PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

Endogenous Depression from the Standpoint of Understanding (Verstehen) Psychopathology

Tsutomu KUMAZAKI
Health Service Center, Tokyo University of Agriculture and Technology
Psychiatria et Neurologia Japonica 123: 801-806, 2021

Abstract

This article reappraises how depressive states are assessed from the standpoint of understanding (Verstehen) psychopathology. Even in current clinical practice, psychiatrists de facto attempt to understand patients' mood, and whether a depressive mood is understandable or not is still significant. There is a type of depressive state impervious to psychological understanding, which has been called endogenous depression. Endogenous depression cannot be understood to be a reaction to stressors; it does not necessarily manifest after life events, and it lacks a reasonable and meaningful connection with stressors. In addition, endogenous depression accompanies incomprehensible bodily feelings. In clinical practice, however, the relationship (or lack of one) between patients' situations and depressive symptoms is complex, and therefore careful attention should be paid to this issue in treating each patient. Later in the article, some ongoing problems with the comprehensibility/incomprehensibility of depressive symptoms are addressed.

Keywords: vital depression, grief reaction, genetic understanding, meaningful connection, psychopathology

Introduction

The terms "understanding" and "endogenous depression" in the title of this article may seem to belong to past psychiatry in the eyes of readers, and they might be skeptical about the relationship between understanding and endogenous depression. In this article, we first confirm that understanding (and incomprehensibility) continues to play important roles in the assessment and diagnosis of mood disorders. Then, I point out that endogenous depression has traditionally been viewed as an incomprehensible mood state, and discuss what it means to be incomprehensible. In the latter half of this article, I will further discuss what points need to be considered in contemporary clinical practice when attempting to grasp depressive symptoms based on comprehensibility (and incomprehensibility).

I. Incomprehensibility of Endogenous Depression

First of all, depression is not always easy to understand. The following fictional case was previously presented in a book chapter on another topic 6), but is presented here again because it is related to the theme of this article.

The case was a male patient in his 40s. He received a promotion about 6 months previously and was pleased that "all my efforts have been rewarded," and worked enthusiastically for some time thereafter. However, about 3 months ago, he began to have difficulty maintaining sleep, could not get up in the morning because he felt sluggish, and was often late for work. When he went to work, he would just look at papers and not get much work done. On weekends and holidays, he did not go out for fun as he used to do, and spent the entire day lying down. His wife, out of concern, booked a trip to a hot spring hotel for him, who usually loved to travel, but he was not pleased. Rather he stated, in tears, "Since I can't work properly, I have no right to go out and play". His wife was so surprised that she took him to a psychiatrist.

This is a common case with a common course of events and symptoms, but when we think about it again, a number of questions come to mind. What does it mean that he lost energy after getting the promotion he desired? What does it mean to feel physically ill with depressive symptoms? These issues are not matter of course, although it might seem so. In addition, what does it mean when a person who usually loves to travel does not look forward to doing so? It becomes clear that there are a number of unknowns regarding the depressive symptoms of this case.

Where does the incomprehensibility of the depressive symptoms in this case come from? First, there is no temporal or meaningful connection between the stressors and symptoms, making it difficult to consider them as normal psychological reactions. It is easy to understand that a person becomes depressed because of a bad event, and then becomes cheerful because of a good event. However, in this case, depressive symptoms occurred after the event that made the person happy. In addition, there was an interval between the change in environment and appearance of psychiatric symptoms. The symptoms could be considered to have occurred without a cause. In addition, as the fictional patient described above was too sluggish to get up, the depressive state caused not only subjective feelings of depression but also changes in bodily feelings. Moreover, many patients with depression complain of heaviness in the chest area, which is referred to by the term "vital sadness" 10).

In summary, in the depressive state, meaningful connections are lost among various mental phenomena, and neither the patients themselves nor psychiatrists who examine them know the reasons why they are in such a state. As tracing and understanding the reasons why a certain mental phenomenon happens is called "genetic understanding," 2) such a depressive state is genetically incomprehensible. Furthermore, it is often difficult to relive the same feelings as the patient with such depressive symptoms. (Note to the English version: Reliving each mental state is referred to as “static understanding” 2), in contrast to genetic understanding.)

