epileptic fit.

This patient was chosen for treatment by group psychotherapy and began to attend shortly after her unsuccessful weekend at home during her first period in hospital. She had been attending the group somewhat irregularly since then. Being a member of a group meeting three times per week, she has been studied much more carefully than is normally possible in mental hospital practice.

The following is a brief outline of her history as it emerged under group conditions. Her early relationships were not at all good, particularly with her mother. As a child, she never felt close to her mother, who quite truly preferred the other daughter who was neat, petite, and very careful in her dress. The patient felt that from early in her life she was casual about clothes and "hoydenish" in her behaviour because it did not seem to matter whether she tried or not. She recalled how on one occasion, Sunday at church, everyone was remarking on her sister's appearance. However, the family did not want her (the patient) and she wandered back home by a different route. At school, however, she was very successful and from an early age got satisfaction from her academic and intellectual success. Her father, she always felt, was petted and spoilt in the home to the detriment of the welfare of the children. She recalls her mother saying that a wife must never, under any circumstances, do or say anything to upset or displease her husband. The atmosphere was one of strict morality of the sternest Calvinistic type. As she grew up she liked to be alone and used to wander among the hills and muse. Her tendency to hill-walk was not approved of by her mother, who thought it "tomboyish".

Although at University she was fairly successful, she did not manage to distinguish herself as she had hoped. Every so often she would stop working and go away into the country. This practice occurred so frequently that it interfered quite considerably with her academic progress. She made no lasting friendships. After qualifying as a teacher, she was fairly happy. During the 1914-18 war a young man, in whom she was interested, was killed but there is no further information about this yet. About the same time, or a little earlier, her sister died. What little she has said about this indicates that she was overwhelmed by the loss and never succeeded in working through the mourning process.

When she married soon after the war, there appears to have been little affection on her part to begin with. She refers back to the early days of the marriage and the physical relationship in bitter remorseful and self-recriminating terms. The marriage was "obscene" and "like prostitution". She hated her husband and used to be happy only when his work took him

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abroad. They had three sons and she sought to establish with them relationships which would compensate for her unhappiness. The absence of her sons in war service and their marriages during this period deprived her of this comfort. Her father had died before the 1939-45 war and the death of her mother in 1944 seems to have precipitated the first illness. The description of her feelings as she lay in hospital for over three years is poignant in the extreme.

When discharged, she lived with her husband and one son. The latter was a comfort to her, though he had not settled well after the war and was inclined to drink a little too much. Then came her accident. While in her son's house she had become agitated and he had struck her on the face. From that occasion she had been unable to control her screaming and finally came to hospital here. Following her first discharge and subsequent readmission there was at first little to indicate what had happened. She did, however, at first criticize her son once or twice for drinking too much. Her husband, of course, was severely criticized as usual. Finally, however, she stated that she had been carrying on at home with difficulty. Her husband was being thoughtless as usual but she felt her son was supporting her more than he usually dared to do. Then one night the son came in having had a fair amount to drink, sat down, and proceeded to tell his father what he thought of him for his behaviour to his mother. The father flared up and terminated the ensuing quarrel by ordering his son to leave the house. The house belonged to the patient and, caught in a situation of great conflict, she at once began to scream, and was forthwith sent to hospital.

The most apparent feature of this patient's psychology is her intolerance of anger. So afraid is she of feelings of this type that even when a situation arises when anger would be justified, she will go to great lengths to deny its presence to herself and to others. In fact, she goes out of her way to be "nice" to those towards whom she would like to direct her anger. Always present is the fear that "something unbridled will break loose". The intensity of this feeling may be judged by the number of defence mechanisms which she employs to deal with it. First of all and predominantly she directs her anger against herself, lashing herself self-punitively whenever she has been annoyed. This, however, is not sufficient and a residue of the emotion is projected into the outside world as a paranoid defence.

