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Existenial Approaches to Depression

Depressive Disorders

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> If you wish to understand a philosopher, do not ask what he says, but find out what he wants.
>
> Nietzsche

Named in the aftermath of the First World War, modern existentialism became influential after the Second. In its responses to questions about the significance of human life and our responsibility to ourselves, each other, and nature, it has informed our understanding of psychopathology in general and depression in particular.

This chapter on existential approaches to depression develops along the following line. First an introduction to existential thought is presented, emphasizing thematic material. Next, a section on depression briefly overviews issues of diagnosis and etiology. Finally, contributions made by the existential orientation to the primary, secondary, and tertiary prevention of depressions are described. Throughout the chapter, content not directly related to existentialism or its approach to depression, yet deemed relevant to its argument, is touched upon.

In 1929 Fritz Heinemann's book *Geist/Leben/Existenz: Eine Einfuhrung*

in die Philosophic der Gegenwart (New Paths in Philosophy: Spirit/Life/Existence: An Introduction in Contemporary Philosophy) (Kaufmann, 1972) gave the word *existentialism* its current sense and piqued academic and public interest in the work of those philosophers he labeled "existential." However, it was not until the publication of Sartre's essay "*L'etre et le Ne'ant: Essai d'Ontologie Phenomenologique"* ("Being and Nothingness") in 1943 that existentialism became *le dernier cri* (Kaufmann, 1972). Overnight, existentialism became a topic of daily conversation and disputation in Paris (Reinhardt, 1960).

Undoubtedly the dynamics contributing to existentialism's ascension at that time were complex. This much is quite clear: the world was in crisis. France, along with most of Europe and large parts of Asia, was under the boot. The state, the capital city, the church, the university, and the family—the fundamental instrumentalities of western civilization—were either subverted by or in collaboration with Fascist savagery. A regrounding, especially a new moral foundation, was necessary. Camus, Sartre, and others set out to provide just that foundation.

Even though existentialism flourished in the twentieth century, its aggregate of intuitions, notions, and affirmations traced roots to pre-Socratic (e.g., Heraclitus) and Aristotelian thought. After lying dormant for centuries, existential concepts burst into consciousness as a result of Kierkegaard's

soul-wrenching struggles in the early nineteenth century. They grew in strength, largely through the efforts of Nietzsche, as that century progressed; they attained maturity in the twentieth century with the writings of Heidegger and Sartre (Kaufmann, 1972; Reinhardt, 1960).

BASIC TENETS

The belief that "Philosophy should begin neither with axioms nor with sense impressions, but with experiences which involve the whole inpidual" (Kaufmann, 1972, p. 76) is common to those considered existentialists. All existentialists accept the phenomenological method as basic and valid (Misiak & Sexton, 1973). When applied to human consciousness, this method has as its goal the simple, unprejudiced observation and description of the phenomenon experienced. Husserl, considered the founder of modern phenomenology, was Heidegger's teacher and Husserl's studies informed the work of Sartre and Merleau-Ponty. Husserl envisioned phenomenology as the methodology through which a clear comprehension of the essential (universal, absolute, unchanging) nature of reality could be discovered.

> For Husserl, reality is comprised of a rich variety of forms of being, including the essences of mathematical being, logical being, animal being, and so on, alongside with natural being.

(Jennings, 1986, p. 1234)

Of these forms of being, human consciousness, Husserl argued, had "ontological priority."

> On the one hand, human beings are part of nature by virtue of their physical bodies. On the other hand, the world "exists" owing to human consciousness, which can behold and study that world.

(Jennings, 1986, p. 1234)

His investigations convinced him that the quintessential property of consciousness is intentionality. The development of existential thought, from Husserl through Sartre, then followed the active tradition of Leibnitz and rejected the reactivity of Locke.

> The Lockean tradition, in brief, holds that man's mind by nature is *tabula rasa* (environmentalist learning); mind does what it is made to do (a leaning toward reactivity and behavioristics); its components are basically discrete (simple ideas), and its organization therefore a matter of cementing bonds (associationism). While not all of these doctrines are fully developed by Locke himself, his particular brand of empiricism paved the way directly for Hume, Hamilton, Mill, and later for objectivism. Darwin gave the tradition a functional turn, and borrowing from Freud gave it depth. ... To Leibnitz, as to Kant, the intellect was perpetually self-active (not merely reactive). When Locke said *nihil est in intellectu quod non fuerit in sensu,* Leibnitz gave his famous retort . . . *excipe: nisi ipse intellectus.* To him, the inner and spontaneous workings of the mind were at least as important as its contents or productions. His concept of the self-active monad easily became the "person" who with his entelechtive strivings pursued a unique destiny.

(Allport, 1957, p. 7)

For Husserl,

> The crucial point is that when consciousness is "seen" as it immediately presents itself, we find a bodily felt aura of implicitly meaningful felt experiencing—not explicit words, concepts, or experiences. . . . Within a given moment, this inwardly sensed experiential datum might encompass, say, a sense of inferiority, a history of paternal domination, a revengeful fantasy, a wish for autonomy, and many other meanings. However, it is the bodily sensed experiential aura that is *immediately* experienced in awareness rather than any one of these potentially conceptualized experiences. . . . [It] is the quality of implicitly meaningful "felt

> experiencing" that is essential: This characteristic of consciousness, like intentionality, is an essence that is eternally the same for persons in all cultures and historical ages.

(Jennings, 1986, p. 1239)

Consequences follow from the decision to adopt the phenomenological method and the acceptance of the inpidual as an active, intentional being. Unlike a tree, which exists in itself (*en-soi*), Sartre asserted, man exists for himself *(pour-soi).* Central to existence *pour-soi* is decision, including the possibility of denying the potential of a human being by transforming it into an existence *en-soi.*

> The thinker who can in all his thinking forget also to think that he is an existing inpidual will never explain life. He merely will attempt to cease to be a human being in order to become a book or an objective something which is possible only for "a Munchhausen."

(Kierkegaard, 1941, p. 317)

"Man is nothing else but what he makes of himself. That is the first principle of existentialism" (Sartre, 1945, p. 29). It is through choice that inpiduals realize their unique existence: *Eligo, ergo sum',* I choose, therefore I am. Marcel described man as a *homo viator*—never at a goal, always on the way (Reinhardt, 1960). Magee (1982) chose a quotation from Matthew Arnold to reflect the same perspective: "We are between two worlds, one dead, the other powerless to be."

Choice inheres in *pour-soi.* However, what may be chosen at any

moment is constrained by an inpidual's situation. By no means does existentialism intend to deny the laws of genetics or suggest we can do absolutely that of which we dream except in dreams.

When Sartre argued that man's essence is his existence, Buytendijk (1957, pp. 208-209) elaborated:

> Existential psychology emphasizes the analysis of the meaning of situations in which the inpidual constantly finds himself involved. Situations of this sort are formed not only by natural and social relationships, but also the body and its biological constitution. ... We may be guided by Merleau-Ponty's observations: *"Le corps n'est pas une chose, il est une situation "* (The body is not a fact, it is a situation), but we will have to add that the body itself is a fact, a structure of facts. . . . The study of facts is "natural science"; the study of the meaning of facts in the context of human existence is psychology.

