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PSYCHOTHERAPY OF DEPRESSION DURING THE MIDDLE YEARS (INVOLUTIONAL MELANCHOLIA)

Severe and Mild Depression

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e-Book 2015 International Psychotherapy Institute

From *Severe and Mild Depression* by Silvano Arieti & Jules Bemporad

Created in the United States of America

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Silvano Arieti

Specific Psychodynamics in the Middle Years

There is a time of life when the human being is prone to reassess his past and, by virtue of this reassessment, to envision his remaining years.

In our day, with the considerable increase in length of life, most people make this reassessment at a rather advanced age of about sixty or older. But one group of people—considerable in number but smaller than it used to be—makes this reassessment much earlier, during the so-called middle years, a period of life sometimes called the involutional age or the age of menopause and the climacterium.

This early reassessment generally is evoked by a deep pessimism about one's existence which emerges in full force when youth is over and maturity takes its place. Discontentment about one's lot in life, and the belief that what is left is not going to be worthwhile, bring about this negative appraisal. To make the situation more complicated, the cognitive substratum on which the

discontentment and negative appraisal are based becomes confused and either remains at the periphery of consciousness or is fully repressed. What does remain in full consciousness is a severe mood of depression. In a nutshell, this is the drama of what used to be called involutional melancholia.

Several issues are subsumed in the previous statements. In women, the first severe depression often occurs at the time of menopause or shortly afterwards. This cannot be considered accidental; but in spite of much research on this subject, no causal connection has been determined between the cessation of estrogen production by the ovaries, and depression. Most women do not become depressed at the time of menopause. Most women, unless seriously depressed, retain sexual desire after menopause and in quite a few women, lust is increased. If menopause is responsible for the depression, it is probably because of psychological meanings attributed to the phenomenon of menopause.

Several factors have to be considered. Although the woman retains sexual desire and may continue to have satisfactory sexual relations for the rest of her life, she knows that she can no longer bear children. In our era, very few women wish to have children at the time of the menopause. Thus we cannot consider the end of reproductive life to be a direct cause of depression. In some patients, however, the age at which it is no longer possible to bear children acquires a meaning which has very little to do with

the ability to procreate. In some women menopause elicits the following constellation of thoughts: youth has ended, attractiveness is diminished, old age is approaching. I will begin to look worse and worse. Life will offer less and less. Nobody has ever really loved me in the past, and the chances of my being loved now are nonexistent. I have nothing to look forward to; I am trapped in a condition from which I cannot escape. The patient would not be inclined to think this way if her life had been a rewarding one. In the past there was the hope that life would be better. Now the woman interprets menopause as a milestone indicating that hope is no longer possible. In chapter 3 it was mentioned that many authors have described the premorbid personality of the involutional melancholic as rigid, meticulous, obsessional, and having a narrow range of interests. These descriptions point out that the patient more or less followed one of the patterns of life that were analyzed in chapter 6.

Menopause seems to remove the last ray of hope for romantic or professional fulfillment. Although lack of professional achievement plays an important role for some women, in most female patients complexes about romantic love are more common. The patient feels that she sought love, but did not find it. If she found it, it was a love with impossible strings attached, or not a worthwhile love, or a love by far inferior to the one she had fantasized in adolescence. Although the patient does not regret the fact that she no longer can have children, she regrets the fact that she did not have children;

or if she did, that they did not bring the joy she expected. The depression which frequently follows hysterectomy has this meaning.

The patient broods over the idea that whatever she aspired to be did not come to pass, and whatever she did accomplish was of little import. Nobody cared for her enough, nobody considered her enough, even a deep and lasting friendship was denied to her. If she did spend most of her life for the sake of a human relationship or cause, that motivation now appears unjustified, badly conceived, disguised, distorted, masked. Whatever compensation she obtained was ludicrous in comparison to what she expected, to the efforts she made, or to what she could have achieved if she had followed a different path. But now it is too late: there is nothing she can do about it. If she looks for a meaning in life, she will end with the conclusion that her life is meaningless. Death may be preferable.

This picture is substantially the one described in chapter 6. The major difference is that the depression is precipitated by the menopause or, more accurately, by the cognitive work of reevaluating one's existence that the end of the prime of life has urged the patient to do. I must stress that the menopause is not simply a precipitating factor; it is a special factor with meanings easily attached to it because of the particular biological effect of the cessation of menses. The patient who has been able to escape depression, in spite of more or less having followed the patterns of life described in chapter

6, is no longer able to do so when she has to face what she interprets as the twilight of her life.

In some cases an unpleasant episode occurs around the time of the menopause, it is interpreted in accordance with the climate of the involutional syndrome, and it is recognized as the precipitating factor. The patient is able to remember the episode after the period of severe depression has subsided.

Szalita (1966) reported the example of a woman who at the age of forty-nine went on a trip abroad. She had been widowed from the age of thirty-eight. From a movie, she got the idea that a trip abroad could bring her adventure. To enhance her chances she traveled first-class and took with her an entirely new wardrobe, on which she had spent a full year's income. The trip was a total failure. She felt not only ignored but avoided by everybody. Szalita continues:

> At a certain point she sat down in front of a mirror in her cabin and started to meditate. She could not recall what she had been thinking about when an intense fear suddenly took hold of her. She felt that she was going to faint— to die. She ran out of her cabin and requested the ship's doctor be brought to to her. She was afraid to be on deck for fear she might throw herself into the water. She became agitated, walked restlessly in circles, and counted her steps. She could not sleep, however, was extremely restless, and decided to fly back home (1966).