She preserves her "good objects" desperately in this situation by splitting the feelings so that the loved person remains immaculate and the "bad object" beyond the pale. Frequently, her "good objects" are authoritative males, terrifying figures, who cannot really be faced, but must be placated and held in impossibly high regard. She unconsciously identifies herself with these figures and can then aggressively manipulate and challenge other people just as she feels herself to be manipulated by the omnipotent ones.

Her reaction in the group to the absence of one of these ambivalently regarded authoritative persons (the therapists) was to behave completely as she thought he would have behaved—not merely sitting in his chair and using his mannerisms but even interpreting in his usual style. Much of her fear of aggression is expressed in oral terms. She commented on one occasion that people had terrible feelings inside them which their consciences did not tolerate, and gave as an apparently abstract example the wish to poison one's husband. She was also much afraid of hurting people with her tongue. The motives of doctors were suspect when they gave her a sedative. She reacted violently to an administrative error when a supplementary issue of milk which she had been receiving was stopped. This upset her for days, as she felt that something was being withheld from her which was vital to her existence.

She commented that her life had been one long struggle for independence, an independence which she had never managed to achieve. She unconsciously believed that threatening figures, upon whom she depended, were always liable to do something unexpected and terrible—in the psychotherapeutic setting she might at any time be rejected, told never to return to the group, and be given E.C.T., a treatment which she regarded with the greatest terror. Her need to establish good relationships was, and always had been, compulsive. However,

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those with whom she could best establish contact were often people whom she fundamentally felt to be her inferiors. Frequently she illustrated her "democratic" outlook by telling how she had long friendly and intimate talks with tinkers, gypsies, tramps or tradesmen. Her behaviour to the other patients in the group was very similar to this pattern.

An outcome of her ambivalent attachment to her mother was an overestimation of the male sex with whom she identified herself. For her, her intellect was her claim to masculinity. Inevitably this discontent with femininity led to disturbances in her sexual life. Her sons became the embodiment of her longed-for masculinity and her eventual disappointments with them were important factors leading to her psychosis. The paranoid delusions can be understood in terms of projection of her own unconscious masculine strivings. The intense anxiety and agitation which followed E.C.T. were the result of a disruption of the psychic equilibrium maintained by the illness. The defence mechanisms were weakened resulting in a breakthrough of intense aggression with resulting anxieties.

Case 2.—Mrs. B.—Age 57 years.—A mental examination carried out at the time of admission to hospital four years ago indicated that the patient was depressed and mildly agitated. Hypochondriacal symptoms were quite marked and she suffered from retching. Her sleep was poor. She felt she was bottling up feelings against her parents.

The following history was obtained from a sister. There were five children in the family, of whom the patient was the eldest. The patient had always been a jolly friendly type of person, who had been very fond of her parents. She had, however, been rather nervous and, as a child, had been unable to travel very well as she suffered from diarrhoea. She left school, aged 14, and worked in an office for two years, leaving because she suffered from indigestion. Employment was found for her nearer to her home. Five years later, she left and came home to act as housekeeper for her parents. At this time, she became more nervous and irritable. She began to suffer from intractable diarrhoea. About this time, she became engaged and her fiancé went abroad. The patient broke off her engagement, stating she was not well enough to follow him.

She remained at home from this time, being usually cheerful and methodical though troubled frequently by diarrhoea. In 1928, a laparotomy was carried out, and she had a portion of bowel resected. Since then she had been increasingly nervous and had been prone to gastro-intestinal disturbances when subject to stress. In 1940, she married a widower, a man much older than herself. She had to share a home with her brother-in-law and adult step-son, neither of whom she liked. The marriage was not as happy as it might have been as a result of this. Later the same informant told one of the medical staff that the patient had had a serious quarrel with her husband not long before his death. During this quarrel, she had threatened to leave, and her husband had been most distressed. Her husband had died early in the year of admission and following this event she had been increasingly agitated and depressed. Her appetite had been poor and she was losing weight. She was sleepless and much troubled by diarrhoea.

