# INITIAL PSYCHIATRIC ILLNESS IN INVOLUTIONAL WOMEN

## I. CLINICAL ASPECTS*

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### INTRODUCTION

THE diagnostic criteria of descriptive psychiatry inevitably vary between the generations and even from decade to decade. New hypotheses imply new selections from the quite illimitable mass of data which may be collected from any patient. Hence new pictures may emerge whose relation to the old may be only partial, and whose inclusion under traditional rubrics may give rise to confusion, or pose problems which are verbal rather than clinical.

Even without any formal hypotheses, however, other factors combine to produce a vexing variation in diagnosis. New techniques of examination, psychological and physical, offer the possibility of hitherto undiscerned classifications appearing, as it were, spontaneously. The development of more adequate statistical methods displays some of the limitations of earlier samples, and points the way to ever more precise surveys. Inasmuch as the content of secondary psychotic symptoms may be effectively influenced by cultural changes, constant re-assessment of symptomatic material may point to what is essential, and what is not, in a classical picture. The impact of effective therapy may stress earlier diagnosis, and therefore give a population of cases showing not only a modified symptom distribution but perhaps also including individuals who would never before have achieved diagnostic recognition. Therapy, again, may perplexingly cut across diagnostic boundaries, so that many clinicians now tend in practice to assess their patients more in terms of potential therapeutic response than in those of orthodox diagnosis. A viewpoint of this sort achieves a formal dynamic recognition in such textbooks as those of Sargant and Slater (1954) in this country, and Leo Alexander (1953) in America. Such therapeutic approaches do not, of course, necessarily imply the abandonment of the attempt to achieve some kind of taxonomic order. Indeed, having available a new operative dimension of unnatural history may conceivably end in a more fruitful classification than hitherto.

This recent multiplication of vantage points, from which one may survey clinical material traditionally arranged, has therefore blurred many of the hallowed margins of psychiatric nosology. Rather than retreat, however, into the anarchy of over-emphasizing the uniqueness of the individual, we may simply consider that a frequent revision of clinical data still has its place in psychiatric research, accepting the dictum of Mayer-Gross, Slater and Roth (1954) that "Description of phenomenologic aspects admittedly is not a prime

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interest in most schools of psychiatry today, but it would be well if it excited more interest than it does".

The considerations mentioned above apply with particular force to the concept of involutional melancholia. For example, one former distinguishing mark was of a duration likely to be longer than that of an earlier depressive episode, as in the average 9½ months, if recovery were to take place at all, of Hoch and MacCurdy (1922), and the minimal 6–9 months of Henderson and Gillespie (1940). Bleuler (1923), who perhaps wisely gave only a page of his textbook to the subject, said that they grow very slowly, readily remain in their height for several years, and again require a long time to decline. Yet today duration with treatment is if anything said to be shorter than that of a manic-depressive depressive episode treated with E.C.T.

Other obvious changes might be cited, but their discussion is more appropriately left to later parts of this paper. It is sufficient to say that while most of us still carry in our minds the Gestalt of a classical involutional melancholia, we may confess that such pictures are increasingly rare, or alternatively are swamped by the larger mass of mild depressions of the involution which therapy has given us the encouragement to discover. Such depressions form a considerable part of mental hospital practice, and it was felt that a further study of their nature might be of profit.

## The Concept of Involutional Melancholia

More perhaps than most psychiatric entities, involutional melancholia has meant many things to many writers. Its very legitimacy, as an aetiological or symptomatic whole, has indeed been suspect since shortly after its birth. In 1896, Kraepelin asserted its independence from periodic insanity, not only symptomatically, but also as an acquired rather than a constitutional disorder. This concept of agitated melancholia was soon attacked on the grounds that the picture was that of a mixed manic-depressive syndrome, and the criticisms of such writers as Dreyfus (1907) were ultimately accepted by Kraepelin. Dreyfus's re-examination of Kraepelin's material was, however, itself the subject of much later criticism by British and American authors, on the grounds mainly of incompleteness and of special pleading in emphasizing very doubtful manic-depressive features. Meanwhile, in Germany, the development of the argument was closely related to matters of theory: it is discussed in the historical review by Lewis (1934a).

It is not here proposed to discuss in full the more recent literature regarding involutional depressions. *Pari passu* with the retention of older criteria, some authors have tended to expand their heading to include, for example, what might formerly have been regarded as climacteric neuroses. Complete comparison of individual papers thus requires an exegetic detail inappropriate to this report, and in any event, the survey by Bellak (1952) covers much of the ground. In order, however, to make intelligible our choice of certain data for clinical assessment it is desirable to sketch a general outline of current descriptions of involutional melancholia, and sometimes to amplify this outline by reference to work which illuminates its source or qualifies its likelihood.