Not only must the physical and social world be considered, but the inpidual's past carries a substantial, though not decisive weight, in regard to the possibilities of the future and decisions of the present. Even the contributions of behavioral psychology must be considered.

> The existentialist emphasis in psychology does not, therefore, deny the validity of conditioning, the formulation of drives, the study of discrete mechanisms, and so on. It only holds that we can never explain or understand any *living* human being on that basis.

(May, 1969, p. 14)

The manner in which the simultaneous interactions of the inpidual's

biological, social, and self-worlds will be represented eventually is not yet clear.

Three promising alternative constructions of the representation of the outer world in the mind have been posited. The first, Popper's (Popper & Eccles, 1977), conceived mind to be an emergent of brain function interacting with language and culture (both material and not), fed back through the senses to influence brain function. Eccles (Popper & Eccles, 1977) differed from Popper in that he conceptualized mind as operating directly on "liaison" formations within the cerebral cortex itself. In either case, each inpidual is unique. Inpiduals experience an emerging existence conditioned by their nervous system, the world around them (including others and the material and nonmaterial aspects of culture), and an active self.

Pribram (1986) took a different track. He argued that the basic components of the universe are neither material nor mental but separate "realizations" of informational "structure."

> The enduring "neutral" component of the universe is informational structure, the negentropic organization of energy. In a sense, this structure can be characterized as linguistic—or mathematical, musical, cultural, and so on. Dual aspects become dual realizations—which in fact may be multiple—of the fundamental informational structure. . . .
>
> Mind and brain stand for two such classes of realizations each achieved ... by proceeding in a different direction in the hierarchy of conceptual and realized systems. Both mental phenomena and material objects are

realizations and therefore realities. . . .

(p. 512)

Information is encoded in the neuromicrostructure of the brain. Sensory transduction of energy from either the internal or external environment results in patterns of neuronal activation in the spectral domain. Pribram pointed out that such processing, if done with lens systems, is called *optical information processing*; if performed with computers, *image processing;* or if storage on photographic film is employed, *holography.*

> This mechanism has direct relevance for the mind/brain problem. Note that storage takes place in the spectral domain. Images and other contents as such are not stored, nor are they "localized" in the brain. Rather, by virtue of the operation of the local brain circuitry, usually with the aid of sensory input from the environment, images and mental events emerge and are constructed. The images *are* Gilbert Ryle's ghosts resulting from the operations of the "machine" (brain). But, when implemented (i.e. realized, materialized) through action (i.e. in the organism's environment), these ghosts *can* causally influence, through the senses, the subsequent operations of the brain.
>
> . . . A similar mechanism involving the motor mechanisms of the brain can account for intentional, planned behavior.

(p. 514)

Whether the paradigms posited by Popper, Eccles, Pribram, or yet another, will prove convincing is unclear. However, their discussions of the relationship of matter, mind, and mentation do flesh-out phenomenological-existential notions of active processing and choice.

Although they insist inpiduals must choose in order to create their being, existentialists differ considerably on how that choice should be made. In fact, it is fair to say that existentialists have more concrete things to say about the grounds on which decisions should *not* be made.

Whatever the rationale, no existentialist is likely to suggest conventional wisdom as a basis for meaningful choice. Each major contributor to existentialism has stood against his times. Kierkegaard rebelled against the desiccated doctrine of "good old uncle" religion, Nietzsche against decadence, and Jaspers against cultural disarray.

Using theology to ground decision also fails for most but by no means all of those considered existentialists.

> Nietzsche, Sartre, Heidegger, and Buber all speak of the "death of God," but to each it means something essentially different—to Nietzsche, the loss of a base for values that makes way for the will to power which creates new values and leads to the Superman; to Sartre, the necessity of inventing one's own values and choosing oneself as an image of man for all men; to Heidegger, a void that cannot be filled by any superman but the occasion, nonetheless, for a new succession of pine images arising out of man's clarifying thought about Being; to Buber, the "eclipse of God" which comes when God answers man's turning away by seeming to be absent Himself.
>
> An essential difference between the so called religious existentialists, which makes them quite as varied as the nonreligious, is that some of them understand the "answers" in as thoroughly existentialist terms as the questions, while others follow an existentialist analysis of the human condition or the situation of modern man with an appeal to traditional theology as the only valid response to that situation. Although one cannot

> draw any clear lines here, we may distinguish between *religious existentialists,* such as Martin Buber, Franz Rosenzweig, and Gabriel Marcel, and *existentialistic theologians,* such as Soren Kierkegaard, Paul Tillich, and Jacques Maritain.

(Friedman, 1967, pp. 262-263)

Perhaps the most that can be said is that to all existentialists,

> . . . human life is an adventure. For some existentialists this has implied the venture to live in constant awareness of the mystery of human existence; for others it has been the call to create meaning in an otherwise meaningless world. In both cases existentialists have asked for a life in which man continuously questions his purpose and accepts responsibility for his actions, one which truly reflects man's special position in this world. To such a life, existentialists refer when they speak of authentic existence, even though they differ widely in their interpretation of it.

(Breisach, 1962, pp. 4-5)

According to the existentialists, this then is the human condition. Each of us enters a world not made by us. We are not the master of our biology, or of our cultural heritage, or of our concrete circumstance at that time. If there is rhyme or reason, or black humor involved in our particular circumstance, it surely is not patent. Instead, when we perceive clearly our situation we experience a sense of *Geworfenheit* (throwness, like a cast of dice) (Magee, 1982). Yet, unplanned as it and our entry into it may be, "[t]he reality of the world cannot be evaded. Experience of the harshness of the real is the only way by which a man can come to his own self" (Jaspers, 1959, p. 178).

Even before we are out of the womb we are in a relationship with the

woman who carries us and the world in which she lives, “In the beginning is the relationship” (Buber, 1970, p. 69). What will characterize it? Will we enter into a dialogue in which mutuality is the goal, or will the prototype for monologues disguised as dialogues be impressed upon experience? Chances are we will be seen as more object than self, both in the womb and “out” in the world.

Very early in life we perceive a lack of “everness”; it is a frightening fact (Patterson & Moran, 1988; Yalom, 1980). Later, as we grow older and cognitively more complex, we self-consciously apprehend that we are terminal (Yalom, 1980). An old German proverb reminds us, “As soon as we are born, we are old enough to die.” This understanding mobilizes us, more so than any other break in the fabric of everyday life for which we are unprepared, for it is irremedial; it is the nonpareil experience of boundary. Death is the one possibility that cancels all others.

The temper of existentialism is passion. Far from shrinking from emotion, the existentialist affirms that dread, *angst, sorge* (care), fear and trembling, guilt, and anxiety are intrinsic to the situation of the inpidual. This ardor galvanizes the inpidual to action. To affirm life requires “tragic heroism” (Frankl, 1985).