She had two electroshocks, then left hospital, returning a fortnight later and receiving a course of 6 shocks, before being discharged. From then until her final readmission in October, 1950, she was readmitted four times, and had two further courses of electroshock therapy. In addition she went to a nursing home, where she had six cardiazol injections. Gradually, she developed marked obsessive-compulsive tendencies. Her memory was poor, and her handbag and cases were bulging with note-books containing her "memory". She could not even decide whether to get up or remain in bed.

During group treatment, the following information was obtained: Her home-life from an early age had been an unhappy one. Her mother had always been a distant, cold, demanding, authoritative person. Pleasure of all descriptions was forbidden. Even reading was discouraged and she had instead to carry out meticulously some trivial household task. Her relationship with her father was not good, but he always seemed unimportant to her. Starved of the essential affective relationships, the siblings turned to each other, and today she is closer to them than to her parents. Always, however, she felt excluded and thought that her mother regarded her as less worthy of affection than the others. As she grew older, her difficulty in travelling increased her sense of being different, and finally dictated her employment as she had to work close to her home. Socially she was never at ease with other people, and some alimentary disturbance frequently interfered with any special occasion. Her relationships with men were almost non-existent, and she always felt ill-at-ease in their company. On one occasion, her fiancé kissed her and afterwards she was sure that she would become pregnant.

Her married life, as her sister reported, was punctuated by quarrels and disagreements. The failure to be on good terms with her step-son caused her much unhappiness. His attitude to her was to ignore her as far as possible. She did not feel any easier for being the previous wife's best friend. With her husband, she found she was never quite sure of her role, for she

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felt that by marrying a man older than herself she had missed his youthful ardour. The painful thought always lurking in the back of her mind was that he had acquired a housekeeper and not a wife.

After his death, she brought her parents and sister into her home. While she had been married they had closed ranks completely, and she was no longer a member of the family circle. When she came out of hospital, she felt that she was not wanted. Her mother, previously so meticulous, was now older. Any attempts on the patient's part to clean up were interpreted by the mother as a slight on her housekeeping. The fact that her parents were now old and frail prevented the patient from expressing her indignation. An attempt to go home while on group therapy failed. It appeared later that the patient, now freer in expressing her feelings, had quarrelled with her mother and the sister had come to the mother's rescue.

Once again the outstanding feature among the internal factors precipitating her illness is her intolerance of hatred. Her silence is a defence against hurting her mother or anyone in her environment. Following a recent period of absence from the group she stated that she had stayed away because her presence was harmful to other group members. Her "good" objects are preserved in that role only by splitting her affective relationships, and again she tends to select people whom fundamentally she regards as punitive and authoritarian. Permanently present is the fear that her "badness" and her "differences" from other people will be discovered and she will be rejected by the person to whom she speaks or by the group in which she finds herself.

Oral problems are present here too. She seeks constant reassurance and if this is not supplied by her doctor she will force him to take some action if she possibly can by presenting a physical complaint. During her stay in hospital she had been treated with many medicines. Unfortunately once she was given a drug she refused to do without it. Her diet was a frequent subject raised by her on the ward round and any alteration in it caused a profound reaction on her part. Her silence and withdrawal represented not only a defence against, and a turning inwards of, anger but a profound regression to a more passive state. Furthermore by her silence she succeeds in controlling people in the aggressive way in which she really wished to manipulate her family.

Her great ambivalence in her relationships with her mother was highlighted when, following a session in which she attacked her mother, she dreamed that she received a black-edged letter notifying her that her mother had died. Her problems with her siblings caused her great pain, and, in particular, she could not face her rivalry with her sister who lived at home. Her relationships with one patient in the group, who hectored her and tried to push her into recovery, were clearly a repetition of her relationship with her sister who frequently behaved in the same way—even, on one occasion, in the presence of one of the authors. Her amnesia represents a protection against the painful memories and affects concerning her dead husband. The price which she pays for this protection is the painful obsessive compulsive doubts and attempts to remember day-to-day trivialities.