If, therefore, one might make a kind of amalgam of textbook teaching on this subject, it would provide a series of defining statements rather of this sort.

1. Involutional melancholia probably exists as a distinct entity, with such potential misgivings as Henderson's Meyerian comment that it is a convenient label for a certain group of cases, where some specified characteristics are unusually common, or as Mayer-Gross's reservation that affective involutional

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psychoses are a somewhat heterogeneous group, but that their several kinds are not easily distinguished clinically.

2. It is largely agreed that the term be reserved for cases not formerly showing any affective illness, and therefore that second or later attacks of depression should be excluded from the concept. It seems obvious that if involutional melancholia is to be regarded as a meaningful entity, and not merely as a pathoplastic variant of former attacks, such cases must in fact be excluded. But it is worth remembering that these exclusions did not always operate, and a number of authors, whose papers have in other ways influenced the textbooks, failed to eliminate from their case material patients who had previously suffered manic-depressive attacks. Thus in Hoch and MacCurdy's differentiation of recovered and unrecovered cases, a scrutiny of their case protocols shows that 12 patients were described as typically manic-depressive; and, although this is not reflected in the text of the article, eleven of these appeared in their recovered group, thus influencing their prognostic criteria, which in turn are still echoed as of general application in some textbooks.

It is generally stated further that cases of initial manic-depressive type should also be excluded. Obviously this must be either a post hoc consideration, in terms of future repetition of illness or the development of cyclical forms, or alternatively it must rest entirely on the further assumption that the entities are symptomatically distinguishable.

3. The next statement, then, in this traditional picture is that the symptomatology of the involutional melancholic differs from that of his manic-depressive confrère. Firstly, one may consider differences in the quality of the essentially depressive symptoms. Here the nature of variation is usually said mainly to lie in the several directions of apprehension or anxiety or agitation as opposed to retardation, of self-reproach or ideas of guilt being unduly prominent, of a hypochondriasis which may be grossly bizarre, and of delusions which may be nihilistic, and even grandiose in their nihilism. Most modern authors, however, implicitly or explicitly regard these symptoms only as frequent condensations or aggregates in the involutional period, and often cite qualifying reservations that such pictures can be seen, even not uncommonly, in younger patients.

The kernel of the matter seems to be to arrive at a definite statement as to whether their occurrence is in fact significantly greater in the involutional period. Some relevant material is available: we would refer mainly to the most considerable clinical study of depression in English, that of Lewis (1934b). In the discussion of his clinical material, Lewis not infrequently draws attention to the occurrence of so-called involutional features in younger patients, although admittedly he, in any event, regards such distinctions as unsophisticated. Unfortunately his material is not tabulated and no mathematical statement is made. However, by using the case protocols in his later paper on prognosis (Lewis, 1936), and identifying by these numbered records the case data of 1934, it is possible to construct an age tabulation relating to those patients over and under 40, and to correlate symptomatology with these groupings. From such a tabulation, it is evident that self-reproach was equally distributed between the two groups; that hypochondriasis, and often most bizarre hypochondriasis, was if anything commoner in the young depressive. It was true that agitation showed some bias to the older, and retardation to the younger, age groups, but none of these biasses, whether in the expected direction or not, approached significance. Jarvie (1950) records a divergent incidence of retardation and what he describes as "anxiety" as between patients under and over 45; each attribute,

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nevertheless, occurs in both groups. Anderson (1936), in his paper on the prognosis of depressions in later life, said for example of agitation that it was difficult to be sure that there was anything which did not occur in cases of depression of all ages.

One should also, perhaps, be wary of ascribing too much significance to the content of secondary psychotic symptoms. Cultural and historical fluctuations in schizophrenic delusions are well known, but von Orelli (1954) has recently drawn attention to changes in the content of depressive ideas in melancholia, assessed from records covering a period of seventy-five years.

Secondly, a number of other clinical attributes, not usually regarded as primarily depressive, are described as belonging to the involutional picture. Recurring statements mention the relatively frequent occurrence of prominent hallucinations, of clearly paranoid elements, of shallowness of affect, of mildly aggressive whining peevishness, and of schizophrenic admixtures in the symptomatology. Here it is worth remembering that Hoch and MacCurdy, for example, discuss quite explicitly the possibility that their unrecovered cases of so-called involution melancholia are in fact schizophrenic. To say that schizophrenic illness is more frequent in middle age than is usually admitted, or even that mixed schizo-affective psychoses are common, are logical statements, whether or not they are true. But to discuss vaguely transitions or part transitions from affective to schizophrenic psychoses makes diagnostic discussion difficult, unless one pursues such implications to their logical end, namely, a further evaluation of the 19th century concept of the Einheitpsychose, recently discussed by Cobb (1943), and in the specific field of depression by Good (1946).