Yalom (1980) schematized the failure of nerve (inauthenticity) that

opposed this passion: Awareness of ultimate concern leads to anxiety which in turn leads to defense. Inauthenticity has many forms and a heavy price. Common to all forms of “bad faith” is the strangulation of being. This may manifest itself as a symptom, the distortion of time (Krauss, 1967), for example; or as the intuition of alienation attendant upon living a “second hand life” (Breisach, 1962), or in psychopathology.

DEPRESSION

As Mendelson (1974, pp. 30-31) indicated, "scientific" thinking about "depression" has nearly come full circle.

> It began in the last quarter of the nineteenth century with some preliminary mutterings about heredity and morbid traits and with a search for the pathological lesions of the numerous entities of the pre-Kraepelinian era. It went on to describe the synthesis that Kraepelin accomplished so brilliantly and that brief moment in time when the psychiatric stage was swept bare of its many players to leave only those two grand protagonists, manic-depressive psychosis and dementia praecox.
>
> The moment could not last . . . was or was not involutional melancholia included within its [manic-depression] scope? Were not neurotic depressions different from manic-depressive psychosis?
>
> . . . Using techniques involving life histories, family studies, genetics, and considerations of age and sex, they [investigators] began to carve up the body of depressive illnesses into different shaped components. . . .
>
> Are subgroups we now read about real or artifacts? . . . [I]t is too early to tell. But the Kraepelinian simplicity is gone. The psychiatric stage now converted into a research laboratory is once again populated by numerous players. Yet there is still a Kraepelinian flavor to it. His confident assumption of pathological lesions has been replaced by a sophisticated search for biochemical lesions. Since the Klinik has been replaced by the laboratory, we hear discussions about neurophysiology, biochemistry and endocrinology, about catecholamines and indoleamines.

Diagnostic Issues

Ample evidence has accumulated that the term *depression* denotes a

variety of affective states differing among themselves biologically and phenomenologically (Mendelson, 1974). Depression, according to Kaplan and Sadock (1981, p. 358), refers to a "normal human emotion, to a clinical symptom, and to a group of syndromes or disorders." These differ among themselves both biologically and phenomenologically; the boundary piding the normal from the pathological is sometimes as far from clear now as it was to William James. In his 1896 Lowell Lectures (James, 1984, p. 15), he said:

> We make a common distinction between healthy and morbid but the fact is that we cannot make it sharp. No one symptom by itself is a morbid one—it depends rather on the part it plays. We speak of melancholy and moral tendencies, but he would be a bold man who should say that melancholy was not a part of every character. Saint Paul, Lombroso, Kant, each is in some way an example of how melancholy in a life gives a truer sense of values.

Because it has been used so frequently to describe even minor dysphoria, some question the distinctiveness of depression as a psychopathological concept (Loehlin, Willerman, & Horn, 1988). Matters are not helped by the mounting evidence that no cross-culturally acceptable conception of depression exists (Marsella, 1980), and that depression's symptomatology varies somewhat as a function of ethnicity. Binitie (1975), for example, found that both African and European patients diagnosed as having a major depression lost interest in work and in their social environment. The Africans reported a greater number of bodily complaints than the Europeans, who experienced guilt and suicidal ideation more often than the Africans. Marsella

(1980), in addition to suggesting depression is more common in western societies, found that those diagnosed as depressed in nonwestern societies were less likely to express guilt and self-abasement. Though the differential diagnosis of depression is acknowledged to be difficult, an argument may be made for its utility. Even if those so categorized are etiologically heterogeneous, the very process of classification, if done reliably and with a modicum of validity will insure at least surface similarity among those so denominated. Among the symptoms that are consistently observed in "depression" (American Psychiatric Association, 1987) are the following:

1. Diminished interest or pleasure in all or almost all activities
2. Fatigue or loss of energy
3. Feelings of worthlessness or "inappropriate" guilt
4. Diminished ability to think or concentrate, or indecisiveness
5. Feelings of hopelessness.

In part because of the variety of operations used to define it and in part because of its protean nature, estimates of the prevalence of depression vary widely. Kaplan and Sadock (1981) indicated that between 15 and 30 percent of adults in the United States experience clinically significant depressions. Of these only 25 percent will seek professional help. Recently Regier et al. (1988), using data from the NIMH Epidemiological Catchment Area Program

Study, reported a lifetime prevalence for Major Depressive Disorder to be 5 to 8 percent, that for Bipolar Disorder to be 0.8 percent, and dysthymia to be 3.3 percent. Of patients with a severe primary depressive disorder of at least one month's duration, they found almost 15 percent end their lives. For the United States, they estimated the total, yearly social cost (e.g., in health care cost, sick days, wages lost, lost productivity) of major depressions to be over $16 billion.

Etiology

Many putative causes have been offered to explain the etiology of the various forms of depression. These include the genetic anomalies that have been linked to Bipolar Disorder: those found by Egeland et al. (1987) on the short arm of chromosome 11 in the Old Order Amish, and those associated with color blindness on the X-chromosome found in four Israeli families of non-European heritage (Baron et al., 1987). The possibility that antidepressant medication in some instances may contribute to inducing an unusual form of the Bipolar Disorder—rapidly cycling, alternating mania and depression—was demonstrated by Wehr, Sack, Rosenthal, and Cowdry (1988). Sundry biogenic amine hypotheses (Rosenbaum, Maruta, & Shatzberg, 1983; Schildkraut, 1977; Van Praag, 1977) have also been proposed. So too have numerous psychosocial and psychoanalytical models of variable comprehensiveness. Many of these focus upon the role that

experience of helplessness plays in these disorders.

Depression's symptom configuration has been found in conjunction with a number of empirically researched circumstances. Davids (1955) and Seeman (1959) argued it is characteristic of "anomia" or alienation. Inpiduals experience anomia when social disruption or disorganization makes it difficult for them to view themselves as valued by society and empowered to achieve socially meaningful goals through their own actions in common effort with others. A similar theme can be perceived in Naroll's (1983) description of the consequences of weak "moral nets" in a society.

Seligman (Garber & Seligman, 1980; Seligman, 1975), in summarizing the results of an extensive laboratory research program, posited that the less the inpidual feels in control of his or her environment and the potential for reward and punishment it offers, the more likely he or she will be to develop a sequence of cognitive, self-esteem, emotional, and motivational deficits that constitute or at least ape the depressive syndromes. He posited that inpiduals first develop an inability to determine the extent to which they are capable of coping effectively with their environment; then, after becoming convinced that there is no hope for them, they become passive in the face of adversity. Eventually an affective defect—depression—ensues.

Beck (1967a, 1967b, 1976) found in depression specific idiosyncratic

cognitive schemes: (a) the inpidual is inadequate to the challenges faced, (b) the external world is impossibly hard and unforgiving, and (c) the future holds no hope. In a similar vein, Bandura (1986) contended:

> [inability to influence events and social conditions that significantly affect one's life can give rise to feelings of futility and despondency, as well as anxiety. Self-efficacy theory distinguishes between two judgmental sources of futility. People can give up trying because they seriously doubt they can do what is required. Or they may be assured of their capabilities but give up trying because they expect their efforts will not produce any results due to an unresponsive, negatively biased, or punitive social environment.