To recapitulate, incomprehensible depressive symptoms are often characterized by the difficulty of reliving the same experiences as the patient and by the occurrence of phenomena that cannot be understood from meaningful connections between mental phenomena. Of these two aspects of understanding, meaningful connections are objective and shared by most people. 10) Therefore, it is possible to objectively grasp deviations from these connections to some extent. In order to grasp mental phenomena that are not understandable from the perspective of meaningful connections, it is necessary to search for factors that lie outside the framework of meaningful connections. As such a factor or cause, a biological abnormality is postulated, although this postulation is not definitive. It is important to note that the cause-consequence relationship and reasons understood as meaningful connections are conceptually different, even if there is some overlap. It is one thing to attribute an increase in human activity to a change in the amount of

neurotransmitters; it is quite another to wonder if something good has happened recently to a person who has become active after previously showing low spirits.

The characteristics of depressive symptoms described above are closely related to the choice of clinical treatment. It is difficult to psychotherapeutically resolve matters that are difficult for both the patient and therapist to understand and likely to be the result of biological abnormalities in the brain. Therefore, the treatment of depression with such characteristics requires biological treatment, such as pharmacotherapy or electroconvulsive therapy.

However, even though psychotherapy alone is not sufficient, it is necessary for the patient and psychiatrist to talk about treatment. If the psychiatrist simply says, "I understand how you experience", the patients may feel that they are not understood. This issue was pointed out by the German psychiatrist Schulte, W. 11).

II. Characteristics of Understandable Depressed Feelings and Coping Methods

The author would like to say a few words about how to cope with understandable depressed feelings. Such states are qualitatively indistinguishable from normal psychological reactions, and can be viewed as an extension of such reactions. In these cases, it is difficult to eliminate the sadness and depressed feelings with reason by medical treatment. Biological treatment may be considered as a measure for symptomatic relief, but it does not eliminate the reason for the sadness. As mentioned earlier, the biological condition and meaning of sadness belong to different realms. Not only biological treatments, but also psychological interventions are fraught with difficulties. There is the question of whether it is even possible to try to alleviate sadness and depression that are close to normal reactions. Overstating the possibility of resolving such distress may lead to further patient disappointment later. There is also the question of whether it is ethically appropriate to try to resolve distress that is close to a normal reaction. Normal sadness and depression can be considered parts of normal life, and trying to remove them because we do not want suffering may even distort the person's life 3)13). In such cases, it is important to explore coping methods rather than aiming to eliminate symptoms.

One of the aspects in which the distinction between endogenous and reactive depression is challenging is the issue surrounding loss or grief reactions. Loss reactions may be important in the

mental health response to the spread of Coronavirus disease 2019 (COVID-19). (Note to the English version: This article was presented orally in 2020 and published in 2021.) It has been pointed out that when a person dies from COVID, normal end-of-life care and funeral services are not possible. As a result, the psychological mourning process also becomes difficult for the survivors. Even when persons themselves and their close relatives are all safe and sound, everyone is likely to experience the loss of a part of their lifestyle that they have been accustomed to.

Shear, M.K.12) of Columbia University, an expert on grief reactions, clearly summarizes the difference between depression and grief reactions as follows: "Depression inhibits the capacity to experience positive emotions. Grief does not." 12) (p. 121) "Grief turns a person inward, but the desire to be with others and appreciation for the efforts of others is preserved." 12) (p. 121) In contrast, a depressive state inhibits this orientation toward others. "A grieving person maintains a sense of self-esteem and self-worth, whereas depressed people have lost faith in themselves." 12) (p. 124) Shear notes that even in the case of prolonged and complicated grief, these distinctions essentially hold.

While there is a great deal of research on treatments for grief reactions, the differentiation of symptoms also poses an important challenge. It is noteworthy that the differentiation between depression and psychological reactions, which is compatible with the tradition of psychopathology, remain in current, mainstream Western clinical practice.

III. Difficulties in Differentiating Depressive states

The distinction between incomprehensible and comprehensible depression, and the principles of their treatment, were discussed in previous sections. However, when treating real-life cases, it is necessary to consider more complex issues.

Earlier, the author mentioned that the characteristics of incomprehensible depressive symptoms are that there are little temporal or meaningful connections between the stressors and symptoms, making it difficult to consider them as normal psychological reactions, and that some symptoms are experienced physically. Since these two are different issues, it is possible that they sometimes diverge from each other. As shown in Table 1, there are four possible patterns 5). Two of the patterns are easy to grasp: the depressive state of endogenous depression takes a non-reactive course and is accompanied by physical complaints, such as the vital

sadness described above, and the depressive reaction as a feeling of psychological depression in response to some psychogenic factor. The problem involves the other two.