Further possible sources of contamination, likely to affect the frequency of such symptoms as are mentioned above, lie in the inclusion in case material of more elderly patients, with arteriosclerotic or senile manifestations, a point taken as regards prognosis by Dreyfus in 1907. More recent surveys, such as that by Anderson already quoted, or that of Malamud, Sands and Malamud (1941), have excluded patients with any evidence of organic defect, but the earlier material still influences some accounts of involutional depression.

4. The prognosis in involutional melancholia has formerly been regarded as in general poor. Those authors, however, who report the results of convulsive therapy (e.g. Huston and Locher, 1948) give ample warrant to Sargant and Slater's statement that "of all depressive syndromes those of later life react best", and indeed this is likely to be the opinion of any experienced clinician. The reasons for this reversal, which was mentioned in its relation to duration in the introduction to this paper, are far from clear. It seems likely, however, that some, though by no means all, of the previous opinions about prognosis were affected by the inclusion of organic psychoses. Possibly some of the more chronic pictures were also the result of hospitalization, and of lack of attention to patients whose age made them physically less active and mentally less adaptable. Thus the reasons for the relative absence of such states at the present time may be in part similar to those responsible for the present infrequency of chronic catatonic syndromes in schizophrenia.

5. The pre-morbid personality of those individuals who develop involutional melancholia is said to be typical, or, if not so, at any rate likely to be different from the personality structure of patients with manic-depressive depressions. Most popular is an emphasis on a meticulous, rigid, inhibited, or obsessional temperament, which was stressed by Titley (1936) and by Palmer and his co-workers (Palmer and Sherman, 1938; Palmer, Hastings and Sherman,

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1941). Anderson delimited a further category of the over-anxious, timid and sensitive, and found them as frequent as the obsessional. Malamud, Sands and Malamud described several different personality groupings, whose differentiation is not easy to follow; but their general conclusion was of a frequency of types of personality organization lacking in plasticity and restricted in interests. Most recent but not all earlier authors tend to find cyclothymic temperaments rare, but sometimes this in itself is used as the only point of diagnostic exclusion, which seems methodologically a little unfair. Of all such comments, one can only say that the problems of retrospective assessment of personality are enormous. Where only descriptive terms are used, where no theory of personality structure underlies the assessments, where no standard test is exhibited which might be repeated, it becomes difficult to communicate or compare the findings of different authors, and the possibility of an unconsciously selective bias in the gathering of historical evidence is always present.

6. It is said, lastly, that some aetiological factors have a specific relation to involutional melancholia.

Of its more distant origin, some have regarded it as genetically distinct from manic-depressive psychosis, others have not. It has been reported as genetically allied to schizophrenia, which may conceivably in part reflect problems in the selection of case material; for here, even more than in other psychiatric conditions, genetic studies are haunted by varying standards of diagnosis.

More immediate precipitating factors have been described, ranging from such stresses as physical illness (which was particularly obvious for the genito-urinary system in Malamud's material) to financial loss, employment difficulties, and so on, but the question of how far such strains are peculiar to the involutional melancholic has justly been raised. It is sometimes stated that environmental precipitation is much more evident in the involutional illness than in depressions occurring earlier in life. But this assertion perhaps accords ill with the equally common statement that involutional depressions are slow to flower, in comparison with earlier ones.

More closely specific are aetiological ideas relating firstly to the menopause itself, and secondly to a notion of the whole involutional epoch as a time of biological regression or dissatisfaction, or alternatively or additionally as a preparation for the senium.

Most psychiatric writers tend to reject the immediacy of the physical menopause as a frequent or sufficient cause; thus both Anderson and Palmer find it rarely significant. Farrar and Franks (1931) express a minority view in this matter, and their data show that in 60 per cent. of their cases first evidences both of menopause and psychosis arose within the same year. Malamud in his original paper thought that where it was closely coincidental this might be of good prognosis, but the point is not pursued in the long-term follow-up study of his material (Malamud, Sands, Malamud and Powers, 1949). One modern writer (Malleson, 1953) who was primarily concerned with the menopausal syndrome, believed that this may shade almost by a quantitative increase into, if not an involutional depression, at any rate an E.C.T. reactive state. Benedek (1950) viewed the climacteric syndrome as separate from psychotic depressive illness, but like Malleson regarded hypo-ovarianism as activating an illness, which she in turn described as "reactive depression—the characteristic psychiatric picture of the climacteric woman". More elaborate endocrine changes were postulated by Hemphill and Reiss (1940) who thought that four endocrine patterns were to be observed. It is likely, again, that different

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selections of case material have produced these varying views on the importance of endocrine changes. Most authors are however agreed that developed psychotic pictures are not responsive to hormone therapy.