Psychically she remains tied to the oedipal situation. Her solution was quite different from that of Mrs. A. Mrs. B. failed to make a satisfactory external adjustment, always being afflicted with hysterical symptoms (e.g. the diarrhoea) and phobias (travelling). She remained tied to her home and her marriage was a repetition of her oedipal problems when she married the widower of an older friend. When the patient's husband died she persuaded her family, against their will, to live with her, recreating the original environment from which she had tried to escape.

Discussion

In an earlier part of the paper attention was drawn to the fact that a high percentage of patients in the first group had originally presented symptoms

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which are usually associated with a good prognosis. Many longer series have been studied which have shown the statistical validity of estimating prognosis in these terms. Nevertheless it is extremely difficult, as the above series demonstrates, to apply the results of such large-scale investigations to the outlook for the individual case. All one can do is to give an estimation of probability of recovery. The prognosis ought to be better where the patient is deeply depressed, retarded and free of hypochondriacal and paranoid trends. A study of "failed" cases shows that this is not necessarily so. The authors feel, therefore, that efforts must be made to seek further guides to prognosis which will aid the psychiatrist in handling a particular patient.

The authors consider that prognosis can be best estimated by taking two factors into consideration, one, an external factor ("socio-psychiatric") and second, an internal factor (psychological). An external factor which frequently precipitated the illness was the death of some close relative or friend. Loss of sons by marriage was also important. Physical illness was a common precipitant. All these events may be regarded as traumatic but are nevertheless part of the life stress of everyone at times. The reaction of these patients to such occurrences must be regarded therefore as unusual. Since their reaction is inappropriate the explanation for the illness must be sought in themselves and not in the environment. Frequently the apparent precipitating factor is a triviality, such as a disagreement with a neighbour. Such patients are no more and no less ill than those in whom the factor is clear-cut and obvious. Among those studied there is nothing to suggest that evaluation of the external factor mentioned above would help to judge prognosis.

The environmental circumstances of many of the patients were and are good when these are viewed in isolation and not in terms of the relationships and attitudes of the patient. For example, Mrs. A. has a conventionally good husband who treats her in a kindly way, though he is not always understanding. She has one son at home. The other sons are very fond of her and she has a standing invitation to visit them whenever she wants and for as long as she wishes. Her material circumstances are very good. Mrs. B. lost her husband but her parents, though old, did rally to her assistance, even giving up their own valued home in order to come and live with her. It is only when we consider how this environment must appear to the patient as a result of the inner difficulties described in the second section of this paper that we can understand how unlikely their recovery is by any form of treatment which does not produce a radical alteration in psychic structure.

Observation of the patients who were studied in detail supports the view that involutional depressions occur in previously poorly-adjusted personalities (Malamud, Sands and Malamud, 1941). Neurotic adjustment, at times concealed, had been the rule, and hysterical, phobic or obsessional reactions had been present in all of them. One might describe them as life-long neurotics sufficiently well protected to manage without medical aid until the added stresses of middle age provoked a catastrophic reaction. The application of electroshock therapy as a specific is of doubtful value. Patients who have failed to benefit illustrate that the treatment does not alter the basic unconscious patterns. Guilt and anxiety over unconscious death wishes, as reported, for example, in the dreams of patients, or severe injuries to self-esteem are not assuaged by the electrical shocks.

An internal factor, namely, the great fear of the destructive force of anger and hate must obviously be considered in any attempt at assessment of prognosis. An interesting case was reported by Grotjahn (1939) in which he observed the

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recovery of a depressed female patient who was given metrazol therapy. He noted that during the depressed period she spoke highly of her mother, but as she recovered she voiced clearly her hatred and hostility. Grinker and McLean (1940) and Levy and Grinker (1943) paid particular attention to the phenomenon which the authors in the second group considered to be one of the most readily observed features of the inner factor, i.e. difficulties with aggression. They were of the opinion that electroshock alters the dynamic equilibrium between the repressive forces and the inhibited aggressive drives, resulting in freer expression of these affects in various ways. By utilizing electroshock as an adjunct to psychotherapy, these writers believed that they could produce a stable therapeutic result, as the aggressive drives were now accessible to a psychotherapeutic approach.

