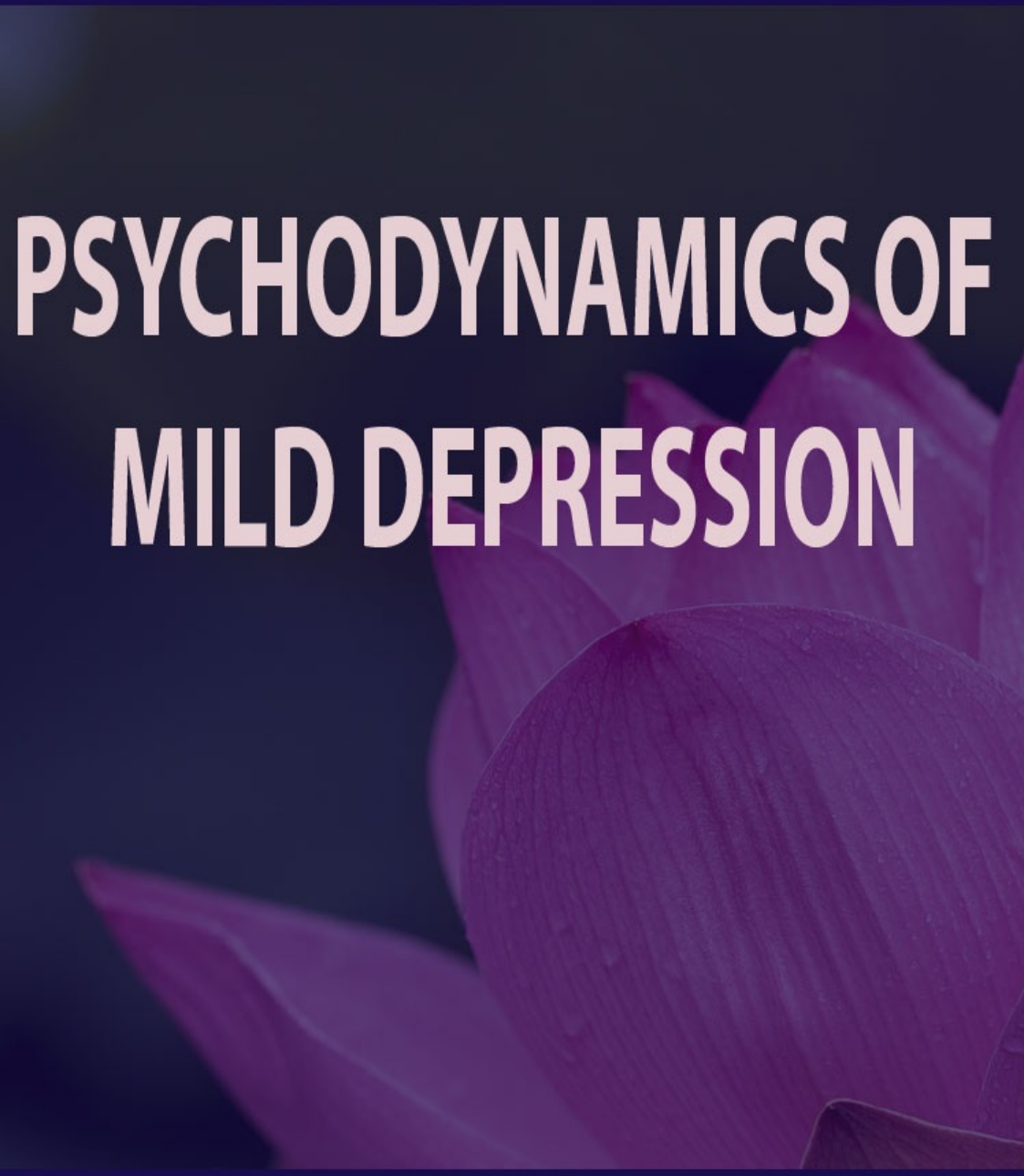
Severe and Mild Depression

PSYCHODYNAMICS OF MILD DEPRESSION



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PSYCHODYNAMICS OF MILD DEPRESSION

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In contrast to the individuals described in the previous chapter, those to be considered in this chapter are not so impaired that the affect of depression overwhelms all other psychic contents. They actively want to be rid of their feelings of depression and try to fight them off. These patients attempt to reestablish the pathological equilibrium that they had achieved prior to being depressed. They do not collapse in the face of overwhelming despair so that their psychic life is devoid of all content except for the repetitive painful ruminations which enhance the misery of their affliction. These individuals, while depressed, manage to function in their everyday lives, albeit often in a reduced capacity. They are capable of reasoning and normal cognitive abilities, and an insight-oriented approach to therapy may rapidly be initiated. Some somatic symptoms such as anorexia or insomnia may be present but are not pronounced. Psychomotor retardation and constipation are not seen, but loss of libido is not uncommon. Most significant, perhaps, is that these less severely depressed individuals maintain their relationships to others: in fact, they may frantically search for comfort and support from other people. They do not withdraw from interpersonal relationships into a silent world of solitary suffering.

Such individuals are typified by the presence of the affect of depression

which may be constant or fluctuate in intensity. As will be further discussed, this sense of mental anguish may take a variety of forms— from an agonizing awareness of loss to a despairing conclusion that life is pointless and lacks any form, purpose, or meaning. Regardless of the cognitive variations, the basic mood of depression is definitely present. Before proceeding with an analysis of such individuals, it may be worthwhile to consider the conceptual status of depression as an affect as I view it, since this view naturally will influence the interpretation of depressed patients.

As described in chapter 2, the psychodynamic interpretation of depression has undergone numerous transformations in the history of psychoanalytic thought. Some authors have attempted to explain the experience of depression as a complex metapsychological phenomenon, such as an aggressive cathexis of the self-representation, or as a conflict between the punishing superego and the helpless ego.

Others have presented the less complicated position that depression is actually a primary affect that cannot further be reduced to more basic constructs. I definitely lean toward this latter conceptualization and agree with Sandler and Joffe's (1965) statement that "if depression is viewed as an affect, if we allot to it the same conceptual status as the affect of anxiety, then much of the literature on depression in childhood (and this could be extended to adults) can be integrated in a meaningful way" (p. 90).[1]

However, considering depression as a primary affect does not automatically imply that it is a simple emotion devoid of complex cognitive components. As indicated by Arieti in chapter 5, different emotions presuppose a greater or lesser cognitive maturity and intellectual understanding. Depression appears to be a third-order emotion necessitating some awareness of the past and the future, some linguistic ability, and some recognition of the effects of human beings on one another. This particular painful feeling automatically arises whenever the individual "senses" that he has either irrevocably lost or never will achieve a needed state of well-being of the self. I have put the word senses in quotes because this awareness is not necessarily explicit; rather, it is the unconscious cognitive system that seems to give rise to emotion. By unconscious cognitive system I mean a structure of aspirations, fears, and general expectations from the self and from others that guide the individual's behavior but of which he may not be explicitly aware. These systems of belief are postulated to be at a different level of consciousness than the superficial pessimistic distortions which occur subsequent to the onset of a depressive episode. These deeper cognitive systems are the cause rather than the result of the manifest experience of depression and are not so readily available to being clearly spelled out in conscious awareness.

For example, an individual may become depressed after a loss but remain unclear as to the manner in which the loss has affected him. Similarly,

other individuals may become depressed without any precipitating environmental trauma or without knowing why they should experience a sense of dysphoria at this particular time of their lives. Freud (1917) astutely noted this lack of awareness: he observed that even when the melancholic relates his plight as resulting from the loss of someone, "he knows whom he has lost but not *what* it is he has lost in them." What has been lost is an environmental prop that allowed the perpetuation of a needed state of self. The depressive does not appear to grieve for the other; rather, he grieves for himself—for being deprived of what the other had supplied. He grieves over his state of self without the other or without his all-important goal (as seen in so-called reactive depressions). Or the individual may grieve over a state of self that finds no meaning or gratification in life, unaware that his unconscious cognitive system has forced him to inhibit himself so that he shuns meaningful achievement or pleasurable activities (as seen in so-called characterological depressions).