(pp. 445-446)

A sense of causal agency, Bandura believed, arises through the successes an inpidual achieves in producing effects through intentional action. With considerable acumen, he also suggested that the interactional characteristics of a "depressed" person are often off-putting. This leads others to avoid the person, further reducing the ability to achieve desired results.

Unlike the laboratory-based theories of depression just reviewed, the psychoanalytic depiction of depression derives its force and its "data" from clinical interactions between therapist and client.

> The psychoanalytic understanding of depression is made up of certain recurring themes which weave in and out of the theoretical tapestry. These themes are the basic human themes of love and loss and hate and vulnerability and happiness. These themes are elemental aspects of human life. Expressed clinically they take on designations, simultaneously both

> aseptic and value-laden, such as dependency and aggression and narcissism. They lead to joy and despair, to elation and depression.

(Mendelson, 1974, p. 295)

There are many psychoanalytic descriptions of the etiology of depression. Each differs somewhat in slant and nuance. Freud himself did not articulate one definitive conceptualization of depression's origin. His most influential statements on depression derive largely from "Mourning and Melancholia" (Freud, 1917/1956) and "On Narcissism" (Freud, 1914/1962).

In "Mourning and Melancholia," Freud argued that in an important sense pathological melancholia is similar to "normal" mourning. In both conditions, something is lost. The two differ in that in mourning the loss of a loved one or a cherished ideal (as liberty), the grieving inpidual experiences the world as poor and empty; in melancholia the ego itself is felt to be barren.

The mourner, to use Freudian argot, has lost an object cathexis; the melancholic has experienced a narcissistic wound.

Because of various circumstances—for example, a genetic predisposition or a rejecting mother—instead of a balanced parallel development of both object and narcissistic cathexes, the ego in some instances adopts predominantly the narcissistic mode of relating to reality in general and to others in particular. These narcissistic attachments are

tenuous; they are made on the basis of a "thing's" resemblance to the narcissist or the attachments' ability to satisfy the narcissist. They are disrupted when they prove unsatisfying. Obviously, as a general rule, narcissists cannot control the behavior of their apparent likenesses in the external world. They are, therefore, threatened continually with frustration, which necessarily leads to ambivalence. They love the likenesses but fear rejection, the frustration of their aims, and the subsequent loss of self-esteem. When frustrated,

> [t]he melancholic's erotic cathexis of his object thus undergoes a twofold fate: a part of it regresses to identification, but the other part, under the influence of the conflict of ambivalence, is reduced to the stage of sadism. . . .

(Freud, 1917/1956, p. 162)

Depression is, therefore, to be considered violence against the self. To paraphrase the more prosaic language of Dollard, Doob, Miller, Mowrer, and Sears (1939), the natural consequence of the frustration of an inpidual's goal-directed behavior is aggression. When the source of frustration is perceived to be the inpidual, the self, that aggression will be self-directed.

Schafer's (1976) translation of Freud's portrayal of the genesis and dynamics of depression into "action" language provided a depiction of the "depression" that is much more in consonance with existentialism's tenor.

> . . . [w]e may say that the valuable part of Freud's account is his

> unsystematized presentation of depression as action. Here, the central figure is not the pathological emotional state of depression; it is the depressive agent; the one who is continuously and desperately acting egocentrically, guiltily, reproachfully, etc.; the one who is deviously, fantastically, and unconsciously attacking others while ostensibly being only self-attacking; the one who is in fact protecting loved ones from directly destructive actions; and the one who is attempting in these and other ways to regulate both self esteem and relationships with others.
>
> [I]n acting depressively one is unconsciously engaged in affirming or enacting the following propositions: I hate those I love (ambivalence); I interact with them lovingly insofar as they support my precarious self-esteem by being loving, admiring, attentive, and steadily available to me (narcissism), and I interact with them hatefully, even to the extent of wishing them dead, insofar as they do not relate to me in the ways I desire (ruthless destructiveness); because I cannot altogether control how they actually behave (hopelessness), and because I think of being loved as being fed (oral fixation and regression), I imagine that I eat them in order to get them inside of me where, fantastically, I can control them, punish them, protect them, and feed off them endlessly (oral aggression or cannibalism). . . .

(pp.349-350)

In addition to these independent part-theories (e.g., Bandura, Freud, Beck), attempts have been made to integrate these sometimes disparate visualizations into a comprehensive statement of depression's origin. A paper by Akiska and McKinney (1975) was typical. In it, they postulated that melancholia is a biological phase of many depressions and that the depressive syndrome is the final common pathway of various processes. Predisposing one to depression may be any and all of the following: genetic vulnerability, developmental events (early loss), psychosocial events (loss of a job),

personality traits (pessimism), and physiological stressors (sleep loss). For any particular person, a somewhat different, powerful combination of these elements may be required to produce the potentially reversible, functional derangement of diencephalic mechanisms of reinforcement that Akiska and McKinney considered central to melancholia.

An appeal of these integrative conceptualizations is their recognition that the interrelationships among events, cognitions, emotions, and physiology are intricate. Unfortunately, no integrative model has yet considered fully how complicated they may indeed be. Both emotions and meaning structures may be activated from the "bottom up." Certain organic depressions seem to exemplify that process. When one allows the likelihood that both emotions and meaning structures can be activated and driven from lower-level mind structures as well as through higher-order interactions with the "external" environment, the probability of finding a final common pathway in "depression" diminishes considerably.

In summary, it is fair to suggest that the proliferation of schemata designed to describe depression reflects the heterogeneity of its phenomenology and causation and our own ignorance of these elements and their interplay. Hubris also plays a part. Mendelson's (1974, p. 289) comments with respect to the boosterism displayed by many adherents of the various psychoanalytic approaches to depression could be generalized

without much strain to the advocates of the many competing and alternating models:

> To one familiar with the open confessions of ignorance in other scientific disciplines it is a little disconcerting to read so many confidently offered global conclusions in the literature on depression. This tendency to make definite pronouncements makes it appear as if legitimate uncertainty has acquired the bar sinister.

APPLICATION OF EXISTENTIAL APPROACHES TO DEPRESSION

The application of the existential outlook to depression, May advised (1969), does not obviate the need for accurate diagnosis, nor does it deny the usefulness of therapeutic interventions of demonstrated efficacy, nor does it belittle psychodynamic or behavioral insights. Rather, the existentially oriented clinician is likely to co-opt them. If nothing else, at the core of the existential perspective is the belief that it and we shall be forever unfinished. It is an exemplary open system. What the existentialist position does insist upon is that the accumulation of knowledge be considered an unending, ever enlarging quest, evolving, hopefully as Heidegger would have had it, toward "truth." The existential position further insists that, as useful as this information must prove, inpiduals or their circumstances can never be defined solely in its terms.

Regardless of etiology, even in primarily "organic" depressions, existentialists remind us that it is an inpidual, a person, who is experiencing and attempting to cope with a situation.