When mental experiences change non-reactively without reason, and when strong complaints involving the body emerge reactively, they do not satisfactorily fit the framework of dichotomizing endogenous and reactive. Many psychiatrists have discussed the endogenous-reactive boundary. Petrilowitsch, N. et al. 7)8) provided a literature review of various concepts of the endogenous-reactive boundary region discussed in West Germany after World War II, of which representative items are listed in Table 2 4). The “endo-reactive dysthymia” (Weitbrecht, H.J.) 14) and “depression in the psychic ground” (Schneider, K.) 9)10) are particularly important, but various other pathologies were also discussed. Table 2 is not an exhaustive list, and similar issues have been discussed in Japan as well.

Endo-reactive dysthymia was described by Weitbrecht 14) around 1952, and while it often develops against a background of psychogenic accumulation and is often accompanied by a depressive mood and autonomic and hypochondriacal symptoms, there is no deep remorse, which Weitbrecht called the primary guilt feeling. Therefore, Weitbrecht argued that endo-reactive dysthymia "is probably not related to the core group of cyclothymia" (p. 257) (Note to the English version: The term “cyclothymia” at that time meant manic-depressive or bipolar disorder), but "is undoubtedly a *disease* and not an abnormal psychological reaction." (p. 257) This led to various psychiatrists' studies on the endogenous-reactive boundary region, as shown in Table 2. It should be noted, however, that Weitbrecht himself was cautious: in "Open Problems of Affective Psychosis,"15) presented orally in 1952 and published in 1953, he argued that endo-reactive dysthymia was exclusively a descriptive concept, and while he was hopeful that endo-reactive dysthymia could be a disease entity, he reserved theories of etiology and hereditary constitution. Weitbrecht later became more cautious 16)18) and reiterated that endo-reactive dysthymia is a syndrome at the descriptive level, and not a concept in disease classification or disease entity.

In the end, Weitbrecht focused on the question of whether it was a "vitalized" depressive reaction or induced endogenous depression 17). The former describes a depressive reaction that is accompanied by physically experienced symptoms. The term "induced" in the latter means that an environmental event triggered the onset of endogenous

depression, but that the environment was not the cause of the endogenous depression. Weitbrecht makes the distinction that in the case of "vitalized" depressive reactions, the triggering experience remains as a theme, whereas in the case of induced endogenous depression, the original experiences gradually recede into the background and the illness takes its own course. If Weitbrecht is correct, then "vitalized" depressive reactions and induced endogenous depression can only be observed after continued follow-up. In actual clinical practice, however, differential diagnosis is difficult because treatment and intervention are necessary even in the middle of the course of a patient's illness.

Even in cases in which the patient once clearly entered a depressive phase and is recovering, it is often difficult to determine whether the depressive phase is still ongoing or the patient is psychologically reacting to events around them. Let us look again at the later progress of the model case 6).

The attending psychiatrist confirmed insomnia, psychomotor inhibition, and decreased appetite, and prescribed drug therapy and home rest. Sleep and appetite were soon restored, and he was able to relax at home. After about a month and a half, he met with his supervisor to discuss his return to work. However, after the meeting with his supervisor, he said, "When I went to the workplace, I was so nervous that I couldn't say anything, and after that I couldn't sleep again. I think I am bothering the colleagues by taking time off, and I think they don't like me". The patient's recuperation period was extended by another month and a half, and his medication was fine-tuned. When he calmed down a little, he practiced going to the library near his workplace. At first, the patient complained of fatigue, but it subsided after a while, and he returned to work.

In this model case, the patient's anxiety and nervousness before returning to work and his mixed feelings of remorse and victimization were treated with pharmacotherapy. However, there may be other similar cases in which specific identification of the workplace environment and environmental adjustment may be necessary. It is necessary to switch the case formulation if something feels wrong on interacting with the patient; even if the case formulation is not actually changed, a flexible attitude open to the possibility of an alternative case formulation is important.

Concluding remarks

Finally, the author would like to point out a few unresolved open issues

surrounding the current state of depression.

The patterns of human behavior and relationships among thoughts, feelings, and will behind them seem to be changing as technology advances and the environment surrounding human beings changes. This may seem obvious, but it could have a definitive effect on a very fundamental aspect of the diagnosis of depressive states. For example, one or two decades ago, the possibility of endogenous depression was judged to be quite low if the patient was able to engage in hobbies. How about now? In an age when video clips are played automatically and endlessly as long as the patient sits in front of a screen, even if the patient is able to watch video clips, it is necessary to consider the possibility of depression if the patient is just passively sitting in front of a screen.

The author would also like to say a few words about depression in young people. Since the author moved to a university health administration department, he has had more opportunities to meet students around the age of 20, and he has come to realize that even though the psychological reactivity of these students seems to be maintained, there are often cases in which maladjustment to life due to modulation of affect is noticeable in the case of clients at this age. It has already been pointed out that young people are biologically different from adults in their emotional functioning 1), and the relationship between emotions and mood (and mood disorders) should be considered differently from that of adults. Furthermore, during the period of emotional change and development, they are exposed to an environment that humans are experiencing for the first time, as described above. What effects this will have are as yet unpredictable, and this is an important issue for our time.