The philosopher Kierkegaard was well aware that the true cause of despair is despair about one's own self, regardless of the apparently precipitating events. He wrote that "when the ambitious man whose watchword as 'either Caesar or nothing' does not become Caesar, he is in despair thereat. But this signifies something else, namely, that precisely because he did not become Caesar he cannot endure to be himself" (1954, p. 152). In describing depression resulting from an environmental loss,

Kierkegaard observed:

> A young girl is in despair over love and so she despairs over her lover, because he died, or because he was unfaithful to her .... No, she is in despair over herself. This self of hers, if it had become "his" beloved, she would have been rid of in the most blissful way, or would have lost, this self is now a torment to her when it has to be a self without "him" (1954, p. 153)

Kierkegaard beautifully and concisely revealed the self-centered aspect of depression as well as its cause that ultimately resides in the deprivation of something which is needed to transform the self and to give the self a sense of worth and well-being, whether this something is the achievement of an ambition, a continued relationship with a needed other, or the maintenance of a particular mode of life.

Therefore depression may be conceptualized as a complex emotion that arises when an individual is deprived (or deprives himself) of an element of life that is necessary for a satisfactory state of self. However, most if not all mature individuals experience such episodes of mental pain during their lives without becoming clinically depressed. Some marshall their inner resources and continue to press on for fulfillment with renewed hope. Others tolerate the shattering of their wished-for state of self and readjust their aspirations or seek other avenues of meaning. Still others do not give in to their depression but defend against it by various external or internal means: external defenses are usually drugs or alcohol, and internal means are

commonly states of depersonalization or an obsession with hypochondriacal concerns. Many individuals, however, progress from the initial depressive psychobiological reaction as described by Sandler and Joffe (1965) to a true clinical depression. These individuals are predisposed to depressive attacks; that is, they have a particular premorbid personality which leaves them vulnerable to repeated bouts of depression. These pathological personality patterns are always present; so that depression has been described by some authors, such a Bonime (1962), as a practice, a way of life, rather than a periodic illness with healthy intervals. According to this view, Bonime has further implied that the predisposed individual decompensates when his maladaptive interpersonal transactions are no longer effective in bolstering a specious sense of self. This position can be widened to include the role of one's concept of self and others in the role of depression. When such a concept either obviates the possibility of meaning or is transformed by a loss or frustration so that meaning is no longer possible, depression ensues.

Types of Mild Depression

As previously indicated, mild (or dystonic) forms of depression may be classified into three major types: reactive, characterological, and masked. The symptoms of these varieties have been described in chapter 3. Here the discussion will focus on the underlying psychodynamics of these varieties first. The reactive and characterological depressions will be considered. The

major clinical differentiation between these two types is that the former occurs after an identifiable and subjectively severe trauma in the individual's life and the latter is exhibited in a chronically ungratifying form of existence.

The reactive forms of depression have already been described in detail and their exposition will not be repeated here. The differences between individuals who develop a severe depression following the loss of a dominant other or frustration in the attainment of a dominant goal, and those who respond to such subjective traumas with only mild or moderate feelings of depression, may lie in the quality and relative quantity of pathological beliefs.

Most, but by no means all severe depressives appear to have utilized the dominant other or dominant goal in order somehow to absolve themselves from a sense of inner evil or badness. In contrast, the individual who suffers from a milder form of depression does not uniformly see himself as evil, but utilizes the dominant other or goal to obtain pleasure and meaning. The search is not to eradicate a negative; rather, it is to add a positive aspect to life. Obviously each situation is more complicated, consisting of a mixture of relative absolution and satisfaction to be derived from others. However, in my experience, individuals suffering from milder forms of depression do not give protestations of personal malevolence or baseness. They may see themselves as deprived, lazy, helpless, or at fault for their loss, but the malignant undercurrent of true self-vilification (not a specious self-blame in order to

manipulate others) is usually absent.

Another difference is the degree to which the dominant other or goal has completely monopolized the person's life. Severe depressives appear to derive their total sense of self from some external agency. Less afflicted individuals, while showing an inordinate need for the other or for the goal to serve vital psychic functions, are able to develop other—-albeit embryonic—forms of obtaining self-esteem. In terms of cognitive beliefs, mildly depressed individuals appear to be better able to discover alternatives in their modes of thought. They are less rigidly bound to one set of ideas which govern all validations of the self. For example, these individuals are able to shift their attention rapidly to the therapist in the hope of reestablishing a pathological relationship. In contrast to severe depressives, they are not bound to so limited a cast of characters from whom to derive meaning. (Other differences between these two groups are presented at the end of this chapter.)

The term chronic depression is meant to describe two general types of patients. One group has a similar psychic structure to the reactive group but differs in that the relationship with a dominant other or the pursuit of a goal does not consistently or adequately dissipate feelings of depression. The other group is chronically depressed as a result of unrealistic standards that result from irrational beliefs of the self and others and which prevent satisfaction or pleasure in life. Both groups share a consistent lack of

joyfulness in life, a low estimate of self, and an oversensitivity to minor environmental frustrations or to trivial negative reactions of others. Most significantly, both groups endure periods of depression of varying intensity. This painful affect is a constant undertone to daily existence, during which it is at times more or less pronounced. This sense of depression, joylessness, and at times even of despair is multidetermined but most immediately results from a stifling self-inhibition of pleasurable activities and a fear of other people's reactions which the depressive often distorts or magnifies.

The first group appears to inhibit normal pleasurable activities for fear of losing the dominant other or because such activities may interfere with the attainment of a dominant goal. In this former case, the cause of inhibition may appear to be initiated externally. However, there is actually an internal restriction of activities since the individual will project all sorts of prohibitions on others in the environment. His fantasied restrictions are often more severe than the dominant other would impose. Similarly, in the latter case the individual erroneously believes that, as if by some sort of malevolent magic, any momentary diversion or pleasure will threaten his quest for the all-embracing goal. Such individuals are in a precarious situation since any sign of disapproval (real or imagined) from a glorified other or any subjectively believed impasse to obtaining a significant goal will result in prolonged periods of depression.

The second, or inhibited, group does not appear to experience depression directly as a result of environmental events. Rather, these individuals suffer from a chronic sense of futility and hopelessness because they do not allow themselves to become actively involved in rewarding activities. They often superficially exhibit a sense of prideful and moralistic superiority that covers a quite infantile personality which is scrupulously hidden from others. Evidences of this underlying pathology are the almost paranoid belief that others watch their every move, and their secret wishes to be passively taken care of by powerful others. These individuals dread the exposure of their dependency needs or the public expression of free, spontaneous behavior. They live ascetic, unfulfilled lives, imagine that others are keeping track of their behavior (as their parents had done), and suppress healthy desires for closeness and mutuality. The mode of existence that such structures impose becomes chronically dissatifying and eventually devoid of meaning. These individuals may gradually become so removed from true involvement in life that their unsatisfied needs become forgotten and they simply feel an inner emptiness or feel cut off from the world. In some depressives this inner emptiness may be temporarily abated by alcohol or drugs which can offer only short-term relief.

From afar, these individuals appear to be paragons of success and proper adjustment as well as of psychological maturity. It is in the course of therapy that they begin to recognize and reveal not only the extent of their

depression, but also the well of unsatisfied yearnings that they have shunned since childhood. They also demonstrate the presence of rigid, inflexible beliefs about themselves and others which prevent fulfillment in life. This strict code of conduct exacts its price in terms of closeness, pleasure, and meaning. In later life they may see through the irrationality of their behavior but be unable to bring themselves to change without the aid of therapy. They see themselves caught in a way of life that no longer brings even the bogus self-satisfaction of alleged moral superiority. Yet there is no awareness of how they can alter their beliefs by themselves. The old parental "shoulds" have lost their former rationality but not their tyrannical power.

Masked depression presents somewhat of an enigma since the concept implies a diagnosis of depression without the major symptom of this disorder —a conscious feeling of depression. However, as described in chapter 3, various authors have maintained that patients who are addicts, have psychosomatic disorders, are accident-prone, or have other behavioral abnormalities are actually hiding an underlying depression. Lesse (1974, 1977), who has contributed extensively on this condition, wrote that "usually the depressive core surfaces spontaneously with the passage of time in a manner comparable to an iceberg that may rise to the surface under certain climactic conditions" (1977, p. 186). He believes that masked depression is a common condition that is often missed by the untrained clinician. He found that over 30 percent of depressives whom he saw as consultant to a medical

unit had masked depression. Others, including myself, have found this condition to be rather rare. The frequency with which masked depressions are encountered may depend on the sample of patients seen, whether in a private psychiatric office or on the wards of medical services.