To cite one example, Boss (1983), explained:

> We maintain that the role of physicality in organic psychoses can be described at best through the following propositions. The most we can say is, first, that there is a regular simultaneity between pathological behavior in paralytics and a certain condition of the brain. Second, what natural science interprets as frontal lobe damage caused by lues spirochetes is

> actually primary and direct injury to the being-in-the-world of an existing human being which destroys the bodily capacity for carrying out most of the normal, appropriate ways of responding to what a person encounters. It follows, third, that a person so affected has at his disposal only an extremely self-centered, restricted mode of human Da-sein. Strictly speaking, the substration of organic illness is only that sphere of the reduced spatiality and temporality of paralytically ill human beings which may also be interpreted, though inadequately, as defects in biophysical brain matter at a specific location in space.

(p. 215)

Yet, it might be added: it is just that paralytically ill human being who must live life. Likewise:

> When patients with occipital lobectomies say that they are blind even though they are able to respond correctly to the location and configuration of visual cues . . . , how are we to deal with "blind-sight" except to distinguish their instrumental responses from their verbal reports of introspection? . . . We accept the inference that the subject has a "mental life," that his or her psychological processes are accessible by way of his or her verbal report and instrumental behaviors, and furthermore, that these different forms of behavior may reflect different processes.

(Pribram, 1986, pp. 508-509)

This inpidual, too, must make his or her way.

The same outlook is maintained when the constraints imposed are poverty or enslavement, wealth or position.

It is reasonable to conclude that the existentially oriented clinician may not, on the surface, offer different treatment than a clinician of another

persuasion, but that the attitude of the existentially oriented clinician will differ decisively from that of a clinician of the biological or behavioral schools regardless of the growing rapprochement between existentialism and the "human sciences." Nonetheless, in the treatment of "psychopathology," attitude may prove pivotal.

Treating Depression

The existential standpoint has important contributions to make to the primary, secondary, and tertiary prevention of pathological depressions. In primary prevention (Macht, 1978), efforts are made to counteract the influence of forces that contribute to the development of a disorder, and thereby reduce its incidence. Those interventions attempt either to provide sufficient supplies necessary to maintain health, for example, vaccinations or prenatal nutritional programs, or to reduce exposure to and contamination by noxious agents. Secondary prevention activities are those which are designed to shorten the duration of severe impairment associated with already established disorders. Examples of such actions include early case finding and effective treatment. Steps taken that effectively reduce the residual deficits or sequelae of a disorder are considered tertiary prevention. Cognitive rehabilitation programs prescribed to ameliorate the functional impairments that accompany brain injury fall into that category. Of course, as with any constructed typology, the lines of demarcation that separate activities into

these prevention categories are not sharply drawn at all times.

Primary Prevention

In common with most critics who "view with alarm," existentially oriented commentators on "the contemporary scene" are more adept at diagnosis than remediation. While there are stirrings in the area of existential political theory and political science (Jung, 1972) they are just stirrings. When system interventions addressing primary prevention are proposed, however, the existentially oriented critics tend to be realistic—even conservative—about the effectiveness of the course of action suggested, if not the suggestions themselves. They believe no "cure" is possible and hold that even in the best of societies authentic existence must always be a matter of inpidual choice and inpidual action. Yet, it is also clear to them that certain social configurations are more likely to facilitate good-faith action than others.

Fromm (1941, 1955, 1964, 1968), more than any other existentially oriented social psychological theorist, developed the notion of the "good" society. He constructed it on humanistic, communitarian, socialistic lines. He envisioned it as a society in which "man relates to man lovingly, in which he is rooted in bonds of brotherliness and solidarity . . . ; a society which gives him the possibility of transcending nature by creating rather than by destroying,

in which everyone gains a sense of self by experiencing himself as the subject of his powers rather than by conformity, in which a system of orientation and devotion exists without man's needing to distort reality and to worship idols" (1955, p. 362).

If the ethos of the "good" society seen through Fromm's eyes bears little resemblance to the *Zeitgeist* of our own, the discrepancy is not accidental. On the whole, existentially oriented clinicians see our society as pathological in itself and as generating pathology in inpiduals. According to Frankl (1985), we increasingly live in an "existential vacuum"; meaninglessness is spreading to the extent that it may be considered a mass neurosis. Its symptoms are depression, aggression, and addiction.

Not only is western society at large viewed as increasingly hostile to human life, but many of its institutional components, even those designed to secure the quality of life, are seen as contributing to its dissolution. The "healing arts" are but one example, as Jaspers declaimed presciently in 1931 (Jaspers, 1959, pp. 65-66).

> In large measure, patients are now being dealt with in the mass according to the principles of rationalization, being sent to institutes for technical treatment, the sick being classified in groups and referred to this or that specialized department. But in this way the patient is deprived of his doctor. The supposition is that like everything else, medical treatment has now become a sort of manufactured article. . . .

> A gigantic "enterprise" of medical practice is arising. . . . "Enterprise" has taken the place of inpidualized care. . . . Joy in the exercise of a profession on humanist lines is replaced by the joy in work that results from technical achievement. . . .
>
> Above all, however, those who are really sick find it less and less possible to have faith in being treated thoroughly, scientifically, and intelligently by a doctor whose whole services are for the time being put at [their] service. The human being as a sick man forfeits his rights when there no longer exists any true physicians because the apparatus designed to place them at the disposal of the masses has, by its very working, make the existence of true physicians impossible.

The family provides another example:

> The family has shifted from a relatively unspecialized, task-oriented organization, bound together largely by ties derived from the performance of the widest possible range of work chores, to a highly specialized organization that is bound by emotional or expressive ties.

(Zwerling, 1968, p. 23)

Therein lies the family's vulnerability.

> it is virtually the only social institution organized around love as a binding force. A necessary corollary of this is that the family is the only locus in which emotional budgets may be reliably balanced.

(Zwerling, 1968, p. 25)

The image of Humanity being made Machine by the mechanisms of "civilization" is compelling. Whether the next generation, born into an age of information, will suppose us bytes is yet to be determined.

Much of the existentialist brief against western culture resembles that made by Durkheim in analyzing the consequences of the industrial revolution. He too focused upon “pathology”; his monograph “Suicide” was a brilliant example of the linkage of social structure and inpidual fate (Durkheim, 1951). Further, he aimed, like the existentialists, at developing remedies for the current situation short of those suggested by Luddites.

Durkheim believed western society was becoming increasingly anomic and egoistic. Anomie results from disruptions in social regularity; egoism, when the meaning structures of a society are weakened. Both lead to increases in the rate of suicide.

Durkheim’s description of egoistic suicide was instructive. Egoists, according to Durkheim, suffer from “the sickness of infinity.” They experience a fantastical sense of unlimited possibilities with no basis to select one over another and no assurance that they will; and they have every indication that they will not be able to motivate others to any sustained effort. Since joint effort is undoubtedly required to realize even the most primitive of goals, let alone construct self-meaning through effective action, egoists die of thirst while swimming in a sea of water.