The concept of a more general epoch of involutional strain is a wide one, as expressed by Henderson's pithy remark that the mind is occupied by the "might have beens"; or in greater detail by the more poetic statement of Curran and Partridge (1955): "The patient has realized his or her assets and has made of them what can be made: the interesting if illusory potentialities that may be lying round each corner of the future of youth are seen no longer to exist: the future is now inescapable and is what the patient's past has caused it to be. The bed is made and must be lain on. It is easy for middle-aged people to view the past with remorse and the future with dismay. Involutional melancholics do so." In agreement with such global comments some authors feel that adequacy of sexual or family life, or of good early object relationships, are of good prognosis for the melancholic; but these assertions do not easily answer the question of why, therefore, symptoms arise in the first place. The general theme of biological regret is emotionally appealing but intellectually lacking in clarity; above all lacking in a clear definition in time, for involutional psychoses are described from the later thirties to the later sixties.

It is natural in this connection to wonder what light psycho-analytic thought can throw on the psychological aspects of biological regression. Recent publications from Glasgow (Freeman and Cameron, 1953; Cameron, Freeman and Stewart, 1954; Cameron and Freeman, 1955) have reported the study and group psychotherapy of patients with involutional depression who had not reacted well to E.C.T. The dynamics evident in this highly selected group are most profitably discussed, but largely—at least to the non-analytic reader—in terms based on orthodox Freudian views of depression in general, without great reference to uniquely involutional events. Benedek, in the paper already quoted, and Fessler (1950) pay more attention to specific psychological problems of the climacterium, but both authors exclude from their consideration clearly psychotic states, Fessler openly describing these as endogenous depressions. Nevertheless, as we are here concerned with those elements in the broad involutional picture which might be age-specific, we may legitimately mention their views.

Benedek feels that many psychological aspects of the climacterium seem to represent "a repetition of puberty, especially the pubertal reaction to menstruation", and finds that "the persistence of premenstrual symptoms, their severity and character, have a prognostic significance for the climacterium"; that is, because of the now permanent decline in hormonal production. The lack of hormone diminishes the ego's integrative strength, and this in turn combined with the inevitable desexualization of emotional needs requires a process of sublimation and further integration. The level of libidinal development formerly achieved affects regressive capacity, and hence the appearance and persistence of symptoms. Fessler thought that climacteric depression had "a marked resemblance to hysteria", and found the defence mechanisms of conversion, phobia and the hysterical character preceding climacteric depression in many of his cases. The menopause is taken as provoking regressive processes, and reviving the original frustration of penis lack, which had been overcome by the child-bearing capacity now lost. In the end Fessler adds two more to our gallery of personality types. His are the over-frustrated, chronically disappointed, belittling individuals, who had self-depreciatingly rejected their genital endowment, and the masculine, intolerant, aggressive, who had characteristically denied any anatomical deficiency.



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## Method of the Present Investigation

The immediate impetus towards a clinical re-investigation of a group of involutional illnesses came from a proposal to collect, with a view to testing other hypotheses, a set of electroencephalographic records from patients in this age group. The EEG side of the enquiry will not be referred to further in the present paper; but, as clinical data were in any event needed for purposes of correlation, it appeared to us opportune to acquire them in sufficient detail to make a general survey possible.

The history of such surveys reflects a gradual change in the nature of the material investigated. Earlier compilations included, as has been said, patients with organic complications, and with a history of previous attacks. Anderson carefully excluded the former group, and Malamud, Sands and Malamud the latter in addition, but their cases were still pre-selected as suffering from depressive psychosis. It seemed to us that because of difficulty in disentangling what attributes are of relevance specifically to melancholia, and what are only of general significance, it would be wiser to start with no pre-conceived hypotheses, and to include in our case selection middle-aged patients who were having their first concrete psychiatric illness, no matter what its nature was; hoping thereby ultimately to achieve some useful dichotomy between those who were psychotically depressed, and those who were not. With this broad inclusion, we agreed that patients should be described and measured first, and, for the purpose of this investigation, diagnosed afterwards.