Part of the disparity in the reported frequency of masked depression also may reflect the definition of depression as well as diagnostic criteria. For example, I believe a depressed person who drinks or takes drugs should not be considered to be a masked depressive. Such a patient's depression is quite conscious and is being reduced by external factors. In contrast, an individual with an incapacitating medical illness or a serious psychiatric problem who experiences an understandable state of depression secondarily, as a reaction to his predicament, would not be classified as primarily depressed. In fact, most patients who request therapy for a variety of complaints are unhappy because their defenses or character adaptations are no longer effective. However, these individuals also would not be called depressed. In therapy such individuals describe different psychodynamics, life histories, modes of interaction, and cognitive distortions. An additional note of caution may be warranted: a large number of patients may become transiently depressed in the course of therapy as they become aware of some disagreeable aspect of themselves or have to relinquish gratifying yet neurotic behavior patterns. For example, an hysterical patient may suffer a temporary feeling of depression when he stops utilizing denial to a massive extent and takes a

realistic look at his life. This does not mean that a hidden, masked depression was present all along; rather, the affect corresponds to a new and possibly healthier way of seeing reality. The process of working through may sometimes be quite painful.

With these provisos in mind, it cannot be doubted that cases of masked depression do exist. In my experience these are truly depressed patients who utilize certain defenses against the unpleasant affect just as other patients evolve methods of eliminating the experience of anxiety. These patients usually present hypochondriacal complaints which absorb their every waking moment. They are so involved with their physical state of health that they apparently manage to fight off feelings of depression. Yet even in these patients some of the familiar depressive symptomatology is present: they are sure they will never get well, they are fearful of novelty and enjoyment, they utilize symptoms to greatly inhibit their behavior, and they manipulate others by their alleged ill health.

Another type of true masked depression I have seen is the rare instance of depersonalization. In these patients the affect of depression is so painful that they cut off all feelings as a way of avoiding experiencing it. As noted in chapter 3, these patients often experience rather severe and incapacitating depression when they do not depersonalize, and it may be questioned whether they should be considered mild depressives. On the other hand, they

do try to fight off the affect of depression and do not realign their cognitions so that the depression is seen as justified. They pay a great price for this defensive warding off of depression but the toll becomes understandable when they reveal the depth of their despair in the safety of the therapeutic situation. I have treated one such patient over a period of about five years. She initially had episodes of feeling empty, during which her body did not seem normal and she sensed herself as apart from the rest of the world. This woman had recurrent dreams of a terribly misshapen child whom no one could ever help. The affect in these dreams was extreme despair. In addition, she gave a history that was typical of depressed patients. As she became stronger in therapy, she was able to see the dream image as a distorted childhood estimation of herself and to confront the depressive affect related to this cognitive construct.

The status of masked depression is still unsettled since clear-cut diagnostic criteria have not been delineated and different authors may use this diagnosis liberally or very conservatively. While I lean toward the latter direction, such individuals do exist and successful treatment depends on recognizing the depressive core of their illness.

All types of mild depression share certain psychodynamic and cognitive features beyond the manifest experience of a dysphoric affect which links them together as variations of a basic disorder. These underlying

characteristics will be elaborated in the following sections in order to define the basis for the spectrum of clinical phenotypes of depression. Each factor may be relatively more or less prominent in different individuals, but the totality of these characteristics form a multifactorial network of beliefs and attitudes that predispose an individual to depressive episodes.

Restriction Of Sources Of Self-Esteem

Pathologic dependency is perhaps the one characteristic of the depressive that has been unanimously emphasized in the psychiatric literature. It was most probably this tenacious, demanding quality of melancholics that suggested to Abraham, in his pioneering work on depression, the existence of a libidinal regression to the oral stage. Although many authors have subsequently disregarded Abraham's formulations of unconscious dynamics, there has been a uniform acceptance of his excellent descriptions of the depressive's mode of object relations and character structure. Later authors have echoed the theme of dependency as central in depression, although they consider this characteristic from vastly different theoretical positions. Arieti (1962) has especially stressed the role of dependency in the etiology of depression. He noted that in his experience, decompensation of the depressive often occurs following the failure to maintain an ongoing relationship with a significant environmental figure. In contrast to the schizophrenic, in whom the psychotic transformation is in

reaction to a failure of "cosmic magnitude involving the relation with the whole interpersonal world" (p. 401), depression seems to result from the loss of a relationship with one highly esteemed person in the immediate environment. Arieti calls this idealized figure the "dominant other." who regardless of substitution in adult life is symbolic of the depriving mother.

Jacobson (1971) described a similar interpersonal situation, although she utilized a different terminology in recounting her treatment of a young woman who had been subject to recurrent depressions. In formulating the dynamics of this case, Jacobson observed:

> Hence her love objects represented glorified parental images with which she identified through participation in their superiority. To be loved and to find recognition by them served the purpose of supporting her self-esteem, which was forever threatened by the overstrictness of her standards and the intensity of her ambitions. It is significant that Peggy (i.e. the patient) did not "borrow" the ego or superego of her love objects, as certain schizophrenics will do. What she needed was respect for them, and love, praise, and emotional support from them (1971, p. 224).

This last point is extremely important in that the depressive does not "merge" with the dominant other; he retains his own identity. However, the depressive will misuse the dominant other in order to maintain self-esteem. The dominant other structures the life of the depressive in the areas of gratification and self-worth but not so globally as in the symbiosis seen in schizophrenia.

Becker (1964) called attention to limited areas of esteem as being a significant determinant of depression. In comparing depression with schizophrenia, Becker wrote, “The depressed person, on the other hand, suffers instead from a too uncritical participation in a limited range of monopolizing interpersonal experiences” (1964, p. 131).

Becker cited Volkart’s (1957) study of bereavement which showed that pathological mourning seems to occur when the bereft has limited his sources of gratification to too few objects:

> Any culture which, in the name of mental health, encourages extreme and exclusive emotional investments by one person in a selected few others, but does not provide suitable outlets and alternatives for the inevitable bereavement, is simply altering the conditions of, and perhaps postponing, severe mental illness. It may, in the vernacular, be building persons up for a big letdown by exacerbating vulnerability (Volkart, 1957, p. 304).

Certain individuals by virtue of their upbringing appear to develop too narrow a range of activities that can supply self-esteem and thus they are vulnerable to depression if their limited number of objectives are not realized. As mentioned in chapter 6, for some the objective is the achievement of a dominant goal; for others the objective is to receive love and praise from a dominant other.

It may be noted that, contrary to the early classical formulation of depression, the predisposed individual does not create an ego introject of the

mother following a loss in infancy. The internalization of parental values does not mean the incorporation of a lost love object as initially intended by Freud. Certainly all children adopt certain values and attitudes of their parents in the course of normal development without becoming depressives in adult life. The difficulty with the different meanings of internalization may be the result of a lack of reconciliation between the Freudian theory of depression and the later conceptualization of the superego. In the former, the infant incorporates the parent; in the latter, the child identifies with the parent as a solution to the Oedipal conflict. However, it is possible that internalization of parental values occurs as a gradual process throughout childhood and the concept of an introject is an unnecessary reification. More recent psychoanalytic contributions that stress infantile superego precursors seem to postulate just this preoedipal acceptance of parental attitudes without having to hypothesize the formation of a pathological introject.

Further clarification of the process of internalization also may be needed. The difference between imitative learning, whereby the child models himself after the parent, and reactive learning, whereby the child is coerced to become an idealized model desired by the parent, should be specified in reference to such terms as self-image and superego. In the case of imitative learning, the self is automatically modeled after an esteemed environmental figure, often without any underlying conflict. Reactive learning as intended here is the process whereby the child is made to become a desired ideal

which does not necessarily resemble the parent, in order to win love or escape punishment. The attainment of this parental ideal leads to a sense of satisfaction not because of any inherent gratifying quality, but because it ensures parental favor.

