PSYCHOTHERAPY OF SEVERE DEPRESSION

CASE REPORTS

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Severe and Mild Depression

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worthwhile goal, and without the fulfillment of an intense love.

Doris has recovered again. Her husband, who incidentally also has learned a great deal by listening to the recorded sessions as Doris advised him to do, has become capable of communicating fully with her and of being more expansive. He also seems to have lost some of his inhibitions. It is never too late. Doris and her husband plan to go on a cruise around the world. The *Aurora* does not exist any more; it has been dismantled. They will go on another ship.

If I may conclude this case with my own free associations, I wish to say that *Aurora* means dawn, but a sunset is often more beautiful than the dawn. The sunset of the Fullmans' life promises to be beautiful and serene.

Henry Tusdori

Dr. Henry Tusdori, a forty-seven-year-old physician, requested treatment on account of a depression which had already lasted seven years. Being a physician, he had been able to prescribe all sorts of antidepressants for himself, but there was no improvement. Recently the depression had become worse and he was wondering whether he should be hospitalized. The exacerbation of his depression had occurred after his divorce. He said that Phyllis, his former wife, had become unable to accept him because he was a discouraged and beaten man. After the divorce he felt abandoned and without

love. In reality he had already found a girl friend named Peggy who was very devoted to him, but he did not appreciate her love very much. He felt that if she cared for him it was only because he was a physician and she considered herself intellectually and economically inferior to him. He was still mourning the loss of Phyllis, who had become tired of him and had abandoned him. Phyllis knew how to love, he didn't; Phyllis knew how to assert herself, and he didn't. On the other hand, it was true that he had wanted Phyllis to submit to all his wishes, but she would not.

Although considered by others to be exceptionally competent in dermatology, the specialty in which he had made noteworthy contributions, Henry Tusdori said that he disliked medical work. As a matter of fact, in the last two or three years his work had become less satisfactory, he had lost patients, and he felt ready to give up his profession. He felt tremendously frustrated, dissatisfied, and unwilling to continue any of his undertakings. He did not know whether life was worthwhile.

Relatively soon in the treatment he disclosed that he did not want to be a dermatologist, but always had aspirations of being a great writer. Since his adolescence he had devoted several hours every day to writing fiction and poetry, but the publishers rejected all his work. He did have a considerable talent for writing but, since he was involved with his medical work, he could not cultivate his literary ambitions. Still he had daydreams of winning the

Nobel prize for literature.

He actually lived for the dominant goal of becoming a world-renowned writer. Everything else in his life was subordinate to this goal. Not only did he neglect some aspects of his clinical work, but his relations with women left much to be desired. They counted in his life only inasmuch as they enhanced his writing aspirations. First Phyllis and then Peggy had to listen to his poetry recitals until very late at night. They constantly had to reassure him that he would succeed at writing. When they protested or would not accede to his taxing requests, he would become angry. He never became violent but, according to his own account, on a few occasions he had a hard time controlling his aggressive impulses. Suicidal ideas occurred every time he concluded that he was a failure both as a writer and as a physician.

Henry was born in Italy. When he was four, his parents sent him to live with friends in a distant city. His father had been a notorious antifascist and the parents felt persecuted by the fascists. They wanted to be sure that their child was safe. Henry could not understand all this very well and felt that he was being punished; that they were sending him away because he was bad. The family reunited later, and Henry always tried to do his best so that his mother and father would never again “reject” him. Mother, and especially father, always stimulated him to become a “great man,” commented on his intelligence, and incited great ambitions in him.

Because Henry had to divide himself between his literary and medical work, he never achieved the high goals to which he aspired. Although he and his family emigrated to the U.S. when he was twenty, no linguistic difficulties interfered with his literary ambitions. He knew English well, but he could not fulfill his literary aims. As a doctor he was always found to be more than satisfactory. Still, he felt that only if he became great in the literary field would he deserve his parents' love, or the loves that later replaced parental love. Although he very much needed the love of a woman, the dominant goal of his literary aims actually prevented him from attaining a genuine intimate relation with a woman. Until the conflicts were discussed and to a large extent solved, Henry continued to suffer frustrations and to nourish hatred for the medical profession.

Eventually he decreased his literary ambitions. He accepted himself as a worthwhile person even if it did not mean becoming a Dostoevsky. More and more he came to value being a competent physician, capable of helping many people. He also became able to apply his unusually high intelligence and inner resources to many other aspects of life. His relations with Peggy improved greatly as he started to consider her as a person in her own right, as a person who loved him dearly but who did not want to be treated as an object for the sake of being loved. Henry continued to write for his own pleasure. He recognized that the medical profession had not been imposed on him; he had chosen it, and not just in order to make a living. Actually it was the literary

work that lost some importance because he came to recognize the role it had played in his life. In other words, he understood that he used the fantasy of becoming a great writer in order to recapture the loss that in childhood he imagined he had sustained. Suicidal ideations disappeared and there was no longer any thought about hospitalization. Occasionally, however, he continued to experience mild fits of unhappiness when the idea presented itself again that he had to abandon his life's great ambition. This dominant goal was so ingrained in the fabric of his psyche that some of its effects could not be totally erased.

