Psychiatria Danubina, 2009; Vol. 21, Suppl. 1, pp 88–92 *Conference paper*

THREE DIFFERENT MEANINGS OF DEPRESSION IN SCHIZOPHRENIA
A phenomenological perspective

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SUMMARY

In this theoretical paper with a clinical focus, three different meanings of depression in schizophrenia spectrum patients – depression as a reaction to schizophrenia, as an integral part of it, and as an independent disorder – are exposed and discussed from a phenomenological point of view. A well-reflected schizophrenia patient is briefly introduced in order to illustrate the clinical relevance of the aforementioned distinctions. The clinical relevance of thorough phenomenological and hermeneutical analysis of patients' experiences ranges from diagnostic to psychotherapeutic implications.

Key words: *schizophrenia – depression*

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Introduction

Depression is reported to be one of the most frequent coexisting mental disorders with schizophrenia from the prodromal and acute to the chronic phases of the illness, ranging from 25 to 80% and even more (Knights 1981, Wassink 1999, an der Heiden 2000, Bechdolf 2002). It is one of the most serious syndromes of schizophrenia, frequently closely connected to suicidal behavior (Roy 1983, Barnes 1989). The epidemiological findings vary extensively, reflecting ambiguities in defining and measuring depression in schizophrenia patients (Hirsch 1989, Maggini 2006).

Phenomenological analyses of these ambiguities do not provide any easy answers to the problem – they even raise many additional questions – but they represent a *sine qua non* for the advancement of diagnostic and psychotherapeutic strategies. Namely, if we do not know what exactly to measure when performing quantitative analyses of depression in schizophrenia and what the findings are, we are not contributing to the transparency of our clinical procedures. We might even be additionally blurring them, at the expense of our patients and the competence of psychopathology.

Phenomenology enables a detailed study of patients' experiences and represents an independent discipline in the study of mental disorders. In the view of the present author and many distinguished psychopathologists throughout the history of psychopathology, phenomenology is an indispensable approach for understanding and explaining mental disorders. All other methods and models in the study of such disorders should actually strive for a mutually enriching dialogue with phenomenology, since it is a systematic exploration of what patients experience when suffering from a specific mental disorder. In psychiatric literature we find different meanings under the heading of phenomenology. There are three prevailing ones: 1) in mainstream psychiatry; 2) in Jaspers; and 3) in Husserl and the following continental phenomenological tradition. Using the metaphor of a house, we can describe them in the following manner. In mainstream psychiatry, phenomenology means an outer description of the house and of the objects the patient brings out of it. In Jaspers it means to be invited into the house and to try to empathically experience how a patient lives in it, with some rooms closed with a label "incomprehensible" on the door. In Husserl and his followers it means to spend a longer time with the patient in his house, entering all the rooms and actively searching for how to understand life in it. For less metaphorical explanations of the differentiations within phenomenological traditions, see Spiegelberg, 1972; Blankenburg, 1991; and Parnas & Sass, 2008.

Let us now try with the help of the third, i.e. the Husserlian phenomenological approach, to address some of the problems of depression in schizophrenia.

Paper presented at ISPS Slovenia, Bled ,September 2007

Three different meanings of depression in schizophrenia

When schizophrenia patients are asked what they suffer most from, they usually say solitude and the inability to interact with other people, feeling simultaneously inferior to and different from them, and the inability to achieve their life goals. There is a long history of detailed descriptions of difficulties of schizophrenia patients in interacting with the world of other people. These have been conceptualized as a *loss of vital contact with reality* with autistic traits (Minkowski 1927, Binswanger 1956), *collapse of common sense* (Blankenburg 1971), problem of mutuality and meeting others (von Baeyer 1955, Storch 1959, Kimura 1975) and self-disorder with a changed grip on the world along with perplexity (Störring 1987, Sass 2007). These experiences were also found to lie at the bottom of despair, hopelessness and suicidality in these patients (Škodlar 2008). Despair and hopelessness with suicidality, lack of perspective with the consequential lack of initiative and motivation, and social withdrawal represent the main body of what we understand as depression. Patients reporting these symptoms are so diagnosed almost without question. We can thus appropriate the first meaning of depression in schizophrenia as the phenomenological consequence or reaction to difficulties caused by the underlying process of schizophrenia. Patients react depressively to the fact that they have schizophrenia and to all its consequences. Some authors called this facet of depression in schizophrenia "chronic demoralization" (Bartels 1988).