The criteria for the selection of cases for clinical study were therefore outlined as follows:

1. The patients were women. There were two major reasons for this criterion: firstly, that the diagnosis of involutional melancholia is more frequently made in females (Bellak, 1952), and secondly that the use of female patients made possible a number of more concrete comments about sexual climacteric change.

2. Their age was between 40 and 55. This age grouping was chosen partly because it coincides with that which includes the common range of the physical menopause, and partly because, above the age of 55, factors of age tend increasingly to influence the results of the psychological testing which formed part of the investigation.

3. They were first admissions to any mental hospital, which for this purpose included psychiatric wards in a general hospital. This gave a crude measure of mental health in that previous social adjustment had been at least sufficient to avoid hospitalization, and also excluded the disturbing effects of treatment on various measurements.

4. As it was primarily desired to cover as wide a range of illness as possible, it was decided to include in this investigation only those patients admitted to the amenity section of our hospital. There it is probably true to say that a higher proportion of neurotic illnesses seek admission than do to free beds. At the same time, there is no converse exclusion of psychotic material, and disturbed individuals are as freely available as elsewhere. By this means we hoped to widen the diagnostic span of our sample without sacrificing a due representation of serious illness. This was effective, but at the recognized cost of having our sample biassed towards higher occupational class, and to higher intelligence, although the latter trend was not statistically significant.

In conformity with these simple criteria, data were collected regarding 54 women consecutively entering two admission units in our hospital. The clinical data related to history, to current behaviour and symptomatology, and

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to response to treatment. Psychological examination included the use of a Standard Psychological Interview, the Thematic Apperception Test, and the Rorschach Test. These were administered, scored, and compared by a colleague working quite independently of clinical information, and are separately reported (Orme, 1957).

The cases were treated and the original data gathered by two of the authors, and the computation and comparison of data handled by a third. After preliminary experiment, a schedule of the information desired was designed. With this in mind, a full but free history was taken and examination made, and only thereafter was this material checked against the schedule and any deficiencies repaired. By this technique the use of check-lists or questionnaires, so liable to diminish rapport and presumably accuracy, was avoided. Thereafter adequate notes were made of course, therapy and result. A similar although less closely structured technique was used in acquiring information about the patients' behaviour outside the medical therapeutic situation, that is in the ward, in recreational and occupational therapy, and in their relationship with other patients and staff. As we believe that rating sheets to be used by nurses are best limited to the most material items of behaviour—as, for example, in chronic dilapidated psychotics—the senior nursing staff were simply informed of our special interest in these patients, and asked to make the descriptive nursing notes which they normally compile as full as possible. From these spontaneous descriptions simple behavioural ratings were made.

There remained the question of whether any of the assessments, either in their original form or in the value assigned to them later, might be coloured by diagnostic pre-conceptions. The heterogeneous nature of the group guarded to some extent against the human tendency to approach one's patients with a set of diagnostic Gestalts and unconsciously bias the examination to suit. On the recording side, data from the case records were transferred to punched cards by the clinically independent author, in a horizontal rather than a vertical fashion; that is, punching any given item for a set of patients rather than punching a set of items for a single patient, a method which is the more tedious but which helps to diminish halo effects. Diagnosis was not entered on the cards until other data were complete, and the diagnosis was that made by the two therapists. The investigation was closed when a total of 54 women had been examined.

## Clinical Findings

The data available can be looked at in various ways. First of all, information about the whole population of 54 patients can be gathered, and compared with what similar information is available for the general population; but for many variables this control information is not readily obtainable, and we would very much wish to make a comparative study of presumptively normal involutional women. Apart from such general statements an internal comparison can be made in respect of certain sortings, as between depressions and those who are not depressed, hoping by this means to indicate factors of possible significance in involutional depression alone, regarding it as an entity. Alternatively we might, for example, sort our data in terms of quality of reaction to electroconvulsive or other therapy.

It is the former division which is discussed in the present paper. Twenty-nine of the 54 women were regarded diagnostically as having endogenous depressive psychotic illnesses; here no attempt was made at further subdivision, as between any who might appear traditionally "involutional", and

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others. A further 20 suffered illnesses which were regarded as non-psychotic, including six hysterical reactions, six alcoholic patients, six anxiety states, and three women with reactive-depressive states. For reasons of convenience this miscellaneous non-psychotic group will henceforward be referred to as "neuroses". The remaining 5 cases were undoubtedly of late schizophrenic or paraphrenic nature. These will be left out of account in making our internal contrast, which will be between the 29 depressions and the 20 neuroses: none of the points to be stressed depend mathematically and improperly on their exclusion. Not all the data collected find a place in these comments, for in the end some historical items proved difficult to ascertain with any certainty, and some assessments proved too subjective to be of value.