Although these cases are tragic and at times devastating in their effects,

the psychodynamics are seemingly easy to understand even at a manifest or conscious level. Why, then, is the treatment so difficult? No matter how simple the psychodynamics are, and how many components are retained at the level of consciousness, the patient is not aware of the totality of the picture—its effects, origin, and implications. When awareness emerges, it is rapidly submerged and replaced by the feeling of depression. Sometimes the patient claims not to know why she is depressed. Other times she finds seemingly plausible reasons to justify her melancholia. Like many depressed patients, she makes rather superficial and negative appraisals of herself, the world, and the future. In other words, she puts into operation the cognitive triad described by Beck (1967). In these cases, too, we must be aware that this triad is a cover-up, a superficial depression covering a deeper one whose cognitive counterpart originated long ago and now has become partially or totally unconscious.

Psychotherapy techniques used for patients suffering from severe depression, as described in chapter 9, can be applied to most cases of severe depression occurring in the middle years. There is a group of patients in whose dynamics we must include an additional factor. Although both males and females are found in this group, we shall refer to the patient as female, since women are much more numerous. When the middle years, menopause, or climacterium occurs, the patient starts to brood over a “lost opportunity.” If she had married the man who pursued her and not her husband, or if she

had pursued another career for which she had an inborn talent and not the one she finally chose, her life would have been completely different and fulfilled. The lost opportunity now becomes the trauma of the loss, and it is often relived at this particular period of life when the woman believes nothing else is left for her. The "lost opportunity," however, is not often referred to, at least at the beginning of treatment. The patient in explaining her manifest symptomatology refers to hypochondriacal symptoms, unexplainable feelings which torture her, or Beck's cognitive triad. Only at a more advanced stage of treatment does the patient start to talk about the lost opportunity. Depression largely based on the complex (or cognitive construct) of the lost opportunity may reach severe intensity, but not to the most severe degree possible. An oceanic state of depression is seldom seen in these cases. Yet the "lost opportunity" is experienced as lost forever, without any hope of retrieving it.

Why do these cases not reach the most devastating degree of depression? This is not difficult to understand if we realize that this complex is a defense. Although it causes the patient to grieve, in a certain way it permits the retention of a moderate amount of self-esteem; the patient feels that she once had a chance in life. Whether what she missed was love or self-fulfillment in a career, she feels that she could have obtained the rewards of that love or that career—she was worthy of it—but it was either her wrong choice or fate (that is, circumstances beyond her control) which determined

otherwise. Regret for what one has not done or left undone is an important cause of depression, but not of the most extreme forms.

Conditions similar to those which have been described in women exist in men, too, although they are much less common.

If endocrinological factors cannot be considered important in the engendering of involutional depressions in women, they are even less important in men. Testicular hormones are produced for a much longer period of time than ovarian hormones. We also know that most men, unless physically ill or depressed, can have normal sexual relations until advanced age. Maranon (1954) reported that Pavlov found active spermatozoa in the semen of men as old as 91, and Metchnikoff in men as old as 103. Men who have reached the middle years are less concerned than women about the ability to procreate or about their physical appearance, and as a rule they do not see life as already approaching the end. Undoubtedly most of these differences between the sexes are to a large extent culturally determined and are probably bound to disappear with greater recognition of women's rights.

Szalita (1966) reported the case of a sixty-two-year-old man who connected the onset of his agitated depression to the following episode.

> He met an old friend whom he had not seen in thirty years, and he barely recognized him. "I saw in front of me an old, decrepit man," he said. "It dawned on me then that I must look like him. I went home and looked at

> myself in the mirror and hardly recognized myself in the image I saw. From the mirror gazed at me a shrivelled-up face, with bags under the eyes. 'This is me!' I screamed, and felt like breaking the minor."

Szalita added that this man had never married, but had had numerous love affairs and regarded himself as being successful with women. After this episode he considered himself "finished." He became hypochondriacal and developed symptoms similar to the ones his mother had had. He started to behave exactly as she had before she was sent to a psychiatric hospital. "Now I know how my mother cracked up," he explained.

Although a certain number of men feel threatened by what time has done to them physically, a larger number are disturbed by the fact that they have not kept up professionally as they should have. Some men feel threatened by younger competitors in matters of love and romantic liaisons, but many more feel threatened professionally. Some men become insecure in their work and unable to make decisions. On the other hand, they resent depending on others. Pathological states of depression occur when the patients experience themselves as being in a serious predicament from which they cannot escape.

Psychotherapy

Today not many patients suffering from typical involutionary melancholia—characterized by severe depression occurring for the first time

in the so-called involutional age and by motor agitation—seek psychodynamic psychotherapy. The material reported in this chapter derives from cases which, although serious, did not reach the nadir of severity.