The authors have no conflicts of interest to disclose in connection with this paper.

References

1) Gruber, J.: Human emotion 15.2: Emotion development II (Adolescence). 2013 (http://www.gruberpeplab.com/teaching/psych131_summer2013/) (accessed 2021-01-03)

2) Jaspers, K.: Allgemeine Psychopathologie: Ein Leitfaden für Studierende, Ärzte und Psychologen. Springer, Berlin, 1913

3) Kato, S.: [Mourning work and 'normal depression' in contemporal society]. Jpn J Clin Psychiat, 37 (9); 1139-1144,

2008
4) Kumazaki, T., Ohmae, S.: [Exhaustive depression (*Erschöpfungsdepressionen*) revisited: Classifications of depressive states in the mid-twentieth century]. Jpn J Hist Psychiat, 15 (1, 2); 105-112, 2011
5) Kumazaki, T., Ohmae, S., Matsunami, K.: [Incomprehensibility in the diagnosis of depressive states]. Jpn J Psychopathol, 34 (2); 161-170, 2013
6) Kumazaki, T.: [Understanding patients' psychopathological states]. [Psychiatric Symptomatology: How to Grasp and Understand the Forms of the Human Psyche] (eds. Utsumi, T., Kanemoto, K.), p.54-64, Igaku Shoin, Tokyo, 2021
7) Petrilowitsch, N.: Zyklothymie. Endogene Psychosen von depressivem und manischem Typ. Fortschr Neurol Psychiatr Grenzgeb, 32; 561-624, 1964
8) Petrilowitsch, N., Baer, R.: Zyklothymie (1964-1969). Fortschr Neurol Psychiatr Grenzgeb, 38 (12); 601-692, 1970
9) Schneider, K.: Die Untergrunddepression. Fortschr Neurol Psychiatr Grenzgeb, 17; 429-434, 1949
10) Schneider, K.: Clinical psychopathology [Hamiltion MW Trans.]. Grune & Stratton, New York, 1959
11) Schulte, W.: Psychotherapeutische Bemühungen bei der Melancholie. Studien zur heutigen Psychotherapie. Quelle & Meyer, Heidelberg, p.52-67, 1964
12) Shear, M. K.: Grief and mourning gone awry: pathway and course of complicated grief. Dialogues Clin Neurosci, 14 (2); 119-128, 2012
13) Suzuki, K.: [Denotation of the concept"depression": in its relationship to normal depressiveness and normal fatigue]. Jpn J Clin Psychiat, 37 (9); 1163-1165, 2008
14) Weitbrecht, H. J.: Zur Typologie depressiver Psychosen. Fortschr Neurol Psychiatr Grenzgeb, 20; 247-267, 1952
15) Weitbrecht, H. J.: Offene Probleme bei affektiven Psychosen. Nervenarzt, 24 (5); 187-191, 1953
16) Weitbrecht, H. J.: Aus dem Vorfeld endogener Psychosen: Klinische Beobachtungen zur Frage der "Auslösung". Nervenarzt, 35 (12); 521-529, 1964
17) Weitbrecht, H. J.: Die chronische Depression. Wien Z Nervenheilk Grenzgeb, 24 (4); 265-281, 1967
18) Weitbrecht, H. J.: Depressive und manische endogene Psychosen. Psychiatrie der Gegenwart, II/1, 2nd ed., (eds. Kisker, K. P., Meyer, J. E., et al.), p. 83-140, Springer, Berlin, 1972

Table1 Differentiation of depressions by descriptive features

(Modified from Kumazaki, Ohmae, Matsunami[5])

	Somatic complaints	Mental distress
Non-reactive course	Endogenous depression (with vital sadness)	?
Reactive course	?	Depressive reaction

Table 2 Concepts of the Endogenous-Reactive Boundary Region

(Modified from Kumazaki, Ohmae[4], which is based on Petrilowitsch et al.[7][8])

Endo-reactive dysthymia (Weitbrecht)

Depression in the psychic ground (Schneider, K.)

Uprooted depression (Bürger-Prinz)

Exhaustive depression (Kielholz)

Vital depression (Petrilowitsch)

Vegetative depression (Lemke)

Endogenous juvenile asthenic insufficiency syndrome (Huber, Glatzel)

Anankastic depression (Lauter)

Depersonalized depression (Petrilowitsch)