The depressive appears to be the product of excessive reactive learning and to have developed a reactive identity; that is, he functions best in a role that reflects the dictates of dominant other rather than any independent standards. These individuals require the presence of an external agency in order to derive satisfaction, and they are unable to gain pleasure from independent achievement.

Fear Of Autonomous Gratification

Patients often exhibit a marked inability and even dread of obtaining self-esteem or pleasure through their own efforts rather than by means of a dominant other. I have found this type of pathological functioning, which may be called the fear of autonomous gratification, to be a consistent feature of depressives. This characteristic may not always be immediately apparent, especially in view of the impressive achievements of some depressives. However, on further investigation it is found that social or professional accomplishment bring the depressive little pleasure in themselves: they are sought in an attempt to win love and acceptance from an external agency or

to affirm an irrational sense of self that still follows parental dictates.

Nancy, a highly successful executive who began psychotherapy after years of visiting internists with vague pains and insomnia, exemplified this fear of autonomous gratification. Although she held a position of considerable importance and made an attractive salary, she could not bring herself to furnish her apartment comfortably or live in a manner commensurate with her income. She considered anything spent on herself to be a shameful extravagance, but would buy inordinately expensive gifts for her parents. Nancy was equally self-sacrificing with her free time and canceled social engagements if her boss asked her to work late or if her father asked to see her. In actuality Nancy was unable to enjoy a social evening unless she could somehow relate it to her work, just as she had to justify buying clothes by saying that she had to dress well for work. She found it difficult to date and dreaded sexual confrontation. When she did go out, she tried to structure the evening so that she would be part of a group and thus escape being alone with a man. Even then she had to drink a good deal in order to fight feelings of guilt and degradation. Eventually Nancy confessed that even her work, which seemed to be her major concern in life, brought her no pleasure in itself but only served as a means of pleasing her boss. Whenever she gained recognition from him or when she was praised by her father, Nancy became ecstatic with a great sense of well-being and felt vibrant and alive.

Although she had been subject to mild depressive episodes for most of her life, Nancy became clinically depressed when her boss decided to retire. She felt betrayed by his leaving after her many years of self-sacrifice. This sense of desertion was intensified by her parents' coincidental plan to take an extended vacation overseas. Nancy felt that her only means of gratification and meaning were abandoning her, and the prospect of life without them was unbearable. Never having been able to gain a sense of self-esteem from her own efforts, but only through the presence of a dominant other, her life now seemed empty and pointless.

Nancy's early history can be briefly outlined. Her mother was described as a shy, helpless woman living in fear of her husband, who tyrannically ruled the household. Nancy was not allowed to form extrafamilial attachments, but was coerced to work hard and study arduously in order to bring honor to the family. She was sent to strict parochial schools and her work was closely supervised by her father, who made her feel guilty and ashamed if she did not perform according to his aspirations. She was repeatedly told how her parents were sacrificing themselves for her and how she frivolously squandered their hard-earned savings by not studying enough or by wanting to enjoy herself with school friends. Nancy grew up determined to win her father's admiration and to redeem herself against his accusations. She reacted to any activities that were not directed toward this goal with apprehension and anxiety, although she superficially disparaged them as childish and

immoral. In keeping with this "pleasure anxiety," Spiegel (1959) commented that the depressive fears the experience of happiness and pleasure as much as the experience of anger. The only thing that matters is to be passively gratified by the dominant other, to be reassured of one's own worth, and to be freed of the burden of guilt. Even patients who strive toward a dominant goal will shun any activity that does not eventually lead toward their overriding objective. Any involvement that is simply fun is carefully avoided because it induces guilt or shame.

A general characteristic of all types of depression-prone individuals which is apparent throughout their lives and not only during clinical episodes is an almost paranoid feeling that others are overly conscious of their behavior. They uniformly see themselves as the center of other people's attention and thus pursue what they believe is model behavior. This characteristic is closely linked with the fear of autonomous gratification in that such individuals can never actively have fun because they are sure that others will deem them foolish or wasteful. Such individuals live highly restricted and hypermoral lives, not from any superior inner ethical code, but because they feel themselves to be constantly observed by others. These individuals also tend to be obsessive and to find safety in conformity and rituals. They constantly speak about one's duty and obligations and are quick to point out the trivial failings of others in a superior, haughty manner. In actuality, these individuals who go by the book often make life miserable for

those around them, reproaching them for not living up to some imagined set of standards and constantly accusing those close to them of having humiliated them in public.

In therapy such individuals reveal that as children they were constantly observed by overly critical parents who expected model behavior from them in order to bring honor or acceptance to the family. As described by Cohen et al. (1954), the childhood behavior of some future depressives was exploited by the parents in the search for upward social mobility. Such individuals soon learn to see their behavior as the constant object of public and parental attention. They also do to their children what had been done to them. As therapy progresses, they often reveal a secret desire to be just the opposite of what they pretend to be. All sorts of sexual, antisocial, and romantic desires emerge which had been strongly suppressed for fear of criticism from parents and later from society at large.

This fear of autonomous gratification appears to play a very significant role in depression and may be primarily responsible for the eventual precipitation of a clinical depressive episode that does not involve an environmental loss. Some depressives decompensate when they realize after years of self-deprivation that they will not receive some special reward which they believed would be granted to them. Others become depressed as a result of the joyless life that they have imposed on themselves; they gain no

pleasure from life and yet feel unable to alter their way of living. One woman who presented a variety of psychosomatic complaints gradually became depressed when she saw herself trapped in an ungratifying mode of existence. She described her life as going through the motions of the role of an upper-class suburban wife and mother. She admitted that she detested her fund-raising activities, her husband's business associates, her clubs, and the usual daily routine to which she nevertheless strictly adhered. Her feeling of being trapped in an apparently successful and enviable life had been the prevalent mode of seeing herself for many years. She had grown up in a wealthy mid-western suburb, but due to the Depression her family had lost most of their capital. However, they continued to live as if they were wealthy, though everyone knew they could not really afford their lifestyle. The parents insisted on carrying out this economic sham and were careful to instruct their children on proper behavior, pointing out to them that others would be observing them to see if their loss of wealth had affected their "breeding." Throughout her life this woman made choices that would ensure social approval at the expense of personal satisfaction. When she reached middle age, she began to realize that it was too late to do the things she had really wanted to do. She confessed that even if she had been younger she could not have allowed herself to go against a harsh code of conformity which she expected from herself, even though it brought her only misery, Her anger at having to live according to her self-imposed restrictions seemed to result in

violent headaches, and her fear that she might act out her secret desires accounted for other bodily symptoms. Her current life, dismal as it seemed to her, at least offered a structured and secure code of behavior. Without it she believed that she would feel not only sinful but alone, abandoned, and without a set course to follow.

Other patients could be presented who throughout their lives have always made the same, if ungratifying, choices. These choices appear to be predicated on the original dictates of the dominant parent and on the later transference of parental authority to current life relationships. Such individuals distort others to fill the role of the demanding, critical parent and then act according to these transferential distortions, culminating in an existence which does not allow pleasure and predisposes them to chronic depression with definite paranoid and obsessive features.

Bargain Relationship

Implicit in the depressive's dependency and inhibition is what may be called the bargain relationship, which typifies some depressives' mode of interpersonal relations. The bargain is simply that the depressive will deny himself autonomous satisfaction in return for nurturance from the dominant other. This relationship is initiated by the parent, but the depressive reestablishes it on unwitting transference objects. This *quid pro quo*

relationship ensures that gratification and acceptance will be forthcoming if willingness for self-sacrifice is properly demonstrated.

This pathological mode of relating was hinted at by Cohen et al. in their study of manic-depressives (1954). They mentioned the patient's use of splitting a significant other into an all-good partial object and repressing the other's bad characteristics in order to idealize the important other. This other has to be inflated and seen as totally good so that the patient can then depend on and utilize the other for his own needs. Jacobson also implied a similar relationship, employing orthodox terminology: "The libidinal cathexis of their self-representations thus depends on the maintenance of a continuous libidinal hypercathexis of the love object, designed to prevent its aggressive devaluation in which their self is bound to participate" (1971, p. 259). Therefore, according to Jacobson the depressive must idealize the dominant other if he is to prevent a devaluation of the self which would precipitate a depressive episode. Actually, in some cases the other may be overvalued so that he can give structure to the depressive. In other cases the dominant other is utilized to absolve guilt, and in still other cases he is needed as a source of constant applause and selfless love.