Naroll, 1962, 1983; Krauss, 1976; and Krauss and Krauss, 1968 have provided the clearest, most ambitious, cross-cultural, empirical

demonstration since Durkheim that societal characteristics can increase or dampen the rate of "mental illness." Building upon both Durkheim's and Freud's conceptualization of suicide, Naroll first undertook to discover in societies the presence of what he later termed "thwarting disorientation traits." These are recurrent and regular patterns of interaction within a culture that lead predictably to the threatened or actual disruption of interpersonal cohesion. These traits increase the difficulties inpiduals have in achieving biological and personal security. Frequent Warfare, Drunken Brawling, Divorce Freedom, Witchcraft Accusation (Naroll was a cross-cultural methodologist), and Defiant Homicide are five of many such traits. Naroll found that higher rates of mental illness and suicide are likely in societies with more of these traits. Conversely, reducing the frequency and intensity of these traits lowers a culture's rate of depression and its equivalents.

Naroll (1983) also focused upon those societal institutions which, if strong, have a salutary influence on mental health and, when weakened, enhance the probability of mental disorders. These he called moral nets. Moral nets make available to inpiduals the possibility of strong social ties, emotional warmth, punishment for transgression, myth and meaning creation, and economic and political support. The family is an exemplary moral net.

In an extensive, methodologically sophisticated investigation, Naroll demonstrated, as he predicted, that the stronger a society's moral nets, the lower was its rate of psychopathology; conversely, the weaker the moral nets, the greater was its rate of psychopathology. These findings argued cogently that to prevent depressions, exertions to strengthen the moral nets of the community and of the inpidual particularly at risk are required.

Even if Durkheim, Naroll, and others like them were not correct in detail, their intuitions are compelling. How but depressed can one feel if nothing and no one can be counted upon, if a common language creates no shared understanding, if no reliable mirror of one's actions is available, if no sustained action in time is possible, if one is thrown back on oneself without a structure?

Secondary Prevention

The importance of early case identification and treatment of depressive disorders has been repeatedly acknowledged (Kaplan & Sadock, 1981; Regier et al., 1988). Yet, case finding has largely been neglected by clinicians of every orientation except those working for Employee Assistance Programs (Dickman, Challenger, Emener, & Hutchinson, 1988). Only 15 to 30 percent of those experiencing depressions of "clinical" severity seek professional assistance. Existentially oriented clinicians, however, have made major

contributions to the psychotherapeutic encounter in general, and to the "treatment" of "depression" in particular.

Toulmin (1988, p. 345) differentiated between the "clinical" and "scientific" attitude toward inpiduals requesting help for their problems.

> A patient may be studied by either a clinician or by a scientist who is researching his or her current disease. The scientist's interest is in any general features the patient may share with others suffering from the same disease. The clinician's interest is in whatever can throw light on his patient, in that bed, here and now. The clinician's knowledge will be "informed by" biomedical science; but it is not, in its details, "entailed by" any biomedical theory and typically goes beyond everything that scientists can yet account for. The patient is not merely an "inpidual" who happens to "instantiate" a "universal law." His clinical state is local, timely, and particular, and universal theories at best throw only partial light on it.

By Toulmin's criteria, existentially oriented clinicians fall at the "clinical" end of his dichotomy.

The existentially oriented therapist encounters a client as an existential partner and has as therapeutic targets:

1. An ever deepening understanding of the life story of the inpidual as he or she is in the world.

2. Helping the client experience as radically as possible when and how he or she has neglected the fullness of his or her humanity.

3. Enabling the client to reactivate the full scope of his or her inner possibilities.

4. Assisting the client to achieve the restoration of his or her existential wholeness and integrity.

5. Facilitating the client's adoption of a decisive, active orientation to life, recognizing that decision often precedes knowledge (drawn from Binswanger, 1962; May, 1958; Reinhardt, 1960).

Clearly these goals have influenced greatly the practice of "humanistic" psychotherapy (Rogers, 1951, 1974). Further, the importance of relationship, meaning, active experiencing, and action in effecting therapeutic change has received substantial support from research. For those formulating an integration of psychotherapies (Beitman, Goldfried, & Norcross, 1989; Greenberg & Safran, 1989), these activities form the core of practice considerations.

To the therapist whose attitude is existential, clinical depressions, whatever else they may be—neurological dysfunction, for example—are the predictable consequences of "bad-faith" reactions of clients to their situations. "The goal of bad faith," to Sartre (1953, p. 197), "is to put oneself out of reach, it is an escape." It is designed, he wrote, to "cause me to be what I am, in the mode of'not being what one is,' or not to be what I am in the mode of'being what one is'" (p. 198). In a sense, bad faith resembles lying:

> The ideal description of the liar would be cynical consciousness, affirming the truth within himself, denying it in his words, and denying that negative

> as such [p. 155]. . . . Of course we have described the ideal lie; doubtless it happens often enough that the liar is more or less the victim of his lie, that he half persuades himself of it. But the common, popular forms of the lie are also degenerate aspects of it; they represent intermediaries between falsehood and bad faith [pp. 156-157], . . . Bad faith then has in appearance the structure of falsehood. Only what changes everything is the fact that in bad faith it is from myself that I am hiding the truth. . . . The true problem of bad faith stems evidently from the fact bad faith is *faith* [p. 202], . . . [B]ad faith is belief; and the essential problem of bad faith is a problem of belief.

(Sartre, 1953, p. 203)

One belief, for instance, is that one's existence ought to be subordinated to that of another.

> It is the whole existence of the melancholic patient which has failed to take over openly and responsibly all those possibilities of relating to the world which actually would constitute his own genuine self. Consequently, such an existence has no independent standing of its own but continuously falls prey to the demands, wishes, and expectations of others. Such patients try to live up to those foreign expectations as best they can, in order not to lose the protection and love of their surroundings. But the longer these patients allow others to govern their ways of feeling, acting, and perceiving, the more deeply indebted they become in regard to their fundamental task in life, which is to appropriate and carry out, independently and responsibly, all their authentic possibilities of relating to that which they encounter. Hence the terrible guilt feelings of the melancholic. His incessant self-accusations derive from existential guilt. The severity of his symptoms varies according to the degree in which he fails to exist as the world-openness in whose light everything encountered can unfold and shine forth in its full meaning and content.

(Boss, 1963, pp. 209-210)

Another form of bad faith may induce the "life of suicide" (Farber,

1976). According to Farber,

> . . . "the life of suicide" . . . must be seen not as that situation or state of mind which *leads to* the act, but that situation in which the act-as-possibility, quite apart from whether it eventually occurs or not, has a life of its own. . . . For the man who is caught up in what I have called "the life of suicide," however, the possibility of being the author of his own death exercises a demonic and seductive fascination over him. This fascination takes different forms. There is a certain kind of person for whom the idea of suicide is a secret and cherished solution to any difficulty life may throw across his path. [p. 66] . . . —potentially despair at least—is both destroying and renewing. . . . While despair means literally the loss of hope, the movements of despair are frantically directed toward hope; but the hope born of despair may turn to the prescriptions of the isolated will.

(Farber, 1976)

Still other motifs of inauthenticity lead to what Maddi (1967) called "existential neurosis." Persons who consider themselves nothing more than actors—players of social roles—must feel powerless in the face of social pressure. Those who believe themselves just embodiments of biological needs cannot but be impotent when injury or illness threatens that identity. Yet as pained as such inpiduals may be, the stress that precipitates existential neurosis is most likely to be that which radically confutes their identity by forcing them to recognize its untruths: its concrete, fragmentary, essential nature. This stressor may be the threat of imminent death, the loss of a loved object, a significant disruption in social order, or the accumulated impact of repeated confrontations with the hollowness of inauthentic identity.