The second problem of depression in schizophrenia is to what extent it can be an integral constituent part of it. We can also phrase this problem in other words: could the label *depression* be a kind of "metaphor" for expressing certain inherent aspects of schizophrenia? Disturbance of will and motivation have since Kraepelin (1913) been reported to constitute an essential part of schizophrenia. Bleuler (1911) considered affective symptoms, including apathy and indifference, among the central symptoms of schizophrenia. Patients experience passivity (most delusional and hallucinatory experiences can be seen as an extrapolation of passivity phenomena) and lack of initiative, of plans and goals. Nothing really matters to them, and with that they lack essential organizing principles for experiencing themselves in the present (attention deficits, context-processing disturbances and self-disorder), the past (memory disorders) and the future (lack of future-directedness). Their whole field of experiencing is narrowed down. Many patients' experiences thus do not only resemble depression, but are essentially depression-like (Bartels 1988). It is a well-known clinical and research dilemma – how to discern between depressive and negative symptoms. Quite a few authors claim there is a considerable overlap between them (Barnes 1989). There is another very important factor to it as well. Our patients and psychopathology lack both the concepts and the vocabulary to describe these experiences. So patients as well as clinicians not uncommonly take refuge in a cliché type of description, depression being one of the most widely used. So we can understand *depression* also as a metaphor for other experiences resistant to linguistic expression. All these phenomena together with the difficulties of verbalization have been extensively described within the phenomenological literature. Many of them are summarized in a recent comprehensive conceptualization of schizophrenia as a self-disorder by Parnas and Sass (2003).

The third perspective of depression within the schizophrenia spectrum is its delimitation as a separate disorder. If we apply phenomenological studies of both disorders, what we could call "differential phenomenology", we can see striking differences between the two disorders (Stanghellini 2000). In many ways depression and schizophrenia are, phenomenologically speaking, antithetical. These distinctions date back to the early 1920s, to the analyses of two exceptional psychopathologists: Eugen Bleuler's discernment between schizoid and syntonic individuals, and Ernst Kretschmer's between schizothymic and cyclothymic temperaments. Patients with depression are excessively centralized and imprisoned in their bodies and their past; meanwhile schizophrenia patients are eccentric, disembodied and alienated to the world. Patients with depression tend to be hyper-identified with their social roles and moral judgments (hyper-normal), while patients with schizophrenia are outsiders and lack social roles. The former face more guilt feelings and have ethical delusions, while the latter face constant analyzing and have ontological or epistemological delusions (Stanghellini 2004, Parnas 2004). Blankenburg, a leading German psychopathologist, wrote that the patient with depression retains the feeling of what he lacks; meanwhile in schizophrenia, precisely this particular feeling – a

"measuring stick" – is also changed (Blankenburg, 1987). In a phenomenological study of depressive versus prodromal schizophrenia patients, similar findings were reported: "Depressive patients report a quantitative decline in energy, mental intensity, and the ability to think efficiently; meanwhile prodromal schizophrenics typically report a qualitative alteration of thought and perception that is far more difficult to describe" (Cutting 1989). McGlashan (1982) writes about a syndrome of pseudo-depression in chronic schizophrenia, which is discernable from true post-psychotic depression on the same grounds. While the latter is characterized by feelings of sadness, guilt, hopelessness and helplessness, the former is very different – pervaded by motivational inertia, interpersonal isolation, anhedonia and feelings of emptiness or blankness.