In a recent paper, two of the authors (Freeman and Cameron, 1953) had independently reached somewhat similar conclusions about the psychodynamic aspects of electroshock therapy. However they drew attention to the release of anxiety which accompanied the emergence of the repressed aggressive drives towards consciousness. Those who recover are those who succeed in re-establishing their psychic economy and integrating the previously repressed anger in their mental structure. The anxiety diminishes as the patient achieves psychic homeostasis of a more satisfactory type. Some fail completely, re-establishing homeostasis of a depressive type by reinforcing repression of the unacceptable drives. Others remain anxious, dealing with it by their old neurotic defences. Patients have been observed during and after treatment with electroshock therapy. Many complain of severe anxiety. This anxiety was most marked in those patients who failed to recover. The content of the anxiety consisted of "persecutory" feelings. The patients felt that they were alone and unwanted and at the mercy of a hostile environment. In particular, this anxiety was centred on the figure of the anaesthetist who administered pentothal and scoline. Many patients described him as an enormous bear-like figure who manhandled them. In actual fact this anaesthetist is not merely skilled technically but is extremely sympathetic in his handling of the patients. The route to the treatment room became fraught with terror. The patients would no longer walk that way when going to the canteen or occupational therapy department although it is the only covered route in inclement weather.

Kalinowsky and Hoch (1952) state "fear of electroshock therapy is a greater problem than was originally realized. This refers to a fear which develops or increases only after a certain number of treatments. It is different from the fear which the patient unacquainted with the treatment has prior to the first application. After several treatments, when the patient is much better, he develops an increasing fear for which he is unable to account. This late and quite intense fear is not explained by any discomfort from the treatment nor by the psychotic fears, which have usually disappeared at least temporarily, by this time."

The authors believe that this anxiety is due to a disruption by the electroshock therapy of defences which were holding unconscious aggressive drives in check (Freeman and Cameron, 1953). Hence this anxiety appearing during the treatment may be used as an index of prognosis in terms of an internal psychogenic factor—a belated sign if the patient is to be spared unnecessary treatment which for her is of a painful nature.

The authors suggest that careful evaluation be made of the aggressive conflicts, particularly where there appears to be a breakdown in the defences against this drive as shown by the presence of free anxiety. It is important to emphasize that this anxiety is a subjective phenomenon of the type mentioned above, and

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is frequently not observed in casual contact with the patient. It must not be confused with the agitation which can be objectively observed in many involutional depressions. It has been noted that the anxiety of the type referred to here increases when the psychiatrist introduces themes of aggression in relation to the ambivalently loved objects. L. Alexander (1953) has also commented on the fact that patients who manifest severe anxiety before treatment do not have such a good prognosis.

The authors propose that the following factors must be considered when estimating the prognosis in involutional depression:

1. The symptomatology—the nearer the clinical picture approaches the classical melancholia with retardation, ideas of self-reproach, etc., the better the outlook (see review of the literature).
2. The "socio-psychiatric" factor—the more isolated the patient, the fewer human contacts, the worse the prognosis.
3. The internal (psychological) factor—this must be estimated, not only with reference to the present conscious and unconscious attitudes and conflicts, but also in relation to childhood object relationships and modes of adaptation. The degree of ambivalence to parents and siblings in the past and in the present to relatives and hospital staff should be assessed as carefully as possible. The prognosis will be worse where there is little capacity to tolerate the aggression which will be freed by the electroshock therapy. This capacity must inevitably be less where the patient had few "good" object relationships in early life.

Summary

Two groups of patients suffering from involutional depression who did not respond to electroshock therapy have been studied. An approach in terms of symptomatology has been found to be inadequate in explaining failure to benefit by treatment. The authors suggest that both an external ("socio-psychiatric") and an internal (psychological) factor must be taken into account in considering prognosis.

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