The reasons hard-core patients with involutional melancholia are seldom seen by psychiatrists today follow:

I. Fortunately, such cases are much rarer than they used to be. Cultural changes are responsible to a large extent for this decrease in number. Women who consider menopause to be a catastrophe or a tragic event are decreasing rapidly in number, and even those who continue to see the cessation of the menses as an undesirable occurrence respond to it in a less intense manner.[1]

II. Practically all severe or hard-core cases after a futile attempt with dmg therapy are hospitalized and/or receive electric shock therapy. Electric shock therapy is an effective treatment in many cases. We can assume hypothetically that the organically induced changes disrupt the pre-conscious cognitive network.

We do see a large number of patients with severe (but not extremely severe) degrees of depression at about the time of the menopause and climacterium. They are in many respects similar to other cases of severe or moderate depression, and in many instances it is difficult to determine whether the present depression is the first in life, as a diagnosis of

involutional melancholia would require. Many patients state that they were never depressed before, but it could be that earlier depressions passed unnoticed or were so mild in comparison to the present one that the patient did not even consider them as attacks of depression.

A rigidity of character at times interferes with treatment. The patient may tend either in the direction of being scrupulous, excessively moral, and motivated by high principles, or in the opposite direction, as an undisciplined person with no goals and principles. The early stages of therapy do not differ from those outlined in chapter 10. When the therapist has become a significant third, and patient and therapist are ready to form a search team, the analysis must be directed to the study of those rigid patterns of living which have led the patient to the present predicament.

What sooner or later emerges is the symbolic importance of having reached the middle years, the menopause, or the climacterium. The patient starts to talk more and more in reference to the issues that were mentioned in the previous section. A recurring theme is that life has come, or is about to come, to an end. The therapist, who by now has established a working relationship, will be able to convey the message that it is only because the patient gave excessive importance to certain aspects of this period of life that she now sees herself in a state of hopelessness. For people who are willing to search, life offers new possibilities for fulfillment during the middle years. As

a matter of fact, the patient is disturbed because in spite of having reached the menopause, she feels full of life and does not want to surrender. Nobody wants *her* to surrender; only some wrong and archaic conceptions she has about herself and life. Her reluctance to surrender is a healthy sign: what is unhealthy is her complex, which consists of archaic conceptions. In the second half of the twentieth century, there are very few human beings indeed who in their forties or fifties consider themselves ruins of what they used to be. The patient is told that she is just one of the few who think so. The truth is that she did not feel fulfilled in the past, but now she interprets the menopause or the onset of the middle years as the event which has given the coup de grace to her hopes. The patterns of thinking and living that she has adopted now make her believe she has no alternatives. These patterns have to be explored in accordance with the procedures described in chapter 9.

Although some patients suffering from involutional melancholia have followed a pattern of submission to a dominant other, or mourn for what they previously thought was a good relationship with the dominant other, most belong to the category of patients who have experienced failure in their attempts to reach the dominant goal. But the dominant goal, especially for female patients, is to find a suitable love object—preferably a husband, but also other reliable romantic liaisons. Like the heroine of some novel, the patient always longed for and searched for a monogamous romantic relationship that would satisfy all her needs. Now she feels that her goal is

unattainable. With this dominant goal, the patient often retains the traditional role of the passive, possibly masochistic woman who at times is even willing to be brutalized by a man in order to be accepted, loved, or desired sexually. At other times, with the passivity there is resentment and even the tendency to see the men with whom she comes into contact in a much worse light than they deserve to be in.

When a good relation has been established with the patient, a resolution of these complexes occurs, alternatives are found, and depression recedes, as illustrated by the following two cases. The first one is reported in detail; in the second one only the fundamental aspects are outlined.

CASE REPORTS

Mrs. Marie Carls

Mrs. Marie Carls was in her middle fifties when she came for the first interview. She appeared distinguished in her manner, with an almost aristocratic demeanor. A college graduate, she spoke in a beautiful literary style which was characteristic of the well-educated, upper-middle class family in which she was brought up. She had been born and had lived in Europe until a few years prior to the onset of treatment.

During the first interview she made several statements, some of which

appeared self-contradictory. She said that ten years earlier she had had a hysterectomy which was necessitated by a very large fibroma. There were no sequelae to the hysterectomy, but unpleasant symptoms had started a few months before she came to see me. She felt depressed and in a constant state of tension or agitation. Her mouth was dry. Since she became depressed, she had slept no more than three hours per night. She stated that her life had been serene and without problems. Why she should feel depressed was a mystery to her. She lived happily with Julius, her husband, and she was happy to be in the United States for a few years, as required by her husband's occupation. When her husband was ready, she would happily return to her country. It was true that in the past she and her husband each had had an infatuation for another person, but neither affair had amounted to anything. Both affairs were now relegated to the buried memories which nobody wanted to resurrect.

All her complaints were somatic in nature. She tired easily, to the point of exhaustion. She knew she was melancholy, but she thought that it was because she did not feel well. She was very religious and had been brought up in an environment in which there was strict adherence to Catholicism. She went to confession very often.

A few sessions after the beginning of the treatment, she started to define her various complaints and general state of malaise as "an obscure force"

which would take possession of her. She knew that this obscure force was a psychological experience. It was something which would come suddenly and make her depressed, tired, and often cause cramps in her stomach. Asked whether she had experienced something similar in her past life, she said that when she had given birth to her first child, at age twenty-four, she felt depressed in a way vaguely reminiscent of what she was experiencing now, but at a much less intense level and not to be compared with her present condition.

