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EDITORIAL

The Evolutionary Value of Tolerance of Depression in Modern Life

The term depression is getting to be more and more mutilated through the abuse of psychiatrists. Instead of stimulating empathy, sympathy, care, and responsibility it has become a conditioned stimulus to swallowing tofranil, ludiomil, tryptizol, parnate etc... As much as the homosapiens is especially characterized by symbolic thinking, language, awareness, and free choice he is particularly characterized by depression.

The psychiatrist, as well as the layman, has to revise the real meaning of the word before submitting to the creeping invasion of psychiatric terminology on human emotions. This warning should not be taken as an antipsychiatric cry or an attitude of nihilism towards drug therapy; on the contrary, it should stimulate thinking in other terms that are more representative of pathology, with the aim of manipulating ourselves and our patients in a better way.

Any clinical artist is familar with many types of depression other than those forced upon his mind through the current shortcomings of scientific language. Any honest reviewer of drug research on depression will find himself lacking an essential dimension in what is written on the "pills of happiness", and how the resolution of this human tragedy is established through mysterious orange, yellow, or red tablets administered t.d.s. This lacking dimension is not simply the poetic touch of the misery of our life but is mostly the profound biological meaning of depression. In the DMP I (The Egyptian Manual of Psychiatric Disorders, 1975), there are 11 types of depression including depressive personality and reactive neurotic and psychotic types. In the DSM II there are 7 types, in the ICD 8 there are 8 and in the DSM III there are 9 types (other than reduplications on various axes). All such types are mainly descriptive with little or no reference to meaning, function, goal, value, or corresponding management.

For a drug research to be fair and valid, it is not sufficient to employ a double blind procedure (as if it is possible to do it), or to declare a title for the syndrome under investigation, but a complete description of the specific dimension tackled is essential as much as there is a need for clarifying the other possibly active variables with a healing potential. Any approach is essentially holistic and drug administration is but one factor in its operation.

Arieti (1974) believes that by being unpleasant, depression seems to have a function in its own elimination. Like pain, depression stimulates a change in order to be removed but it is a psychological change, and ideational change, a rearrangement of thought and clusters of thought. Eventually the actions of the individual will change, too, as a sequel of this cognitive rearrangement. According to Arieti (1974), "depression is the evolutionary outcome at a human symbolic interpersonal level of biologic nociceptive pain". This extremely condensed orientation should be thoroughly analyzed with special accent put on the words 'symbolic', 'interpersonal' and 'biologic'. On the other hand Zewar (1975), states that "...we can say that what characterizes depression is the deterioration of the ability to 'become', which results in decrease in the sense of existence i.e. in the sense of 'being' ". Early in my hypothesis on Levels of Mental Health (Rakhawy, 1972); I suggested that one of the outcomes of evolutionary crises is characterized by depression which is naturally motivating for the individual's own growth. Later on (Rakhawy, 1978) I started to avoid the term depression for describing such positive feelings met with, for example, during and after a psychotherapeutic impasse in group therapy. To quote the statement "...I am inclined not to label such feelings associated with this confrontation as depression, I prefer to name them 'psychic pain', since depression has become a symbol of a specific symptom or syndrome that was too much malused, while psychic pain (which I mean) is characterized by: a) It evolves through a certain degree of awareness and free choice. b) It is devoid of guilt feelings. c) The individual who suffers its impact is striving with his 'ambivalence' and is trying to replace it by the stage of 'tolerance of ambiguity'.

continuum. Rakhawy et al. (1978) have considered depression as an advantageous step, rather than a side-effect during reorganization of the schizophrenic disorganization. In a trial with perphenazine enanthate in the schizophrenic phases described by object relational theorists (Guntrip, 1965). We recommended that it would be better not to be hasty in interfering with such emotions, since they may resolve into natural therapeutic improvement as a step towards recovery.

Based on my clinical experience, I am going to present a tentative typology of depression with various psychostructural organizations corresponding to different biological and neurological associations. These types have, ipso facto, different responses to drug therapy, as well as different therapeutic approaches.

1. Defensive neurotic depression :

This type is simply an exaggerated defence mechanism serving to avoid and alleviate intolerable anxiety. In so doing it is just like dissociation, displacement or any other neurotic defence. The underlying psychopathological rationale is that : actualizing frustration on a fantastic level is better than expecting it vaguely all the time*. This type should not be mixed with reactive depression which is an exaggerated response to depressing environmental stimuli, nor with mild non-psychotic periodical depression which is biologically determined and harmonious with dialectic pulsations. This type could only be altered by considering the underlying anxiety and manipulating it both biologically and psychologically. Drug-wise, the drug of choice, then, is a MAOI (in my experience, tranylcypromine) or even any anxiolytic agent, cutting down the autonomic-psychic vicious circle.