Sandra Carquois

Sandra was a 24-year-old married woman who, three months earlier, on awakening one morning felt that she could not get up from bed. Her husband, whom she had married a year and a half previously, urged her to get dressed but she insisted that she couldn't. She felt miserable and wanted to die. And yet the night before when she retired she felt everything was all right. During the night she felt restless, but she did not remember having unpleasant dreams. At the suggestion of the family physician, she sought psychiatric treatment.

Sandra was quite an attractive young woman, spoke without hesitation, and repeatedly said that she felt depressed to the point of having no desire to

live. She did not know why she had become depressed all of a sudden. She loved her husband George, whom she had known for three years before deciding to marry him. All this she told me during the initial interview.

During a few of the following sessions, she repeatedly described an interesting phenomenon which she did not know how to explain. It was still very difficult for her to get up in the morning. Everybody knew that she was ill and her mother came from a nearby city to help her. Sandra was an only child. In reality the parents had had another child, a boy, who died a few days after his birth. Sandra's mother became fully devoted to her after her birth and would do anything for her. But in the presence of her mother, Sandra became even more helpless. She acted like a child; or rather, like a baby. She did not want to do anything. She had no energy to move, and she needed help to get dressed. When her mother went away she felt helpless, lonely, and a complete invalid. But if the mother was around, she underwent complete infantilization and wanted to be treated like a baby. If her mother refused to do anything for her, even giving her a glass of water, she felt resentful, rejected, and angry. Thus there was no way for her to get out of this predicament. She felt hopeless and wanted to die. This behavior in front of the mother lasted several weeks. Later it continued to be difficult for her to get up from bed and to come for the sessions, but nevertheless with the help of George she managed to do it. Once she was up, getting out of the house was relatively easy.

A brief history of the patient follows. The mother was described as an extremely overprotective person, an overloving mother who would do everything for the patient. She actually lived through the patient in a vicarious way. Mother was an extremely anxious person and Sandra seemed to have "inherited" her anxiety. When Sandra was a little girl she was not allowed to practice sports for fear that she would hurt herself. She wished she could be like her father, her preferred parent. She never understood why her parents got married, because they seemed to be so poorly matched. Father was a well-to-do man who treated Sandra like a princess and provided for all her financial needs. The patient and her husband had recently moved to a rather elegant part of New York City. They used to live in a town in New England, but since her husband wanted to be a physicist and had to go to school, it was easier to live in New York. Sandra too wanted to continue to go to school for her master's degree in English literature, but recently she had dropped out.

The morning in which she felt unable to get up loomed for her like the beginning of a new era, or actually the end of another era; the very end of her life. Why did she have to get up? she felt. What for? What was it all about? What was there in life to live for?

In the beginning of treatment she said that she did not know how to explain the striking experience of that eventful morning. She was apparently happy. It was true that her husband on the one side was a dreamer who

wanted to discover the secrets of the atom, and on the other side was a person who enjoyed life in a material way and did not mind being supported entirely by his rich parents-in-law. But the fact was that George and she got along well. There was absolutely nothing wrong in her life which should make her feel depressed.

Many sessions were devoted to interpreting what had happened that eventful morning. Eventually she was able to verbalize what she had never been able to say or even to think about. She insisted that even when she tried to do some serious thinking while she was alone, she was not able to say to herself the things that she could later express in the therapeutic situation.

All of a sudden life had appeared false to her. That morning even the furniture in her home became flashy, appeared *nouveau riche*, and was not to her taste. It reflected the artificiality of her life, a "pseudo-life which was filling the emptiness of her life." The night before, her husband had made love to her in a routine and meaningless manner. She herself was no longer interested in making love. Everything appeared grey, even her marriage. Even George, a man whom she had insisted on marrying against her parents' advice, appeared boring and common to her. George was not really devoted to becoming a great physicist. Now he seemed much more interested in savoring the pleasures of a mundane life. Sandra and George lived in an expensive apartment in a nice part of the city, but all that was artificial too. How much

more genuine was life in the New England town where she used to live! She could not divorce her husband; he was fundamentally a nice fellow. Moreover, what would her parents say? She had insisted on marrying him against their advice. She had given up everything, even going to school. She wanted to be a child. Mother would give her everything she wanted, but then she would become a baby again. But she did not want to be a baby.