During much of her treatment, which lasted three years, the patient spoke repeatedly about the obscure force. At times she felt well, and then suddenly she would become depressed. The psychosomatic symptoms— the tiredness, the general malaise, the cramps—would completely possess her. She felt as if she were being invaded by a black cloud or fog.

Marie Carls was the youngest of three children. Her mother was described as a woman of whose presence everyone was immediately and intensely aware. She had a "volcanic" temper and was passionate and emotional, but also obsessive-compulsive. There were some drawers in the house that only she was allowed to open. Once, when the patient's father opened them, the mother became hysterical and threatened to throw herself out of the window. The father slapped her face. The father was very conventional and was described as a loving person and a devoted family man.

He had always confided in the patient. As a matter of fact, when he was seventy-eight years old and a widower, he confided to her that he was still disturbed by sexual desires and did not know what to do about it. Did she have any advice to offer? She didn't.

The patient had always felt very attached to her mother. As a matter of fact, they used to call her "Stamp" because she stuck to her mother as a stamp to a letter. She always tried to placate her volcanic mother, to please her in every possible way. The mother, however, did not fulfill her maternal role very well. The patient remembered that when she started to menstruate at the age of thirteen, she did not know anything about it. She went to her mother, who explained, "It is a natural thing, but a dirty one." The subject of menstruation was never brought up again; it was taboo. The patient described herself as being naive for a long time. She remembered hearing from a girl friend that a thirteen-year-old girl had found out that she was pregnant and had not known how this could happen. In a state of desperation the girl killed herself.

The patient remembered that her menses were often late, and until the age of nineteen she was always afraid that she was pregnant, although she had had no contacts with men. When she got married at the age of twenty-three, she was a virgin. However, when she had intercourse with her husband on the wedding night, she did not bleed. The husband said to her, "Perhaps

when you are seventy years old, you will have to confess a little sin." But she was a virgin, and the husband did believe her because he never spoke about this matter again. She, on the other hand, thought from time to time about the "little sin", and what came to mind was the beautiful garden of the home where she had spent her childhood and adolescence. Two boys also came to mind, the sons of the gardener; but the patient was sure that she had never had any physical contact with them, nor had she wished to. She admitted, however, that she might have repressed fantasies of that type. No: she was proud of having been a virgin when she got married. She came from a family where religious precepts, traditions, rules, and laws had to be respected. She had an aunt, however, who had challenged the world with her free behavior. Everybody ostensibly criticized her; almost everybody secretly admired her. Unlike her aunt, the patient did not challenge the world or any human being. She submitted to and obeyed the wishes of society.

When the man who became her husband revealed his intention to marry her, she shared the unanimous opinion of her family that he was an excellent match. Although she was not enthusiastic about this man, she could find no fault in one who appeared so honest, reliable, a good provider, and a good Catholic. After the marriage she continued her pattern of submission and compliance. Before her marriage she had difficulty in complying with a volcanic mother, and after her marriage she almost automatically assumed a submissive role. Actually, she described her husband as very considerate,

egalitarian, and not domineering at all. His only fault was that he did not have a volcanic or dynamic personality. He was too placid, too good, and rather boring.

The first few months of treatment were devoted to describing the placidity of her life, the goodness and the considerate attitude of her husband, her great respect for him, the boredom of life and of her marriage, and her lack of any desires—including sex. Only two things were prominent in her life, and they were repeatedly mentioned in her sessions: her profound religious devotion; and the obscure force which came from an unknown place to possess her, make her feel depressed, or fill her with psychosomatic symptoms.

Her dreams contrasted with the placidity and uneventfulness of her life. After reading Dostoevsky's *Crime and Punishment*, she dreamed of having committed a crime with one of her brothers. In another dream a girl had been found killed. Many dreams repeated the motif of guilt and retribution.

Several months after beginning treatment, the patient reported a dream. Ignatius and she had decided not to see each other again. She would have to leave him forever. I asked who Ignatius was, because I had not heard the name until then. The patient replied almost with surprise, "But the first time I came to see you, I told you that in the past I had had an infatuation." She then

told me that when she was thirty years old, in the middle of the Second World War, she lived at the periphery of a city which was frequently bombed. Ignatius, a friend of the family, had had his home completely demolished by bombs. The patient and her husband invited Ignatius, who was single, to come and live with them. Ignatius and the patient soon discovered that they had an attraction for each other. They both tried to fight that feeling; but when Julius had to go to another city for a few days, the so-called infatuation became much more than that. There were a few physical contacts, but the patient had no complete orgasm. However, there was an intense spiritual affinity. Ignatius understood her: he spoke her language, liked what she liked, and gave her the feeling of being alive. She remembered that before she married Julius, she had invented a slogan which she often emphatically repeated, “Long live life”; but only with Ignatius could she believe in that slogan again. Ignatius suggested that they elope, but she did not take him seriously. A few months later everybody had to leave the city. Ignatius and Marie promised to keep in touch, but both of them were full of hesitation because of Julius, a devoted husband to Marie and a devoted friend to Ignatius. Nothing was done to maintain contacts. Two years later, approximately a year after the end of the war, Marie heard that Ignatius had married. She felt terribly alone and despondent.