Clinical case

A 23-year old student diagnosed with schizophrenia according to ICD-10 and DSM-IV was at the time of reporting hospitalized for the second time due to an explicitly delusional psychotic episode. He felt persecuted and believed all the people he knew were endangered by him. He wandered the streets of Ljubljana and felt completely lost, as he reported later, "in a story (he) built upon sadness and anxiety". His first hospitalization took place at the age of 19, when he was diagnosed with severe depression with psychotic features, following more than six months of depressive mood, loss of energy and motivation, sleeplessness and social withdrawal. He had experienced minor depressive states with anxiety since the age of 12. He described his experiences at the time of this first hospitalization in the following way: "I felt dark, as if I had fallen into another world, into a black hole far from all people. It was a horrible world, where I didn't feel any contact whatsoever with other people. I was completely without any grounds or orientation. I didn't know who I was or who my parents were, nothing." After the first hospitalization he returned to his "usual state": inactivity, amotivation and social isolation. He was explicitly suicidal at both hospitalizations, but also several times before them. At the time of the first hospitalization, he reported being suicidal because he felt so different and far from others and unable to interact with them. At the time of the second hospitalization he wanted to commit suicide in order to accomplish at least one courageous act in his life, feeling that so far he had not accomplished a single one. At other times outside the acute symptoms he was suicidal because he felt incompetent to live a decent life, to study, to found a family and so on. When looking back on both phases of his illness, he said: "Before I had certain other aspects of emotions. There was much more pain, but maybe there were some healthy parts too. I lost my pain, but I'm afraid that with the pain I lost also something healthy. I don't feel pain anymore, but maybe I'm not the same person any longer."

Discussion

How to reconcile these three seemingly contradictory views of depression in schizophrenia? They may be in fact coexisting and complementary. Clinicians don't have problems understanding all three meanings of depression when they are displayed within their contexts. They can well understand patients' depressive reactions to many experiential obstacles and consequences caused by schizophrenia. They also understand the complexities of the "negative" syndrome of schizophrenia, where depressive and psychotic symptoms can be almost inseparably intertwined. Finally they know about differences, in many instances antithetical, between the experience of depression and symptoms of schizophrenia. The problem arises when they try to decontextualize depression and schizophrenia and treat them as readily definable independent clinical entities. This consideration is far from trivial, because precisely such decontextualizations and quasi-objectifications are systematically at play in modern "operationalized" classificatory systems of mental disorders. It is beyond the scope of this article to tackle the complex interplay of reliability and validity, or form and structure issues in the study of mental phenomena, e.g. in schizophrenia (Andreasen & Flaum, 1991; Maj, 1998; Bell et al., 2006; Parnas et al., 2008). I would like to stress the clinical importance of studying manifestations of depression in schizophrenia within their natural contexts in order to identify and treat the relevant aspects of it.

As we could see in the patient presented above, he clearly displayed symptoms of both depression and schizophrenia. They appeared not only independently, but on several occasions, as depicted above, also simultaneously. At the time before the first hospitalization he was depressed in the stricter sense of the word, with heavy and painful emotions, loss of energy, motivation and

perspective; this was antithetical to the explicit psychosis a few years afterwards. At the peak of that depression, at the time of the first hospitalization, the depression and psychosis assumed an intrinsically intertwined status of lost grounding, identity and relations to the world of others. The periods before the hospitalizations, marked by a lack of motivation, social drive and active engagement in the world, and with an insight into devastating consequences, were expressive of a reactive type of depression. In the same vein, we can also interpret his three suicidal motivations: as depressive in the intrinsic sense (feeling different, far from and inferior to others); psychotic as antithetical to depressive (when he was trying to accomplish a courageous act); and as reactive to the deficits caused by the illness.

Conclusion

When we try to define depression in schizophrenia patients, we inevitably run into troubles and are torn between the possible options: depression as a reaction, an integral part or an independent, antithetical disorder. We need to employ our clinical ear for the context and essential characteristics of different disorders in analyzing patients' experiences in order to break through to an accurate determination of the depression within their clinical picture. Such a process has important diagnostic, therapeutic and preventative implications.

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