An example of the first type of bargain relationship, in which structure is given by the significant other, is a brilliant graduate student who did extremely well under the tutelage of his professor. The student had a godlike

reverence for the senior man and would consult him about all of his life decisions. He felt himself to be safe and secure as long as the professor approved of his work, and he subtly used the older colleague to structure his day and to plan his lectures and research. While he was fawning in regard to the professor, this student was indifferent to his wife, competitive and suspicious with his fellow students, and generally terrified of life outside the university. However, he managed well until the time came to do his dissertation. His professor found the student a prestigious job in a physics think tank where he could support himself while doing his thesis. The young man took the job without questioning his elder's choice, though it entailed moving to a nearby suburb and essentially cutting himself off from all regular contact with the university.

In his new job the student felt immediately uncomfortable; there was no academic hierarchy, people did their own jobs without competing, and the atmosphere was loose and egalitarian. Worst of all, the director of the institute was a quiet and benevolent figure who did not interfere in the lives of his employees, all of whom were expected to be mature self-directed scientists. The student gradually became depressed in these new surroundings. He could not work unless he felt he was being observed and supervised by an esteemed superior, and the director simply refused to take on the role that the former professor had filled. Without the secure sense that a dominant other was watching and directing him, this promising scientist

lost all interest in physics. He began to bother his co-workers with elementary questions in order to gain attention and developed a great dislike for the director for not fulfilling his inappropriate needs. When he was deprived of the structure supplied by the dominant other, all activities became meaningless. The student gradually started staying in bed, complaining to his wife, and having difficulty sleeping. His dreams of being empty and lost reflected his waking psychological state.

In this case the positive or gratifying aspects of the bargain relationship are illustrated rather than the more painful type of bond in which coercion by guilt is prominent and usually results in a more severe form of depression. In the latter case, the dominant other is needed to reassure against feelings of inherent evil and badness. In addition to an air of helpless resignation and a sense of worthlessness, these patients believe themselves to be inordinately vile and malicious and they are convinced that only the dominant other can free them this self-image. One such patient who required brief hospitalization described herself in the most derogatory terms imaginable, whereas in reality she seemed to have led an exemplary life. Her mother was a selfish woman who resented any responsibility and detested the mothering role. When her husband left her, she blamed the patient and repeatedly told her that if she had never been born the father would have remained. The mother continued to blame her for her later misfortunes and in addition projected all sorts of sexual desires onto the patient, eventually making her believe that her

incestuous desires had driven her father from the house. This woman accepted the blame for her mother's unhappiness and dedicated her life to seeking forgiveness. She could not tolerate her mother's being cross or angry, and she did everything she could to soothe or please her. For more than twenty years this woman forced her husband and children to visit the mother weekly in another city where the patient would fuss over her and try to win her praise. The patient's mood for the following week depended on the success of these Sunday outings.

This woman became severely depressed when she developed intimate feelings for her employer. She could not tolerate her desires, which proved to her that her mother had been right in the estimation that she was wanton and base. All her previous efforts to redeem herself were now without meaning. She would never change; she had always been and always would be evil and worthless. She succumbed to the image of herself that she despised and which disgusted her.

A third example of the bargain relationship can be illustrated by a businessman who demanded to be adulated and nurtured by his wife. However, his needs appeared insatiable; he had to be told constantly that he was loved and that he was appreciated. If the wife dared to express interest in any topic that did not concern him, he would become hurt and begin to pout or to berate his wife for not realizing how hard he worked for her welfare. At

times he would threaten to leave her just so she could beg him to stay. On the rare occasions when his wife told him that she felt "sucked dry" by his demands, he punished her by crying and going through his speech of being unappreciated. The wife eventually unconsciously evolved her own defensive maneuvers by developing (and on occasion feigning) illness so that he could not ask her for nurturance.

This man feared that his wife would abandon him at any moment and his manipulations were pathological attempts to continue his needed relationship with her. At times he was also convinced that he was unlovable and so had to put his wife to the test to see if she really loved him, which meant he was worthy of love. While his behavior might appear controlling and even sadistic, as Rado (1928) described the depressive and his love object, this man truly believed that he was only trying to get the love he so desperately desired. His pathological needs blinded him to the destructive effect he had on his spouse. When she was sick and therefore not in danger of leaving him, he became solicitous and kind, only to revert again when she appeared healthy. This man had a long history of depressions following emotional abandonments throughout his life. He had married a submissive and frightened women in order to ensure that she would stay with him, and he continued to fight off his neurotic fear of abandonment by his machinations. It must be mentioned that her effect on him was totally out of proportion: if she smiled and told him she loved him at breakfast, he felt sure

of himself the entire day; if she were sleepy and quiet, he felt depressed and neglected.

This bargain relationship demonstrates the depressive's excessive reliance on a dominant other for maintenance of self-worth and a sense of meaning. It may take various forms, but basically it is a revival of a real or fantasied childhood relationship in which the parent was able to grant the child a needed state of self in return for appropriate behavior.

Finally it should be stressed that what predisposes one to depression in the bargain relationship is not only the exclusivity but also the quality of the relationship. For example, Lewinsohn (1969) suggested that depressives tend to limit their range of personal interactions. This conclusion seems valid but incomplete. An individual may lead a happy, productive life with only a few mutual, sharing relationships and not become depressed upon termination of these relationships. It is only when the relationship serves pathological needs, prevents autonomous gratification, and enforces the inhibition of independent self-worth that a predisposition to depression exists.

Felt Helplessness To Alter The Environment

As a result of this excessive reliance on external agents for gratification, and in certain cases for structure, the depressive displays a glaring lack of mastery over self-rewarding functions. Some are so constricted by strong

inhibitions that they simply cannot overcome the guilt and shame that accompanies simple enjoyment. Every act that might be perceived as pleasurable must be rationalized and disguised as leading to a productive or serious goal. These individuals experience intense anxiety at even the dim prospect of enjoyment, so that they strongly shun such activities. Therefore they complain that they are helpless to alter their depression and they feel overwhelmed and weak. Other depressed individuals who depended on a dominant other for gratification feel similarly hopeless and helpless if this other is lost. However, these individuals are not really helpless but they would rather be depressed than break the taboos that they impose on themselves. Obviously this is not true of all depressed states: some people face situations which they are indeed helpless to alter. However, these individuals usually do not totally collapse in their efforts; they may feel frustrated, cheated, and angry, but not uniformly depressed. In addition, nondepressives do not display the undue emphasis on moral issues which are so often seen in individuals with recurrent depressions who must see everything as someone's fault— usually their own. Healthier individuals also do not show the characteristic maneuvers of involving others to relieve their suffering through manipulation and guilt-inducing behavior that is seen in neurotic depression. To repeat what Sandler and Joffe (1965) elaborated in detail: we are all susceptible to the initial psychobiological response of depression which carries with it a transient sense of helplessness, but only

selected individuals will progress to a clinical episode of depression in which the sense of helplessness is magnified and utilized to control others to reinstate the lost sense of well-being.

Seligman (as mentioned in chapter 2) proposed a theory of learned helplessness to account for some forms of depression. Seligman essentially postulated that the depression-prone individual has learned that action does not result in reinforcement of needs, and so he gives up and gradually lapses into a state of depression. Actually, the depressive is far from helpless in that he is adept at manipulating others and also is capable of impressive accomplishments when required to gain love or approval. Rather, the depressive's apparent helplessness results from a disruption in his usual mode of behaving and gaining esteem through pathological means. The sense of helplessness is both an automatic and pathological attempt to induce others to supply the needed reassurance, and it is a result of training that one must act in reaction to others in order to win the desired acknowledgment. Therefore learned helplessness does account for some aspects of depression, but it is limited to the areas of assertion and pleasure without guilt or shame. It is understandable how the depressive might superficially appear to demonstrate that effort and reward are unrelated, yet on closer inspection it becomes evident that his efforts are just more surreptitious and devious in achieving their reinforcements.

Two depressed patients will be briefly described who had an overwhelming sense of helplessness. It is of interest that while both had histories of only mild depression, both had received electroconvulsive therapy (which effected only temporary relief). Their air of helplessness may have resulted in their being given this form of treatment since they refused to take any responsibility for their own therapy once they became depressed. In retrospect, they appeared to derive some pleasure out of being thought of by loved ones as severely incapacitated and requiring hospital care and shock treatment.