For several sessions Marie spoke almost exclusively about Ignatius, and in this period the so-called obscure force acquired prominence. She described

this force as “a feeling which grows to gigantic proportions; an internal sensation, physical and psychological, occasionally accompanied by thoughts. It is a malaise which first spreads through the whole organism, and then becomes localized in the stomach or in the whole abdomen.” On one occasion she said, “The obscure force is a faceless entity which often strikes me with a terrible violence. It leaves either physical illness or deep depression. It comes suddenly, at the most unexpected moments. For instance, once I was watering the geraniums and all of a sudden the force struck me.”

During this stage of therapy Marie revealed that there had been a period during which she felt very guilty because of her relationship with Ignatius, and she decided to confess the whole thing to Julius, ready to accept whatever decision Julius made. Julius’ reaction was unexpected on more than one count. First, he did not become at all incensed or punitive. Second, he said “Marie, I must tell you something I never told you before. I, too, had a brief affair with a woman during the war. Let’s forgive each other entirely, forget the whole thing, and continue to love each other.” At first Marie felt injured that her husband had had an affair, but then she was relieved, and accepted her husband’s “supreme wisdom and maturity.” Moreover, after her husband found out about Ignatius he seemed to become more intensely interested in her sexually.

Many years passed, during which she lived a comfortable and

uneventful life. She had two children, who married at a young age. To further Mr. Carls' career, the couple emigrated to the United States after the war. She became enthusiastic about the United States; she had what other people would call a happy life; and yet, in spite of it, she became depressed.

In a subsequent stage of therapy Marie concentrated on her marriage. Had she really accepted her husband's proposal to forgive and forget? Only ostensibly. The pact with her husband partially relieved her guilt, but not her loneliness and her thirst for life. The obscure force stood for the suffering that she wanted to repress. Her suffering had become more acute as she realized that old age was approaching and she had lost all her chances. Ignatius remained as the memory of lost opportunities. Yes, Ignatius had wanted her to go with him, but she wouldn't, because she felt that her husband and God would never forgive her. Even that beautiful short relationship was spoiled by her feeling of guilt. Her life of compliance and obedience had not permitted her to reach her goal. An Ignatius existed in the world, but she had lost him forever. She had never loved her husband, and that was what was wrong with her marriage.

For many years she had tried to forget Ignatius, to minimize her encounter with him as her husband had suggested. But how could she? The encounter with Ignatius was the most beautiful episode of her life, and she was happy it had happened, although she should prefer that it had never

happened. The rest of her life did not seem to count. Eventually the obscure force struck her.

For many years she had hoped she could make up for the loss of Ignatius, but now she could no longer do so. She could no longer scream, “Long live life!” She would rather think, “Down with life without Ignatius, a life which has lost its meaning.”

When she became aware of these ideas, she felt even more depressed. She was complaining less and less about the obscure force, and more and more about her marriage. She felt that everything she had built in her life was false or based on a false premise. In a certain way her husband was not so compliant, permissive, and tolerant as she had seen him; but possessive because she had to live by his way of living, with all its placidity and the boredom. But this was impossible to do when she really did not love the man.

A few sessions later she said that there was only an empty space in her life. She had utterly and irrevocably failed. She had made terrible and irreparable mistakes. It was better to contend with the obscure force than with the truth; better not to know than to know. At times the ideas of the past were forgotten and the obscure force returned, but not for long, because it was not possible to suppress the truth any more. Had the therapist really helped her? Why didn’t he leave her alone in her blessed obscurity, less

painful than the enlightenment?

At this point we have to take stock of what is known about this woman before proceeding to illustrate the subsequent course of treatment. It was obvious that her life had not been a happy one from childhood to the present time. When she was a young girl, she was brought up to believe that her happiness would eventually come as a result of a romantic encounter. An ideal husband would fulfill all her needs and would give a complete meaning to her life. Both the family's influence and the general contemporary culture, especially fiction and the cinema, nourished such expectations. Even in her daydreams she, like many contemporary women, assumed a role of dependence on a man. The man would be the fulfiller of her dreams.

The finding of such a love became the dominant goal. But this goal was not reached in marrying her husband, who fell so short of her ideals. Ignatius appeared on the scene and was immediately invested with all the attributes of the dominant goal. He came and then went away, becoming a dominant goal which could no longer be achieved. It was difficult to suffocate and suppress gigantic feelings and to adjust to a pale, conventional marriage. To some extent Marie succeeded with the help of her religious beliefs. As a matter of fact, during confession she made two promises to the priest: she would no longer look for Ignatius, and would no longer pray for him. But it was obvious that she always looked for him and she always had a rock-bottom hope that

she would find Ignatius, or another Ignatius, or what Ignatius stood for. When she realized that Ignatius was no longer likely to appear, the ideas and feelings which she had suppressed—or actually repressed—threatened to reemerge. She tried to suppress them again and again, but the depression and the so-called obscure force were conscious. Part of the depression was psychosomatically transformed into the effects of this obscure force.

When the patient became able to verbalize what she had kept within herself for a long time, her conscious ideation increasingly assumed the form of mourning for the "lost opportunity." She could have decided to elope with Ignatius, and her life would have been a beautiful realization of a love dream. But she had spoiled everything because of her guilt and conventional habits. As much as she could stick to the idea that her goal had had the possibility of being realized, she preserved some self-esteem and sustenance, and her depression never reached a stage close to stupor or to the point of having serious suicidal intentions. She had an ambivalent feeling toward her feelings of guilt: at times the guilt feeling had spoiled her life; at other times it was the redeeming feature which had protected her from total catastrophe.