The mean age of our 54 women was forty-seven, and the age of the depressive group did not differ from that of the neurotic. Their dates of admission fell between September, 1954 and February, 1956. In May, 1956, only 3 of the 54 remained in hospital. Four had been re-admitted and re-discharged, and a further 3 had had a very short period of absence before re-entry, which in their case was not counted as a separate admission. The mode of stay was under two months, and the mean stay a little longer: depressions did not differ from neuroses in this respect. The immediate prognosis for these women's illnesses was therefore good, and it was good for the depressions among them as a separate group. A six months' follow-up study is in progress, so far with reasonably gratifying reports.

We may next make some comments about the general background of these patients. The numbers are not large, and it is obviously sanguine to expect any single factor to emerge as of striking importance; but generalizations have been made, and have had some effect on psychiatric thought, on slender evidence, and it seemed worth while to look at the facts concerning our group.

Seven patients had close and clear evidence of family mental illness, which we defined in the first instance as having siblings or parents who had either been admitted to a mental hospital, or had had E.C.T., or had committed suicide. More distant, and also less tangible, evidence of psychiatric illness in relatives was also collected. The figures were small, insufficient to express any expectancy beyond the normal, and did not discriminate between the depressions and the neuroses. The ordinal place in the family group was noted. Traditionally precarious positions as only, first or last children, or as first girls, were not more frequent than might be expected, and these family places did not differentiate between depressions and neuroses. Of upbringing and possible deprivation, in 5 cases maternal death had occurred while the patient was under five years, and in a further 11 one parent had died before the patient achieved her majority. There is nothing unexpected in these figures, and the groups did not differ in this regard. Evidence of other types of deprivation and restriction was gathered, but its assessment and comparison proved unsatisfactory.

Concerning the biological history of our patients, the mean age at the onset of menstruation was 13·6 years, which compares with the normal average figure of 13·49, reported by Wilson and Sutherland (1953). Twenty-two patients had passed the menopause, 6 with artificial intervention. Fourteen of the 54 had had a gynaecological operation (this to include dilatation and curettage) at some time in their lives, a proportion which at first sight seems rather high, although we could not find a normal estimate for comparison. In none of these respects did the depressions significantly differ from the neuroses.

Of their marital state, 10 were single, 39 married, 4 widowed and 1 divorced. Age at marriage showed a normal distribution, as did fertility. Depressions did

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not differ from neuroses in any of these ways. Evidence was gathered of sexual adjustment. Of 10 single women, 5 had never had any real male friendships, while the remainder had had at least one friendship sustained for some months; 9 of the 10 had no physical sexual experience. The sexual adaptation of the 44 married women was ultimately rated in three categories. Three women had a grossly negative sexual history, of either non-consummation or homosexual difficulty. Twenty had a neutral sexual history: having neither appetite nor satisfaction in the sexual act. Twenty-one came into the class of positive sexual response, for which our requirements were very far from stringent—it might be occasional or even rare. The implication of these figures is that our group may perhaps contain a higher proportion of sexually inactive women than might be expected. Comparative figures are difficult to find for this country: Slater and Woodside (1951) reported some orgastic response, even if infrequent or insufficient, in 85 per cent. of their control group, which was drawn however from an urban working-class group of younger age than our series. Thirteen of the 29 depressions, and 5 of the 20 neuroses, were in our category of positive marital sexual response, but this difference is not significant.

Because of our doubts about the validity of retrospective assessments of personality, we included only one descriptive statement; that most commonly mentioned—of the rather rigid, meticulous, perhaps house-proud, particular but not pathologically obsessional character. Twenty-two women came into this category, 14 among the 29 depressions, and 6 among the 20 neuroses; the difference is not significant. A firm previous history of either mood swings, or of depressed states without treatment or hospitalization, was found in 11 patients, 7 in the depressive group and 4 in the neurotic; again the difference is immaterial.

In summary, then, we collected background information regarding attributes which have been reported or which might be thought to be of significance for the concept of involutional melancholia, selecting data capable of reasonable accuracy in ascertainment and of some degree of quantification. Ignoring any possible dynamic interplay of experiences, there was little in the crude data indicating any distinguishing factors between our 54 patients and the normal expectations for women of their age. As between depressions and neuroses, no differences significant for the numbers available for study were found.