One of these patients was a woman of thirty-five who had suffered her first depressive episode fifteen years earlier when she was in college. Her mother was a teacher and had essentially ordered the patient to attend a local teacher's college while continuing to live at home. Throughout her childhood this woman had been trained to gauge her own worth by the amount of approval she received from her mother. She was restricted from playing with others and her nonscholastic pursuits were severely criticized. However, she was allowed—indeed strongly encouraged—to achieve in school. This woman remembered that as a child whenever she excelled in some scholastic activity, she would immediately think of her mother and hoped that the latter would be pleased. The woman's father was a pleasant but weak figure in the household. His role was to earn money (which was never enough for the mother) and to appease his wife. Another clear message that the mother gave

to the patient was that the world was a very dangerous place where others would trick you and take advantage of you. The mother further implied that the patient was no match for such a world and could only survive with the mother's protection.

As the patient reached adolescence, she began to rebel mildly against the mother, mostly in her fantasies. Boys started to show an interest in her and she was starting to derive pleasure outside the maternal orbit. She made secret plans to leave her local teacher's college and to go to an out-of-town university where she could live on her own and study what she herself chose. At this point her father suffered a severe heart attack which necessitated giving up his job. As a result, they shortly experienced financial problems and her hopes of leaving home were thwarted. With their dwindling income the mother became even more critical of the father, whom she berated in the crudest terms. The patient found it impossible to live at home with her mother, who appeared to have been continually angry, yet she did not see how she could afford to live on her own. Her one escape was to marry a young local businessman who did not fit her romantic ideal although he did offer a haven from the unhappy situation at home.

These were the circumstances in which she suffered her first attack of depression. The reasons for her decompensation appear fairly clear. She could no longer please her mother, who had become obsessed with money

and filled with venom against the world. Furthermore, the mother had changed in the patient's own eyes; the patient now saw her as uniformly punishing and abusive. The patient wanted to defend her father who, after all, had supported the household until his illness, but she dared not assert herself against the mother. She also was not assertive or adventurous enough to move out on her own and support herself. Instead she chose the security of a marriage which rapidly revealed that it would not satisfy her needs.

After recovering from her initial depression she returned to school, received her teaching degree, and from then on felt herself locked in a profession and a marital union which were both ungratifying. Her husband furthered her sense of helplessness by discouraging any social or personal activities that she might independently enjoy. Throughout the remainder of her life and until she entered psychotherapy, she succumbed to a semiparasitic and largely childish existence. Whenever external pressures, such as having a child, put additional demands on her, she became depressed.

It is noteworthy that in her dreams during therapy, she repeatedly returned to the original situation in college. Another telling incident about this patient was that as she began showing signs of assertion, her husband tried to get her to discontinue therapy in spite of her history of frequent hospitalizations. It is to her credit that she refused his demands and decided to pay for her therapy herself. At the beginning of her therapy, this woman

exuded a sense of helplessness, of everything being too much trouble, of being incapable of any independent action. She wanted things done for her, and to be taken care of by others or to be told what to do by others. She did not dare to make any decisions on her own. However, she had been far from helpless in other areas; she was a competent teacher, housewife, and mother. Her area of helplessness centered on assertion of her beliefs and independence from the evaluations of others.

The second patient was in his late twenties but already had been given two courses of electroconvulsive therapy. Initially, he constantly complained of being ineffectual and of being mistreated by others. Actually, he was very adept at indirectly getting his own way by manipulating those around him. He never considered the numerous times when other people tried to help him or treated him fairly. He focused only on those incidents when others had not lived up to his own idiosyncratic code of honor and had not accorded him special treatment. His two depressions had occurred when he could not get what he wanted, namely, the approval or special attention from esteemed others through his usual machinations. This patient believed he was helpless, but what actually occurred was that his usual mode of controlling others had failed.

This young man had been raised in an atmosphere of deception, secret deals, and obligating behavior and he could not at first consider any other

mode of conduct. This form of interaction had become automatic and unconscious. What remained in consciousness was a highly exaggerated response to the slightest rebuff and a feeling that everyone should go out of their way for him. The following excerpt is from a note he brought to one of his early sessions in order to convey his plight:

> My heart is so affected by things, it cries. I am sad and I can't stop it and say "be happy." It just doesn't seem to do any good. But what else can I do — do it myself or have it done for me. What can I do. Something has to be done before one day I jump off a bridge or at least seriously want to. Will it pass? I pray, but if God exists I don't even know if he cares—look at the world we live in. I am lost.

On the surface, this pathetic passage may illustrate the helplessness this patient felt in terms of improving his condition; others had to do it for him. However, during the time he wrote this passage he reluctantly worked at his job and even gloated over making some especially good business deals. His despair actually related to being unable to attain the special recognition he felt he deserved from his father, who was also his boss.

There is no doubt that even mild depression can be an incapacitating illness which not only involves a felt sense of helplessness but also may affect an individual's level of performance. However, when the origin of this feeling of helplessness is traced psychotherapeutically what usually emerges is that the individual first felt helpless in achieving meaning or gratification either as praise from a dominant other or in pursuit of a dominant goal. Having failed

in these pursuits, the individual finds little meaning in any of life's other activities and his sense of helplessness generalizes to his entire social space. In other depressed individuals, such as the woman just described, the individual has made choices throughout life that lock him into an ungratifying existence. Here again the individual lacks the courage to break his self-imposed taboos and thus despairs of his helplessness first to gain pleasure and eventually to accomplish even the most rudimentary tasks.

The Cognitive Avoidance of Overt Anger

In a recent paper on depression, Coyne (1976) related a strange cure for depression practiced by a Dr. Williams of London in the early nineteenth century. When a depressed individual consulted Dr. Williams, he informed the patient that he should seek out a certain doctor in Scotland who was famous for his ability to cure the disorder. The patient obediently journeyed to Scotland only to find that the highly able physician did not exist. After this fruitless search, the patient found that "a desire to upbraid (Dr. Williams) had engaged his entire thoughts on his way home, to the complete exclusion of his original complaint cited" (Coyne, 1976, p. 38). This anecdote suggests what has been almost universally found by authors on depression: the affect of depression is incompatible with the overt expression of anger. This finding has led to specific behavior modification techniques (although less circuitous than those of Dr. Williams) to evoke anger in depressed patients by assigning

them to monotonous, repetitive, and ungratifying tasks until the patient "blows up" and anger replaces depression (Taulbee and Wright, 1971). On the other hand, the incompatibility of overt anger and depression has also led to the notion that depression is a result of repressed rage. Indeed, as described in chapter 2, some have seen it as misdirected anger which torments the ego or the self-image.

The fact that clinical depression appears to decrease as the ability to directly express anger is displayed, however, does not prove this "repressed rage" hypothesis. Brenner (1975) reviewed a number of contributions which assert that enjoyment is also incompatible with the affect of depression. Does this prove then that enjoyment is repressed during depression and therapy should induce the patient to "get the enjoyment out"? It gradually becomes evident that direct repression of an affect is a complicated affair, if such a process can occur at all. What actually appears to be the case is that an individual's unconscious cognitive system structures a situation to produce a specific effect. Therefore the depressive does not overtly display anger because he automatically structures his view of himself and others so that anger is not produced. Rather, the depressive appears to respond to what most individuals call anger-producing situations with self-blame, feelings of hurt, or some sort of excusing the other. Rather than simply assuming that the depressive represses anger or directs it at himself, a search for the cognitive distortions which fail to elicit an aggressive response may be more

productive.

The depressive's lack of overt anger recently has been interpreted in terms of his tenuous object relations. The expression of anger may antagonize the dominant other and jeopardize the depressive's sources of gratification. For example, Arieti (1974) described that anger in depressives ultimately leads to more depression; it creates the fear that the dominant other will abandon the individual, which leads to an increased sense of loss and hopelessness. Anger is seen as a highly dangerous affect which must be concealed and suppressed. Klein's classic formulation of the depressive position emphasizes the infant's fear of losing his inner good objects through his aggressive wishes. She interpreted the infant as attributing the pain and frustration of loss to his own angry behavior with a subsequent suppression of overt hostility. If Klein's basic formulations are extended to the interpersonal sphere, the depressives plight of being angry while in a state of need for nurturance from the other, and the resultant fear of the manifestation of that anger, becomes more understandable. To express anger directly means to lose the all-important other who supplies the incorporated good objects, that is, gratification and self-esteem. The depressive eventually believes that any expression of anger will catastrophically result in the loss of gratification.