A therapist could easily pick out what was wrong with Marie Carls's cognitive structure and formulate a therapeutic strategy. She could be helped to demolish the dominant goal, with all its accessory constructs, and be guided to find alternative patterns of living. But it was not easy to do so in

practice.

When the patient had established a good rapport with the therapist, had started to relate to him as to a significant third, and had revealed a large part of her history and its implications which she had repressed or suppressed, the cognitive structure was at first challenged in its more superficial and common-sense aspects. Was Ignatius really the ideal man she had envisioned? What was so wonderful about him? Even sexual life with him had not been completely satisfactory. Why did he go away so easily and not return after the war? Evaluation of past events was complicated by her strong feelings that she had done what God demanded. The patient attributed these feelings to herself and to Ignatius. She continued to defend Ignatius and to keep him on a pedestal, but with less and less strength. Eventually the patient asked herself whether in real life Ignatius corresponded to her image of Ignatius, or whether he was a mythical figure. She became more and more inclined to think that Ignatius was a myth. But when she thought of him as a myth, the depression— unless replaced by the obscure force—became more pronounced; obviously because she needed the myth of Ignatius, the myth of the "lost opportunity." As mentioned, these interpretations remained at a rather common-sense level.

But a much more profound blow to the cognitive structure of the dominant goal was struck when she was asked whether, before Ignatius

entered her life, she had ever daydreamed about a man who would one day appear and be like Ignatius. And indeed she said yes, she had often daydreamed about such a man; and when Ignatius appeared, he was the exact embodiment of what she had been expecting. When the patient reached this conclusion, she rose from her chair and said with a profound melancholia which was full of strength, not weakness: “The myth of Ignatius existed before Ignatius.” She paused awhile, and then added, “Three myths. The myth of the expectation of Ignatius, the myth of having lost a wonderful Ignatius, the myth of the return of Ignatius.” This was indeed a great revelation. The cognitive trap started to be dismantled. What I and my pupils call the dominant goal was more poetically called a myth, and a myth generating a series of myths. I told her that I thought she was quite right, but could she explain why the myth of the Ignatius-to-be, or the expectation of an Ignatius, was a myth? By making such a request, I obviously intended to make her work on restructuring the cognitive substratum of her problems.

She told me again the many reasons which throughout her youth had made her focus on the expectancy of this ideal man. First, her grandmother had been a writer of romantic novels, which the patient had avidly absorbed. In those novels the woman was a passive entity whose main job was to wait for some male to acknowledge her existence and finally discover her secret virtues. But the few who do notice her are not worthwhile. The man who is worthwhile is either a sadist or a marvelous man who for various reasons is

unattainable. These themes recur even in contemporary American novels, the patient added, novels written not only by women but by men as well. The patient wanted to stress that the origin of her trouble did not reside in her grandmother. Her grandmother was only representative of a culture which fostered a false goal in women. The goal was false in that it was the only one, or one of the very few, that a woman in her social environment could have. In subsequent sessions the patient made connections between this goal and the predominantly patriarchal, male chauvinistic society which seduces women into accepting such a goal. Her original desires to placate her volcanic mother and to please her father, for whom she had an Oedipal attachment, were channeled toward the aim of being the lady that she had believed she was expected to become.

Mrs. Carls explained that after the termination of the Ignatius episode she herself had done some reconstructive cognitive work, but it had been wrong and led nowhere. Once she realized that Ignatius was lost, she tried to improve her marriage, but she also made this attempt in an erroneous way; she was still searching for the perfect life or the ideal goal in a relationship in which she again could assume a dependent role. But every time Julius showed his human weaknesses—or rather, his human dimensions—they appeared very small. If she could not have the ecstatic, voracious flame of love she had for Ignatius, she thought she could have a solid, profound, spiritual relationship with Julius based on commitment, loyalty, companionship, and

shared experiences. But she still depended on Julius, and Julius could not share life's experiences with a strength equal to hers. She had what she called a thirst for the absolute, which she was trying to find in her marriage. Occasionally she would refer to a thirst for perfection which cannot be found on earth, for it belongs only to heaven. As a matter of fact, at times during the night she would wake up with a sense of anxiety or what she called religious terror. But it was interesting that one of the nights when she woke up with a "religious terror" she had been having a dream in which she was kissing Ignatius. During the dream she experienced an intense pleasure whose sweetness was impossible to express in words.

Thus there was no doubt that searching for the absolute was really a substitute for searching for Ignatius. She was still searching for Ignatius; but with her religion, sense of loyalty, and the pact made with her husband (to forget the past and to love each other) she also was trying to suppress Ignatius, or whatever myth was a derivative of the Ignatius myth.

I have already mentioned that while Marie was trying to demolish the myth of Ignatius, she was at times experiencing very intensely both the obscure force and wave after wave of depression. The depression at times became very severe, and I was under pressure from the family doctor to give her antidepressants. I resisted the pressure. With some patients I consider it advisable to prescribe antidepressants, but not for patients with whom I feel

that I am about to make psychological progress. In the case of Marie we had reached a psychological understanding of why the dominant goal had had a chance to develop, but we did not know why it was still so necessary for it to exist. Eventually we came to understand that this dominant goal has a special flavor or nuance: loss of Ignatius represented the lovelessness of life, and lovelessness of life was equated with death. The dominant cognitive constructs in her mind thus could be summarized as, "I have discovered the lovelessness of my life. Lovelessness equals death. My life is a living death. Real death would be preferable."