We shall now consider a set of items regarding events closely preceding illness or hospitalization. Fifteen of the patients, including 10 depressions and 4 neuroses, had had a relatively material physical illness within the two years before their admission to hospital—an illness of the magnitude of an operation, a physical trauma, or an entrance to a general hospital for treatment. Other stresses of various kinds were much more difficult to assess, and ultimately only those happenings which seemed immediately related in time to the onset of symptoms were considered. In only 3 of the 54 cases was a major real bereavement associated sharply with the onset of illness. Miscellaneous stresses, of the order of loss of work, disruption of home, severe marital disagreement, etc., and here including physical illnesses, were apparent at the onset of illness in 21 cases, including 10 depressions and 8 neuroses. The meaning of these findings is hazardous to estimate, because of the absence of any control series and because also of the possibility of incipient psychiatric illness influencing events.

As a final specific happening we considered either the actual occurrence of the physical menopause, or the clear appearance of such premonitory symptoms as menstrual irregularity or marked flushings, where these events were immediately linked in time with the onset of symptoms. This was the case

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in 17 of the 54 patients; 12 of them were depressed and 5 neurotic, a bias which is not significant. As has been mentioned earlier, most though not all psychiatric writers tend to discount the direct influence of the menopause on involutional illness. One wonders whether, in some cases, this factor has not been obscured by the relative chronicity of the case material before it came under observation.

The duration of the illness, before the patient was admitted to hospital, was measured. Of the 54 patients, 7 had been ill for less than three months, and 22 more for less than one year. Twenty of the 29 depressions were ill for under a year, and this contrasted significantly with the 20 neuroses, in only 4 of whom were symptoms of such short duration. ($\chi^2$ (Yates)=6·8: P< ·01.) The onset of depression therefore did not appear to be unduly insidious, as it is often said to be in this age range.

The last heading of the clinical findings relates to symptomatology. It must first be said boldly that the typical features of traditional or developed involutional melancholia were remarkable in this material only for their almost complete absence. Bizarre hypochondriasis, nihilistic delusions, great agitation, and so on, were confined to a handful of cases, and often occurred there only in isolation or for a very short period. Of the recorded items we can make the following comments.

A number of symptoms did not differentiate between our depressed and neurotic patients. For example, an emphasized complaint of exhaustion or fatigue occurred in 29 patients, without discrimination between the two groups. Apprehension and tension, not amounting to sustained fear or motor agitation, was likewise proportionately shared among a total of 33 patients. Loss of appetite, and/or loss of weight, were common (34 patients); loss of weight was more evident in the depressed (13 of 29) than the neurotic (6 of 20), but not significantly so. Hypochondriasis was divided into two grades. The lesser, which we called "repetitive hypochondriasis", included only complaints which were expressed in reasonably meaningful physical terms—as of headache, rheumatism, palpitation, etc. These, among 22 patients, were voiced by 12 depressions and 10 neuroses. Only 5 of the depressions, and no neuroses, achieved our second category of "psychotic hypochondriasis"—of any even mildly bizarre complaint. Thus the remaining 12 depressions expressed no hypochondriacal concerns at all. Obsessive-ruminative trends were seen in 3 depressions, and 3 neuroses. Simple insight did not materially differ in our groups; only 6 of the 54 patients (3 of these being schizophrenic) were utterly without realization that their illness might legitimately be regarded as psychiatric in nature.

Those symptoms which did seem to discriminate significantly between the two groups were limited to the constellation of pure depression, and to a lesser extent to secondary psychotic manifestations. Thus 52 of the 54 patients offered some complaint, however transient, of being depressed. However, a depression rated as acute, evident, sustained, and effectively unresponsive to the environment occurred in 20 of our depressive group, and in none of the neurotic. ($\chi^2$=20·5: P< ·001.) Only 7 of the 54 patients did not have some complaint of sleeplessness; but late insomnia, of the early morning type, was found in 20 depressions and only 3 neuroses ($\chi^2$=11·6: P< ·001). Diurnal variation of symptoms was recorded in 12 depressions, and in only 1 neurosis ($\chi^2$=6·2: P< ·02). Self-reproach of psychotic and unreal quality was found in only 7 depressions, but a lesser degree of what was called self-criticism in a further 11; only 4 neuroses were self-critical ($\chi^2$=6·8: P< ·01). Objective or subjective retardation of some extent was noted of 16 patients in the depressive group,

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and 4 in the neurotic ($\chi^2=4\cdot7$: $P<\cdot05$). Motor agitation, which was recorded even if only of small extent, was seen in 8 of the 29 depressions, and none of the neuroses. Of the occurrence of these two latter symptoms in the depressive group, we may therefore say that neither was agitation very frequent nor retardation unusual. Of secondary psychotic symptoms among the 29 depressions only 6 were positively deluded, and only 2 actively hallucinated; and clearly paranoid ideation was recorded only in 4. One neurotic patient claimed hallucinatory experience. Regarding the various descriptive assessments of ward attitudes, in respect of demanding behaviour, dissatisfaction, early and late contact with fellow-patients, etc., only in one respect was there an indication of difference between the groups. Two of the depressive patients were assessed as unduly dependent in their current behaviour, while 8 neurotics were so regarded.