The depressive's lack of overt hostility can also be due to his distortion

of relationships. Some depressives idealize the dominant other and so implicitly trust the other's judgment that they see no reason for resentment or anger. If they fail to obtain the other's acceptance, it is because they have not tried hard enough to be worthy, and not because the other is stingy or unjust. They feel they have only themselves to blame and thus have no cause to become angry. A middle-aged depressed woman, describing the failure of her considerable attempts to win praise and love from her father, exclaimed, "What is wrong with me that he doesn't love me?" This woman could not conceive of her father as ungiving or unloving; it was her fault that she could not please him. Although married and the mother of three children, she still believed that her chief role in life was to please her father and devote herself to him. As in her childhood, her father was the only one who could make her happy and give meaning to her life. To alter her view of her father would have required an alteration of her entire mode of being.

Another possible reason for the depressive's inability to express anger is that the capacity to feel angry and to use anger as a direct mode of achieving an objective implies a sense of autonomy and independence that is just the ability the depressive lacks. These individuals are tuned to the reactions of others rather than to the expression of self, regardless of consequences. To become angry means to satisfy one's impulse without considering the effect on others, and it requires exactly the sense of self that the depressive has not developed. Thus he resorts to more reliable

manifestations of displeasure such as pouting or suffering, which produce the appropriate impact on others—guilt and forgiveness. Some depressives that Bonime (1967) so aptly described are stubbornly uncooperative in therapy; they spitefully refuse to take their share of responsibility and take pride in their resistance to change. Manipulation and control of others seem to be the cardinal features of their activity. This type of depressive, which is similar to Arieti's claiming type, may be understood as rebelling against the disappointments in past bargain relationships. These individuals feel themselves cheated by past dominant others who did not fulfill their promise, real or imagined, in return for self-sacrifice. These patients then resolve never to show any signs of true mutuality or cooperation as a way of punishing the dominant other, whose role the therapist has transferentially assumed. They will demand all sorts of favoritism and support while refusing to take any initiative in therapy and ultimately want to frustrate the therapist by not becoming what they believe he would wish them to be.

However, such patients never show anger overtly but punish the therapist by continually reminding him of their lack of improvement in therapy —that is, of the therapist's inability to change them. In this manner they make the therapist feel powerless and frustrated, but never give him cause to terminate the relationship. Thus they defeat the dominant other without losing him. Yet these patients continue to center their existence around the therapist and in reality defeat themselves in order allegedly to

control the other. Their activity continues to be judged in terms of the effect it will have on the therapist and the reaction it will elicit. Living in a world of reflective gratification, the depressive cannot conceive of himself as acting simply for himself. His every thought and act implicates the other and includes the other's reaction.

A talented college student who began experiencing episodes of anxiety and depression as she approached graduation described this type of other-dependent relatedness. She became immediately attracted to any man who showed her attention and would rush into a close relationship without adequately evaluating the other person. Her main concern was that he be pleased with her, and she devoted herself to fitting into her boyfriends' preferences. Despite her efforts to hold onto the relationship and placate the other, she was often exploited and treated with little consideration. When this occurred, she persistently blamed herself for having been rejected. She believed that she had somehow offended the other or that she had not been sufficiently perceptive of the other's needs. The other was right even in mistreating her. Each failure to maintain a relationship proved to her that she would be an old maid and condemned to a life of solitude. She believed that the only way she might escape abandonment would be to surrender autonomy and spontaneity. Any display of assertiveness, especially of anger or disagreement, would surely drive the other away. This young woman did occasionally get angry, but always after the fact: in the presence of esteemed

others, she was overcome with the desire to please and to endear herself. Even her considerable gifts were at the mercy of others, and a project that had taken her months to prepare became worthless if mildy criticized by a teacher. The teacher's judgment was never in question: if she had only worked harder, she might have pleased him.

A specific confirmation of the lack of repressed anger in mildly depressed patients comes from studies of their dreams. If they were bursting with unexpressed rage rather than distorting their view of the world in order to avoid anger, their dreams should reveal the repressed hostility. Beck and his colleagues examined the dreams of 218 patients who were independently rated by two judges as nondepressed, moderately depressed, and severely depressed. The major characteristics of the dreams of the depressed groups was a consistent masochistic trend. The dreams of the depressed patients revealed themes of disappointment, rejection, humiliation, or other similar unpleasant experiences, but the dreams did not exhibit notable anger.

Hauri (1976) reviewed some of the literature on the dreams of depressed patients as well as reporting his own study on eleven patients remitted from depression and who were matched with eleven control subjects. Past studies had shown that several depressed individuals report dreams that are bland, barren, and involve mainly family members. As depression lifts the dreams become more conflictual, although masochistic

and dependency themes persist even after clinical improvement.

Hauri's own study is noteworthy in that patients who had recovered from a depressive episode were selected and therefore their dreams reflected basic personality structure rather than the possible distortions of an acute depressive state. In addition, Hauri utilized all-night EEG tracings and awakened each subject to report dreams in order to reduce selective recall of only pleasant or socially acceptable dreams. In comparing recovered depressives with control subjects, Hauri found a number of significant differences in their dreams. Dreams of remitted depressive patients showed more past than present or future events, more unhappy than happy emotions, and more action exerted by nonhuman entities (storms, motors, bullets, and so on). Equally important was the finding that depressives did not show more hostility toward others or hostility toward the self in the dreams. Hauri commented that this may be the most important result of his study. Hauri concluded that on the basis of dream content, the depressive may see the world as dangerous or ungiving or even hostile, but this hostility neither emanates from the dreamer nor is directed against him.

Even Bonime, who believes that much neurotic depressive behavior is a distorted manifestation of anger, does not report excessive aggression in the dreams of depressed patients presented in his book, *The Clinical Use of Dreams* (1968). His work as well as that of Beck does not support the

repressed rage hypothesis.

Overt anger may occasionally be seen in some mildly depressed individuals when they view their situation more realistically. This may occur through therapeutic effort, or in some individuals before change through treatment. They can experience periods of insight when they are not blinded by their needs and distortions. This is usually not the case with severe depressives for whom reality has become completely transformed in its meaning. However, even in mildly depressed patients these periods are short-lived and the patients return to their accustomed mode of cognitive interpretation of events.

On the few occasions that I have observed depressive openly express anger, their expression was consistently clothed in moralistic terms with great attempts to justify the outburst. Even then the show of anger was not a simple expression of self, but a calculated attempt to coerce another to do something or to justify the feeling of depression by showing how they had been mistreated. Cohen and her co-workers (1954) also were not impressed with the importance of anger in their study of manic-depressive patients. The conclusions they reached are:

> We have said little in this report about the manic-depressive's hostility. We feel that it has been considerably over-stressed as a dynamic factor in the illness. Certainly, a great deal of the patient's behavior leaves a hostile impression upon those around him, but we feel that the driving motivation

> in the patient is the one we have stressed—the feeling of need and emptiness. The hostility we would relegate to a secondary position; we see hostile feelings arising in the patient as the result of frustration of his manipulative and exploitative needs. We conceive of such subsequent behavior—demandingness toward the other or self-injury—as being an attempt to restore the previous dependent situation (1954, p. 252).

The Washington group further adds "that much of the hostility that has been imputed to the patient has been the result of his annoying impact on others rather than of a primary motivation to do injury to them."