A psychiatrist must agree that love is important, and a life without love is an impoverished life. But love means many things, just as there are many types of love. For Marie it meant only romantic love, all passion and flame, like the one she had imagined with Ignatius. Life without that type of love is not at all a life characterized by lovelessness, and by no means to be equated with death: but it was so for her. There are many strong and pleasant feelings that one can feel for family members, career, friends, humanity, cultural interests, and so on. They are different loves, but they count too. A life without the type of love she imagined with Ignatius can be a rich and rewarding life. In summary, the meaning of Marie's life did not have to be found in the actualization of the Ignatius myth. A long time was devoted to the discussion of these basic issues.

In many cases of involutional depression occurring in married women, we find a picture simpler than the one presented by Marie. The woman was led to believe in her youth that she should want to have a nice companionable husband who would be a good provider, with a house in the suburbs. She has to depend on her husband, become his appendix or satellite, live for him. At a certain time in life she wakes up, realizing that those goals which indeed she has attained are not what she intended to live for. Depression then ensues. In the case of Marie Carls, she did not reach her goal, and her unattainable goal was transformed into the myth of the lost opportunity.

In spite of the differences that I have mentioned, Marie's pathogenetic complexes had several characteristics in common with those of many other depressed women: total reliance on a man for fulfillment of life aspirations, and belittlement and finally impoverishment of all other aspects of life for the sake of reliance on a man.

Marie Carls gradually understood all the complicated ramifications of her complexes or cognitive constructs. Many of these components had to be disentangled, rectified, and put into the proper perspective. She came to see her life as not wasted, and she came to recognize that her good qualities and potentialities were worthwhile when not put at the service of lost opportunity. She became active in many cultural directions and found fulfillment in life. Her relations with her husband improved; the marital

situation was given an important but not all-inclusive role among the array of life's possibilities. The patient, of course, always had been able to distinguish the periods of depression and anguish from those which were apparently asymptomatic. But now she became able to distinguish apparent calm which is only a tacit resignation and a forceful repression of rancor from the serenity which reflects real acceptance of oneself and one's life.

There were many ups and downs during the first half of the treatment, because the patient had fits of depression when old constructs or subcomplexes had to be given up; but the main upward trend was discernible from the beginning of the second year of treatment. Treatment lasted three years and ended with complete recovery. At this time six years have passed, and there has been no relapse.

Before concluding this report, two points deserve further discussion. If we use Freudian terminology, we can say that one of them deals with the patient's id psychology and the other with her superego psychology.

A psychoanalyst of orthodox orientation would have put more stress on the Oedipal fixation of this patient and on other sexual connotations of the case. There is no doubt that the patient had a strong attachment to her father, and her father possibly had some counter-Oedipal attachments, which may be subsumed from some remarks made by the patient. This Oedipal attachment

could have strengthened the patient's desire for the unattainable man, since one's father is unattainable. It is also very possible that sexual desires for the gardener's sons, which had been repressed from consciousness, were once very strong and made her feel very guilty. They came back to her mind, during the wedding night, when the husband spoke of her "little sin" that she eventually would have to confess. What was once an imagined or fantasied little sin in childhood was transposed in time, and became the sin with Ignatius which she did confess.

The second point has to do with the role that the patient's religious devotion played: Did it do more harm than good? Love of God protected her from experiencing the "lovelessness" of her life even more deeply. On the other hand, it increased her guilt; when she felt that she could not accept life without a sinful love, she believed she would lose even God's love. We have seen in chapter 6 that some depressed patients, especially those who live in a very religious culture or subculture, can make a dominant other of God. The loving attributes of God are minimized, and the demanding and exacting attributes are stressed. In these cases the patient can experience more or less toward God the conflicts or ambivalence that are experienced toward a human dominant other. Mrs. Carls's attitude toward God did not reach such a pronounced involvement. When she became able to dismantle her myth of romantic love, the practice of religion and love of God resumed an important place among the several loves of her life. Love for children, husband, work,

and culture—together with love for God—helped her find rewarding and rich aspects in life. These loves bestowed serenity and optimism on what had been an anguished existence.

The word “anguished” elicits a final comment. Were there sufficient and irreversible causes in this case that would ineluctably confer anguish to Marie’s life? The answer seems to be no. Her mother was as temperamental as a volcano, but not cruel or hostile. Her father was not tyrannical or seductive, and only when senility approached did his behavior seem somewhat inappropriate. The family was on the whole a loving one, although dominated by restrictions, conventions, and a strong sense of duty. One gets the impression that if an atmosphere of spontaneity had prevailed in which it would have been possible for the patient to build less rigid patterns of thinking, feeling, and behavior, then she never would have known a deep depression. This is another case that shows how ideas chosen by the culture, the family, and the patient himself can entrap the human being into rigid patterns and absurd myths, and confine him in a desperate position to which he feels ineluctably tied. The alternative left to the patient is generally to submerge all his perceptions of life in a mood of depression; or at other times, as in the case of Marie, to experience something strange that comes from the obscurity of the inner self and possesses one entirely—an obscure force.