(*) في المثل العامي المصري « وقوع البلا ولا انتظاره »
وفي الشعر العربي :

أيتها النفس أجملي جزعا ان الذى تحـــذرين قد وقعا

2. Rationalizing nihilistic depression :

This type is characterized by a serene despair. It is equivalent to the schizoid existence where psychic equilibrium is maintained by the delusion of hopelessness. In such a way it rationalizes a sarcastic nihilistic attitude. Management of such depression is rather dangerous if it really succeeds in shaking the underlying delusion. Not infrequently suicide occurs when hope becomes that near or realistic. This type is sluggish in response to drug therapy if the patient ever accepts to take the chance of therapy at all.

3. Guilty stagnant depression :

Here, life is brought to a standstill through tightening the ties to an overvalued, usually imagined sin. The self-reproach and guilty ruminations serve to arrest the naturally evoluting process. The result is stagnation, self-centered existence and a closed circuit pseudolife. Breaking this circle by tricyclic antidepressants, and/or psychotherapy, may liberate the entangled energy in this stagnant existence. Thus the dose of therapeutic interference, including ECT should be appropriately adjusted.

4. Character trait habituated depression :

In this type depression becomes so fixed that it forms part of the strutcure of the personality itself. It looses its sharpness and becomes stereotyped. It is usually a late phenomenon since it results from both habituation and intellectualization of depression so much so that it becomes less and less genuine and very difficult to manage. It is expected after intensive interference in a group or a milieu which is not available for most, if not all, such cases.

5. Nagging paranoidic depression :

If the second type is equated with the schizoid compromise, this type is to be equated with schizophrenic existence or what has been

recently called in the DSM III (1978) schizotypal personality. The individual is characterized by being sticky, nagging, clinging and ever complaining of his claimed depression. The management of such type should be taken as serious and deep as management of chronic schizophrenia considering the acted out infantile dependency all the time. Intensive phenothiazine, milieu mangement and early-prolonged rehabilitation are essential.

The categorization of such syndrome with its various grades under depressive illness may explain the occasional favourable response of some depressives to phenothiazines.

6. Periodical biologic depression:

The term biologic does not signify that other types are not biological but it only stresses that this type is related basically to biological pulsation (Rakhawy, 1978). It could be met with in a non-psychotic or psychotic intensity if the systole it presents is not well tolerated and utilized in the synthetic growth as will be soon mentioned. Alleviating this type, when pathologically presenting, is mainly by physical (ECT) or biochemical (tricyclic drugs) measures. However it is the type that should be tolerated as much as possible since, if well directed, it could turn to the next type which is the core of this article.

7. Confrontation dialectic depression:

This is the same type which I previously labelled as 'psychic pain' (Rakhawy 1978), and Arieti (1974) called it "the evolutionary outcome at human symbolic interpersonal level... etc". It is the natural result of confronting the dichotomy of our existence and at the same time the ambiguity of our world. The result of such confrontation is utilizing the biological systole in a dialectic synthesis permitting expansion of awareness which corresponds to extension of neuronal associative ability. The latter may again correspond to lengthening and organizing the coherent memory chains (perhaps on an intracellular level through higher orga-

nization of macromolecules). The result of this process is more and more stepping along the evolutionary scale along with more and more pain. It is definitely regretful to mix such experience with the above mentioned types of depression, so much so that whenever available it is instantaneously eliminated, if possible, by the available chemical or physical measures. However, this problem could not be safely solved by considering such confrontation type as a normal depression that should not be liable to mishandling by psysiatrists. First, the associated pain and the loneliness resulting from increased awareness is frequently beyond the individual's tolerance. Second, the chocking psychiatric propaganda does not permit anyone to tolerate such essential pain long enough to permit unfolding. The steady diminution of manic depressive illness (Cohen, 1975) with both its disasterous and possible positive aspects, is relevant to this point.

Conclusion : We may assume that depression, in general, needs to be understood and rechanelled rather than feared and eliminated, and more recently, in the lithium era may be prevented. In proper therapy, it is searched for and reactivated in the proper context. For instance dialetic group therapy advocated by the author is said to be "...growth oriented, deliberately reactivating the malorganized personality compromize into a dialectic synthetic confrontation." Sleep deprivation therapy, in its proper application (Mahfouz **et al.,** 1978) tried to integrate this depression in a lengthy plan of growth therapy in a special milieu. Physical therapy, if properly applied, should aim at helping to tolerate such experience rather than to eliminate it.

If the human species is going to persist, it has no choice but to continue its evolution against all resistance forced upon it, not only by external dangers and natural calamities, but also by the products of its own mind. Abuse of chemicals and mishandling of human experiences even under scientific claims are among such dangerous products.

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