Perhaps much of the confusion of the role of anger in depressed states owes its origin to differences of opinion regarding both the nature of depression and of anger. As Mendelson (1974) accurately observed, there is no uniform consensus about the definition of either affect. Some psychoanalysts require the presence of aggression in some form or other as necessary for the diagnosis of depression. These manifestations can be self-recriminations (self-directed anger), low self-esteem (aggressive cathexis of the self-representation), or manipulativeness (controlling others by anger). This difference of opinion shows the equal lack of agreement on the nature of aggression. When Jacobson writes about an aggressive cathexis, she is describing a highly abstract metapsychological process that does not coincide with the overt, conscious expression of anger as known to the layman. The same is true of the intersystemic conflict between ego and superego. However, Bonime (1960) conceives of aggression as the covert motive of the depressive's behavior in his lack of cooperation in therapy or his control of

others. Here aggression is implied from nonaggressive behavior by its end result or by its alleged motive. Still other psychiatrists describe anger or aggression as a felt state of self—of being angry. Therefore it appears that there is a discrepancy in the psychiatric literature as to whether aggression should be seen as a primary instinct or form of psychic energy (that cannot by definition be directly experienced), as a motive force behind behavior which is not phenomenologically felt as anger, or as a primary feeling state.

Despite this confusion over the conceptual status of aggression, it is clinically evident that the depressive shuns the direct expression and even the experience of anger. He does not use overt anger in the service of his needs; rather, he utilizes manipulativeness to control others. If this manipulativeness is termed a form of anger or aggression, then this special use of the term should be made explicit.

The extreme emphasis on the role of hostility in depression may be a lingering influence of Freud's original theories stated in *Mourning and Melancholia,* which described a good deal of depressive symptomatology as misdirected aggression. As Mendelson (1974) wisely observed: "Freud's explanation of the melancholic's self-reproaches and Abraham's description of the manic-depressive's ambivalence became universally and, it is feared, uncritically and uniformly applied to all depressive phenomena. And later authors frequently sought to justify these constructions rather than to

investigate their applicability" (p. 194).

Family Background of Mild Depressives

As mentioned in chapter 2, there is a paucity of studies on family transactions in depression as compared with schizophrenia. The few studies that have attempted to determine the childhood roots of adult depression mainly have centered on the experience of parental loss. This interest in childhood bereavement appears stimulated by the hypotheses that adult depression is the reawakening of a childhood trauma, or that object loss is the basic problem in depressive disorders. Most studies have compared the frequency of the death of a parent during the childhood years of adult depressed patients and of matched controls. The results of these studies have been contradictory except for the finding that childhood loss (through death of a parent, divorce, or some other form of separation) is more common in all forms of psychiatric disorders, especially delinquency. Brown (1968) made an additional intriguing observation: 55 percent of the poets listed in the *Oxford Book of English Verse* and the *Dictionary of National Biography* (in England) lost a father or mother before the age of fifteen. This is a higher rate of parental death than is found in depressive (or delinquent) samples. Brown speculated that these poets turned to internal sources of gratification through fantasy to soften the blow of the parental loss, and their native genius later allowed these fantasies to be expressed poetically.

The rate of parental loss may not be the significant factor for later disturbance if it is taken in isolation. The effect of the loss on the surviving parent, the subsequent disruption of the family, the availability of substitutes, the child's age at the time of the loss, and his conception of the loss must all be taken into account in retrospective studies. Loss of a parent through death or other misfortune is certainly a significant childhood trauma but it does not appear specifically to predispose one to depression as an adult. To view the adult depressive as the recapitulation of an actual childhood loss is somewhat simplistic. Freud, who originated this concept of reactivated childhood trauma, did not intend the actual loss of the parent but the loss of the parent's love, which is a totally different matter. This loss of love may then represent an unconscious decathexis of the object representation and thus an unconscious object loss, but it is not meant to imply a loss of the parent in reality. Here again a metapsychological hypothesis and clinical data become confused. Sandler and Joffe (1965) tried to clarify the matter by stressing that depression is not the result of the loss of an object but a state of well-being of the self supplied by the object.

Cohen et al. (1954) did attempt a retrospective reconstruction of the childhoods of their twelve manic-depressive cases. They did not find evidence of early object loss or of a childhood depressive reaction equivalent to Abraham's "primal parathymia" (1924). Rather, these investigators noted that the families felt isolated or ostracized from the mainstream of society, the

mothers blamed the fathers for the alleged social failure, and the child was expected to redeem the family's honor or prestige. In terms of more specific child rearing, this group found that the mother accepted the child when he was a helpless infant but began to reject him when he displayed the normal willfulness of a toddler. These findings are confirmed by Arieti in chapter 6: in the early childhood of severe depressives the mother is initially giving and loving but quickly begins to make stringent demands on the child so that continued nurturance is contingent on the child's fulfillment of expectations. The important aspect of this interpersonal relationship for the child is the realization that love can be abruptly withdrawn if parental expectations are not met. It may not be an actual loss that predisposes the individual to depression, but the constant fear that a loss can occur if the proper behavior is not forthcoming.

A later development noted both by Cohen et al. (1954) and Arieti is that the parent assumes the power to redeem the child, to make him feel worthy. The child is convinced that it is his own fault if he does not achieve this redemption: if he had tried harder he could have obtained the needed support of the parent. This interchange sets up the process by which the adult depressive attempts to attain love by obedience and hard work, blaming himself if he does not achieve his objective. Much of this aspect of the future depressive already has been covered in chapter 6 and will not be repeated here. It is sufficient to note that the child's failure to fulfill parental

expectations is experienced as guilt and worthlessness.

Slipp (1976) studied the family setting that produces a depressive individual. He found that the child is given a contradictory message from the parents: the child is expected to succeed socially and at the same time expected to fail, so as not to become too independent of the parents. Slipp described the parents as expecting achievement and yet simultaneously rewarding failure. The child learns to succeed but fears that this success will bring abandonment. According to Slipp:

> The depressive evolves an oppositional form of symbiosis as a compromise solution to this double bind. By partial compliance to both succeed and fail messages, he does not risk abandonment by either parent; yet by rebelling sufficiently against these injunctives, he preserves some autonomy. Through halfhearted performances to his parents' wishes, he can play off both pressures and avoid being either strong or totally helpless. By partially defeating himself and losing he can claim to be a victim of external circumstances, and he does not have to take responsibility (1976, p. 398).

Therefore Slipp traces the pathological behavior of the adult depressive to the childhood solution of a double message: succeed for the family but fail lest you become independent of the family.

While I do not agree with every aspect of Slipp's analysis, the observations presented by him are important in demonstrating how the experience of independent success is perverted in the childhood of future depressives. In my experience, some future depressives have been given a

clear message to succeed, but the success later was robbed of its meaning; rather, it was presented as rightful repayment to the parent, as simply keeping up with the alleged superiority of the family, or as a way to get love from the parent. The child was told to succeed but that he should not enjoy his success.

The disparities between the childhoods of severe and mild depressives appear to be more a function of the amount of this thwarting of development than a function of qualitative differences. As a rule, the childhood of mild depressives was not so blunted by moralistic blaming and early threats of abandonment. Often the patients were made to feel weak or lazy rather than evil. They also did not have to work as hard or to distort their perceptions as much to gain parental approval. They often were the family favorites and were able to maintain this role by compliance. Therefore their inducements for buying the parental distortions were positive (favoritism, praise) rather than negative (guilty recriminations, threats of abandonment). Finally, for most but not all mild depressives, the father rather than the mother was the dominant parent. This finding was also reported by Slipp (1976). While such individuals soon became imbued with the family distortions that everyone owed everything to the father and their task was to insure the father's benevolence, they managed to continue a close relationship with a loving though weak and submissive mother. The threat of abandonment also came at a later stage of development and so had less impact on the personality. It

was not until such individuals could bring social value to the family by model behavior or excellent grades that the father became interested in them. Before this time they were treated as unimportant charges of the mother.

Nevertheless, in these individuals as well as in the severe melancholics there is a basic instability of self-esteem. They also have been unable to internalize sources of worth and must constantly derive their meaning as individuals from external agencies. They remain forever excessively vulnerable to the disappointments and losses which, for better or worse, form part of human destiny.

Notes

[1] Some confirmatory evidence for considering depression (as a primary feeling state and not as a clinical syndrome) as a basic psychobiological response is that it can be produced by physiological means. Mild depressions can be observed following viral illnesses or in states of fatigue. Depression also can accompany hypothyrodism or pancreatic disease or be produced by drugs such as reserpine. All this seems to indicate that depression, while most frequently caused by psychological events, is closely tied to basic neurochemical alterations and thus appears to be a fundamental mode of reaction which is similar to other emotions.

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