This case also shows that no matter how intricate the labyrinth of the

cognitive structure may be, psychodynamic therapy can disentangle it, lift the depression even when it presents itself as an obscure force, and make the human being feel receptive again to the array of life's aims and loves.

Mr. Rafgaf

Mr. Paul Rafgaf asked for a consultation at the suggestion of his sister, who realized that he was terribly depressed. He was forty-nine years old and had worked for twenty-four years in a travel agency. Several months earlier he noticed that he could not keep up with his work because he was becoming slower and slower. His company agreed to give him a prolonged leave of absence. They did not want to dismiss him because of his prolonged, effective, and loyal work. When he left, they told him that he could come back whenever he felt well. Several months had passed, however; and instead of feeling better, Mr. Rafgaf felt he was getting worse. The idea of going back to work terrified him. He thought he would never have the courage to call his boss and ask to be reinstated. Why should they reinstate him? He was not good.

When asked why work terrified him, he replied that the company had computerized most of what had to be done in the various offices. He believed that he could not learn how to use those terrible machines, those computers which were supposed to be very simple, but appeared to him so complicated.

The idea of using computers was enough to put him into a state of panic. He felt he could not survive in the business world. He would like to fall asleep and never wake up. He had contemplated committing himself to an insane asylum, but had decided against it. Perhaps the best thing would be to commit suicide.

The patient was living alone. I told him to call his sister and me every day. These telephone calls would make him feel less alone and would alert us for the real possibility of suicidal attempts. When he was asked why he lived alone, he said that he was not married; he was a homosexual. For twelve years he had had a relationship with George, three years his senior, but now even that relationship was fading. It had not kept up its initial momentum and had become purely platonic. The patient had the most negative appraisal of what this relation had been for twelve years. He was suffering from premature ejaculation in his homosexual relations, and sexual encounters had always lasted only a few seconds. He was a lost man, unable to love, unable to work. There had been only one important homosexual relationship in his life, and that was now extinguished without the possibility of being replaced by another one. He did not feel up to finding a new one.

The patient was reassured about the possibility of treating the depression with psychotherapy. A therapeutic team was established, and he became able to talk about his past life. He was brought up in a very religious

Catholic environment. When the patient was seven, his father lost his job and the family had to split up for economic reasons. Mother, father, and sister went to live with the paternal grandparents. The patient went to live with his maternal grandmother and aunt. After a few years the family was reunited, but the parents did not get along. They could live neither together nor apart. The patient admired his father, who was a hard-working man, but never loved him. Father could not communicate with him, and the patient felt distant or not considered enough by him. Nevertheless the patient had frequent crushes on father figures from an early age. He remembers that when he was eight he had a crush on the priest. He became an altar boy to please the priest. Later he experienced pain when he had to leave the young priest. He felt abandoned by the priest, as he had when mother and father left.

The patient became aware of his homosexual orientation very early in life and he felt very guilty about it. His father called him “sissy” from the age of six or seven. Later the patient tried to enter the heterosexual world, but without success. When he left high school, he thought of joining a religious order. Perhaps religion would cure him of his homosexuality: priesthood would make him forget sex and avoid sin. However, he indulged in masturbation with homosexual fantasies.

Mr. Rafgaf described his youth as marked by constant self-depreciation and disappointments. He had to leave college after two years for lack of funds.

He had acne and felt ugly and unwanted by both women and men. Nevertheless, through hard work and discipline he managed to make some kind of adjustment. His work with the travel agency gave him some satisfaction, and his long relation with George gave him the feeling that there was somebody who cared for him. He tended, however, to comply and have a submissive role toward George.

Now at the age of forty-nine he realized that the relationship with George was fading and no longer sexual, and he would not be able to find another partner. He had been "abandoned" by George as he once was by father and mother and later by the priest. The use of computers by his firm was the culminating point of his desperation. It was a symbol of the fact that life always confronts one with new challenges, but he was not up to it. The little security he had found in his job and in the relation with George was now crumbling, and he felt open to the hostility of the world. He also felt more and more inadequate now that old age was approaching.

Establishment of a therapeutic team was easy. Attitudes that the patient had repressed or suppressed reemerged to full consciousness. Explanations of basic facts were accepted and decreased the intensity of the depression. The patient understood the significance of childhood events and the original feeling of inadequacy that reemerged when his citadel of security seemed to be crumbling. He understood how the fear of being abandoned again, which

he experienced early in life, had reacquired supremacy in his mind.

The difficulties of homosexuals in establishing new relations in the middle years were explained to him so that he would not consider his situation to be a personal defeat. He was encouraged to find new liaisons. He understood that his age status required some readjustments, but it did not indicate the end of life or a state of hopelessness. The patient gradually reacquired the feeling that he was wanted in the travel agency, they would accept him again, and he would be able to work with the computers. I encouraged him to call his boss and to ask to be reinstated. The boss was happy to have him back. Mr. Rafgaf started work again with no difficulty or trace of depression. Treatment lasted eighteen months, although depression had subsided a few months earlier. Three years have passed with no recurrence.

Notes

[1] It has already been mentioned in chapter 3 that Winokur (1973) found a 7.1 percent risk of developing an affective disorder during menopause, and a 6 percent risk during other times. He considered the difference not significant.

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