Summarizing the symptomatology, therefore, we found that the 29 depressions among our 54 patients showed effectively only the primary signs of a psychotic depression, and rarely any of the stigmata which are or were ordinarily regarded as peculiarly typical of involutional melancholia. It was only in respect of these primary signs, which are regarded as non-specific for age, that their symptoms differed significantly from those of 20 patients suffering from neuroses.

## Discussion

The findings of the clinical side of the present investigation are essentially negative in a number of different ways. A simple survey of certain items in the past history of women undergoing their first major psychiatric illness in the involutional period failed to show any material peculiarities which might easily distinguish them from what we know or guess about normal women in these respects. Of the 54 women, 29 showed to our minds a picture of psychotic depression; but these depressions did not seem markedly distinct, symptomatically, from psychotic depressions appearing at other ages, and it was only as regards their purely depressive aspects that they differed from 20 neuroses in the group. Background data, and assumed precipitating factors, similarly did not discriminate between the two sub-groups.

The data we were considering were crude, and the question of any dynamic interplay of factors has not here received attention. However, it is in respect of such single descriptive items that involutional melancholia achieves its usual recognition. Analysis of the psychological test data (Orme, 1957) may indeed indicate that the women in this series were more than ordinarily concerned about certain psychodynamic constellations, but this dimension of preoccupation was not primarily related to whether or not they suffered from a depressive psychosis. If, for example, one arranges all these women in rank order of their typicality in respect of the test responses, those who were clinically specified as being depressed do not significantly cluster together on such a scale. We may therefore entertain the notion that there is a dimension of being psychiatrically ill during the involutional period, but that this may be separate from the dimension of being psychotically depressed. In more old-fashioned terms, any contribution of the involutional period to the clinical picture of depression may be accidental or at best pathoplastic, and the origin of the depression itself therefore remains just as autonomous as that of other endogenous psychoses.

For our small sample, then, we found that our depressions were not symptomatically of the classical "involutional" mould, and they were not

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aetiologically isolated from non-depressive illnesses appearing at the same biological period. Reasons for our negative findings require some consideration. It might be that our method of selection failed somehow to include a due proportion of serious or malignant illnesses; but the cases were consecutive, the mental state of the patients often alarming, and while our hospital receives a number of patients from outside its immediate region the reason for such referrals often is related to severity rather than otherwise of the particular syndrome. Nevertheless, it might be argued that an actively therapeutic hospital, with a high proportion of voluntary admissions, inevitably receives many early cases, where the traditional symptomatology might be embryonic, and where its further development is inhibited by treatment. This view of a modern attenuation of the picture of involutional melancholia may well be true. But inevitably its acceptance then raises the further question of what symptoms are essential, and what are to be regarded merely as secondary elaborations, or chance accretions in a chronically hospitalized patient.

The survival value of any descriptive syndrome may be a just criterion of its reality, and despite the historical vagaries of the concept of involutional melancholia it retains a place in current nomenclature. The question nevertheless arises whether involutional melancholia remains a useful working classification in clinical psychiatry, or whether the retention of the word "involutional" as a qualifying adjective of particular meaning for depressive psychoses does not obscure rather than clarify our thinking about affective illness. Such a question has been put often in the past, and all the present report claims is that perhaps today it may be asked more pointedly and urgently.

SUMMARY

1. The present status and something of the origins of the diagnostic concept of "involutional melancholia" are discussed. Reasons are advanced for believing the boundaries of this traditional syndrome to be more nebulous than those of other diagnostic groupings.

2. A clinical survey of 54 consecutive female first admissions, between the ages of 40 and 55, is reported. Analysis of historical and symptomatic observations shows a remarkable absence of traditional pictures. Internal comparison of those patients who suffered from a psychotic depression, and those who did not, betrayed no obvious differences between the groups, unless in regard to the ordinary primary symptoms of endogenous depression. The meaning of these findings is discussed.

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