The equations describing depression's many sides have a fundamental sameness: fear of life and fear of extinction provoke defense. Defense hardens into psychopathology, "a graceless, inefficient mode of coping with anxiety" (Yalom, 1980, p. 110). "Even defensive maneuvers that successfully ward off severe anxiety, prevent growth and result in a constricted and unsatisfying life," Yalom indicated (p. 111). Every attempt to avert one's face from the boiling, chaotic abyss that is life is definitive, as is the denial of the liberating force produced by the experience of dread and despair as they creatively inform our existence. So too is the distorted experience of temporality that attends the tension between decisions already made and those needing to be made as the inpidual's inevitable march to nothingness continues. Depression represents the failure of human transcendence; existential therapy's purpose is its resurrection.

Tertiary Prevention

Although there are indications that tertiary prevention efforts potentially pay large financial and moral pidends to client and society alike, relatively little or no attention has been paid directly to such issues as: Does existentially informed treatment ameliorate the scope and severity of residual deficits associated with some forms of depression? Does it reduce the likelihood of secondary impairments developing? Alcohol and drug abuse and cancer (Backman, 1989) have been implicated as the sequelae of depression.

Does it reduce the possibility of economic invalidism by facilitating return to work? Ii these questions are answered affirmatively, another remains: How do existentially oriented interventions accomplish these ends?

With its focus upon inpiduals and their phenomenology; its insistence upon a realistic appraisal of the life situation, and its emphasis upon decisive, responsible action with respect to it; and its stress upon transcendence, the existential attitude likely has an important contribution to make in the tertiary prevention of depression. This impression is strengthened by the mounting evidence that, for example, feelings of personal control are related to successful adaptation to chronic illness (Williams & Stout, 1985). Research also supports the existential insights that the therapist's recognition of a client's need to assume responsibility for self-regulation increases treatment compliance (Brownlee-Duffeck et al., 1987) as do reciprocally respectful client-therapist interactions (Haynes, Taylor, & Sackett, 1979). Nonetheless, considerable additional evidence must be sought and accumulated before the case for efficacy of the existential orientation in tertiary prevention is made. Topics for these investigations might be the degree to which existentially designed interventions reduce self-stigmatization and increase return to meaningful social interactions and gainful employment. Other researchers may attempt to gauge the impact of existentially oriented therapy upon the likelihood of self-destructive acts; yet others, whether inpiduals treated existentially are less at risk for additional "depressive episodes."

SUMMARY

The existential viewpoint brings scope, depth of field, and clarity to the appreciation of the human situation. It informs our understanding and treatment of psychopathology in general and depressions in particular.

Among the strengths of the existentialist stance, and they are many and formidable, are the following: a concern for inpiduals and their view of their particular circumstances; the realization that the inpidual is embarked upon a lifelong quest in which transcendence over local circumstances is natural; an acceptance of dread and despair as emotions which attend, motivate, and inform the actions that determine direction; and the intuition that although each inpidual's path is unique, others, even though they are engaged in their own voyages of discovery, may contribute necessary coordinates.

While rejecting as necessarily incomplete the premises of systems claiming truth, existentialism has been quick to borrow and apply pragmatically the techniques these alien orientations have generated, be they psychopharmacological or behavioral.

The existential attitude does have its weaknesses. One is its inability to inspire in its clinical adherents a desire to depict and elucidate the tactics of therapeutic intervention in the same detail with which they have described its strategic considerations. Another failing of existentially oriented clinicians

has been their general disinterest in personally participating in the development of transpersonal methodologies and data bases. These tasks they leave to others, thereby depriving themselves of the enhancement of reality that engaging in such a process provides. That such work can be conducted profitably within a humanistic framework has been amply demonstrated by the extraordinary research program of Rogers (1951, 1974) and those influenced by him.

REFERENCES

Akiska, H. P., & McKinney, W. T., Jr. (1975). Overview of some research in depression: Integration of ten conceptual models into a comprehensive clinical frame. *Archives of General Psychiatry, 32,* 285-305.

Allport, G. W. (1957). European and American theories of personality. In H. P. David & H. V. Bracken (Eds.), *Perspectives in personality theory* (pp. 3-24). New York: Basic Books.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: American Psychiatric Association.

Backman, M. E. (1989). *The psychology of the physically ill patient: A clinician's guide.* New York: Plenum.

Bandura, A. (1986). *Social foundations of thought and action: A social-cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.

Baron, M., Risch, N, Hamburger, R., Kushner, S., Newman, M., Drumer, D., & Belmaker, R. H. (1987). Genetic linkage between X-chromosome markers and bipolar affective illness. *Nature, 326,* 289-292.

Beck, A. (1967a). *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania Press.

Beck, A. (1967b). *Depression: Clinical, experimental, and theoretical aspects.* New York: Harper.

Beck, A. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Beitman, B. D., Goldfried, M. R., & Norcross, J. C. (1989). The movement toward integrating the psychotherapies: An overview. *American Journal of Psychiatry, 146,* 138-147.

Binitie, A. (1975). A factor-analytic study of depression across cultures (African and European). *British Journal of Psychiatry, 127,* 559-563.

Binswanger, L. (1962). Existential analysis and psychotherapy. In H. M. Ruitenbeek (Ed.), *Psychoanalysis and existential philosophy* (pp. 17-23). New York: Dutton.

Boss, M. (1963). *Psychoanalysis and Daseinanalysis.* New York: Basic Books.

Boss, M. (1983). *Existentialfoundations of medicine and psychology.* New York: Aronson.

Breisach, E. (1962). *Introduction to modern existentialism.* New York: Grove.

Brownlee-Duffeck, M., Peterson, M., Simonds, J. F., Goldstein, D., Kilo, C., & Hoette, S. (1987). The role of health beliefs in the regimen adherence and metabolic control of adolescents and adults with diabetes mellitus. *Journal of Consulting and Clinical Psychology, 55,* 139-144.

Buber, M. (1970). *I and thou.* New York: Scribner.

Buytendijk, F. J. J. (1957). Femininity and existential psychology. In H. P. David & H. V. Bracken (Eds.), *Perspectives in personality theory* (pp. 197-211). New York: Basic Books.

Davids, A. (1955). Alienation, social apperception and ego structure. *Journal of Consulting Psychology, 19,* 21-27.

Dickman, F., Challenger, R. B., Emener, W. G., & Hutchinson, W. S., Jr. (1988). *Employee Assistance Programs: A basic text.* Springfield, IL: Thomas.

Dollard, J., Doob, L. W., Miller, N. E., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression.* New Haven, CT: Yale University Press.

Durkheim, E. (1951). *Suicide.* J. A. Spaulding & G. Simpson (Eds.). Glencoe, IL: Free Press.

Egeland, J. A., Gerhard, D. S., Pauls, D. L., Sussex, J. N., Kidd, K. K, Allen, C. R., Hostetter, A. M., & Housman, D. E. (1987). Bipolar affective disorders linked to DNA markers on chromosome 11. *Nature, 325,* 783-787.

Farber, L. H. (1976). *Lying, despair, jealousy, envy, sex, suicide, drugs, and the good life.* New York: Harper.

Frankl, V. (1985). *The unheard cry for meaning.* New York: Washington Square.

Freud, S. (1917/1956). Mourning and melancholia. In J. Strachey (Ed. and Trans.), *Collected Papers of Sigmund Freud* (Vol. 4, pp. 152-170). London: Hogarth Press.

Freud, S. (1914/1962). On narcissism: An introduction. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 73-102). London: Hogarth Press.

Fromm, E. (1941). *Escape from freedom.* New York: Rinehart.

Fromm, E. (1955). *The sane society.* New York: Rinehart.

Fromm, E. (1964). *The heart of man.* New York: Harper.

Fromm, E. (1968). *The revolution of hope.* New York: Harper.

Friedman, M. (1967). *To deny our nothingness.* New York: Dell.

Garber, J., & Seligman, M. E. P. (Eds.). (1980). *Human helplessness: Theory and applications.* New York: Academic Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist, 44,* 19-29.

Haynes, R. B., Taylor, D. W., & Sackett, D. L. (Eds.). (1979). *Compliance in health care.* Baltimore: Johns Hopkins Press.

James, W. (1984). *William James on exceptional mental states: The 1896 Lowell Lectures.* E. Taylor (Ed.). Amherst, MA: University of Massachusetts Press.

Jaspers, K. (1959). *Man in the modern age.* London: Routledge & Kegan Paul.

Jennings, J. L. (1986). Husserl revisited. *American Psychologist, 41,* 1231-1240.

Jung, H. Y. (Ed.).(1972). *Existential phenomenology and political theory: A reader.* Chicago:

Regnery.

Kaplan, H. I., & Sadock, B. J. (1981). *Modern synopsis of comprehensive textbook of psychiatry III.* Baltimore: Williams & Wilkins.

Kaufmann, W. (1972). The reception of existentialism in the United States. In R. Boyers (Ed.), *The legacy of the German refugee intellectuals* (pp. 69-96). New York: Schocken.

Kierkegaard, S. (1941). *Concluding unscientific postscript.* Princeton, NJ: Princeton University Press.

Krauss, H. H. (1967). Anxiety: The dread of a future event. *Journal of Inpidual Psychology, 23,* 88-93.

Krauss, H. H. (1976). A psychological theory of suicide. In B. B. Wolman & H. H. Krauss (Eds.), *Between survival and suicide* (pp. 25-54). New York: Gardner.

Krauss, H. H., & Krauss, B. (1968). A cross-cultural study of the thwarting disorientation theory of suicide. *Journal of Abnormal Psychology, 73,* 353-357.

Loehlin, J. C., Willerman, L., & Horn, J. M. (1988). Human behavior genetics. *Annual Review of Psychology, 39,* 101-133.

Macht, L. B. (1978). Community psychiatry. In J. A. M. Nicholi (Ed.), *The Harvard guide to modern psychiatry* (pp. 627-649). Cambridge, MA: Harvard University Press.

Maddi, S. R. (1967). The existential neurosis. *Journal of Abnormal Psychology, 72,* 311-325.

Magee, B. (1982). *Men of ideas.* New York: Oxford.

Marsella, A. J. (1980). Depressive experience and disorder across cultures. In H. C. T riandis & J. G. Draguns (Eds.), *Handbook of cross cultural psychology: Vol. 6 Psychopathology.* Boston: Allyn & Bacon.

May, R. (1958). The origins and significance of the existential movement in psychology. In R. May, E. Angel, & H. F. Ellenberger (Eds.), *Existence* (pp. 3-36). New York: Simon &

Schuster.

May, R. (1969). *Existential psychology* (2nd ed.). New York: Random House.

Mendelson, M. (1974). *Psychoanalytic concepts of depression.* New York: Spectrum.

Misiak, H., & Sexton, V. S. (1973). *Phenomenological, existential, and humanistic psychologies: A historical survey.* New York: Grune & Stratton.

Naroll, R. (1962). *Data quality control—A new research technique.* Glencoe, IL: Free Press.

Naroll, R. (1983). *The moral order: An introduction to the human situation.* Beverly Hills, CA: Sage.

Patterson, R. J., & Moran, G. (1988). Attachment theory, personality development, and psychotherapy. *Clinical Psychology Review, 8,* 611-636.

Popper, K. R., & Eccles, J. C. (1977). *The self and its brain.* Berlin: Springer-Verlag.

Pribram, K. H. (1986). The cognitive revolution and mind/brain issues. *American Psychologist, 41,* 507-520.

Regier, D. A., Hirschfeld, R. M. A., Goodwin, F. K., Burke, J. D., Jr., Lazar, J. B., & Judd, L. L. (1988). The NIMH depression awareness, recognition, and treatment program: Structure, aims, and scientific base. *American Journal of Psychiatry, 145,* 1351-1357.

Reinhardt, K. F. (1960). *The existentialist revolt: The main themes and phases of existentialism.* New York: Unger.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implication, and theory.* Boston: Houghton Mifflin.

Rogers, C. R. (1974). In retrospect: Forty-six years. *American Psychologist, 29,* 115-123.

Rosenbaum, A. H., Maruta, T., & Shatzberg, A. F. (1983). Toward a biochemical classification of depressive disorders: VII urinary free cortisol and urinary MHPG in depression. *American Journal of Psychiatry, 140,* 314-318.

Sartre, J. P. (1945). *L'Existentialisme est un humanisme.* Paris: Nagel.

Sartre, J. P. (1953). *Existential psychoanalysis.* Chicago: Regnery.

Schafer, R. (1976). *A new language for psychoanalysis.* New Haven, CT: Yale University Press.

Schildkraut, J. J. (1977). Biochemical research in affective disorders. In G. Usdin (Ed.), *Depression: Clinical, biological, and psychological perspectives.* New York: Brunner-Mazel.

Seeman, M. (1959). On the meaning of alienation. *American Sociological Review, 24,* 783.

Seligman, M. E. P. (1975). *Helplessness: On depression, development, & death.* San Francisco: Freeman.

Toulmin, S. (1988). The recovery of practical philosophy. *American Scholar, 57,* 337-352.

Van Praag, H. M. (1977). *Depression and schizophrenia: A contribution to their clinical pathologies.* New York: Spectrum.

Wehr, T. A., Sack, D. A., Rosenthal, N. E., & Cowdry, R. W. (1988). Rapid cycling affective disorder: Contributing factors and treatment responses in 51 patients. *American Journal of Psychiatry, 145,* 179-184.

Williams, J. M., & Stout, J. K. (1985). The effect of high and low assertiveness on locus of control and health problems. *Journal of Psychology, 119,* 169— 173.

Yalom, I. (1980). *Existential psychotherapy.* New York: Basic Books.

Zwerling, I. (1968). *Alienation and the mental health professions.* Richmond, VA: Virginia Commonwealth University.