Good progress was made relatively soon. The patient came to accept the fact that she was not accepting her present life. She was praised for recognizing the false values which characterized her style of living. She understood how she grew up making claim after claim which was methodically fulfilled by her parents. By satisfying all her wishes, they actually retarded her maturity. The claims that she was making now to her husband could not be fulfilled, and certainly she would have to determine which of her claims were legitimate or illegitimate. She eventually would have to decide whether or not to continue in her marital situation. She realized that she had not continued to go to school when she sensed that her husband did not really have the devotion to become a physicist as he pretended. She did not want to be better educated than he was.

During the first few weeks of treatment the patient was almost always confined to bed, but she became quite active later. At first she became involved in philanthropic activities. Then she worked for a while in a nursery

school. Soon, however, she resumed going to school in preparation for her master's degree, and did very well. Fits of depression continued, and she seemed fairly sure now that they were related to her marital situation. While she was attending school, she noticed that several teachers and often students were paying a great deal of attention to her. That did not surprise her because she had always considered herself to be very attractive. What surprised her was that for the first time since she was married she was responding to other men's attentions. After a period of a few months during which she had serious conflicts, she started to become involved with men and had a series of short love affairs. None was serious enough in her opinion to justify leaving her husband, but each of them gave new moment and zest to her life, and rekindled her desire to live. Not many months passed when she discovered that her husband too was having repeated affairs.

After a period of about a year during which there was no depression, the patient terminated treatment against advice. I felt that the patient's problems had not been solved to a sufficient degree, and that some of her solutions were questionable. On the other hand, there was no sign of depression, and depression has not reappeared since then.

José Carrar

José Carrar was a thirty-nine-year-old South American businessman

who purposely came to New York to seek treatment for his deep depression. He had been diagnosed as manic-depressive and indeed he occasionally had periods of euphoria and hypomanic state. However, these euphoric periods were very mild and rare. What disturbed him and his family most were the attacks of depression, which were long and intensive. According to the patient, he had had episodes of depression since he was twenty-one but the attacks became worse since the age of thirty-five, shortly after his father's death.

The father of the patient was a self-made man who built up a successful chain of stores over his country. He started as a porter and ended up as a multimillionaire. He stimulated his six children to follow his example. The patient was the second child, looked very much like his father, was considered the most intelligent of the children, and was expected to take his father's place in the corporation. José lived for the goal of becoming the chief of the company. He got married and had six children, just as his father had. He did well in school and displayed unusual intelligence and interest in many aspects of life.

At superficial examination it appeared that José was using the attacks of depressions in a manipulative way to provoke anxiety and guilt in his wife and to avoid unpleasant situations. It also seemed as if he would use hypomanic episodes to obtain what he wanted and to request what he did not

dare to ask for when he was in a normal condition. For instance, when he was hypomanic he acted as if he were already the chief of the company, and would give orders and dispositions which were not appropriate to the circumstances. Upon deeper analysis, however, it became obvious that his depressions started when he realized that his brother Pedro, the oldest of the children, was also the most qualified by temperament and business talent to take his father's place. Each attack of depression was precipitated by an event which indicated to José that Pedro would eventually become the chief. When the father died and Pedro did take his place, a very intense depression with suicidal indications occurred. At first the depression was interpreted as mourning for the death of the father. José denied that rivalry for the brother was at the base of his depression. He said that intellectually he knew that Pedro was the more qualified to take that position. Although it was true that José had intellectually accepted Pedro's access to the prominent position, emotionally he had not. Since childhood he had lived for the day when he would take his father's place. All the other aspects of his life were minimized for the sake of this ambition which now would not be fulfilled. It was quite revealing to observe how everything else in his life had lost significance.

The psychodynamics of this case were simple. However, it was very difficult to change the attitude of the patient and to help him to pursue alternatives. It was not enough for him to realize the implications of his great life's disappointment. He had to reconstruct his whole attitude toward life

and find other avenues for fulfillment. This was made difficult also by the fact that he had learned to exploit the secondary gains of his illness. In other words, he could say to others but especially to himself that if Pedro was more qualified for that position it was because he, Jose, was ill. Within two years of treatment there was marked improvement.

Five Depressed Women

Brief reports of five female patients are presented in this section. The outcome was favorable in four cases, although in one of them divorce was necessary. Three of the patients showed striking similarities in life history, symptomatology, and successful outcome. The fifth patient contrasts sharply with the others both in her life history and because of her negative response to therapy.

Rose Farsmith, a forty-five-year-old woman, made a suicide attempt when she learned that her husband was in love with another woman and wanted to divorce her. She took an overdose of barbiturates and was miraculously saved when even her doctor had started to lose hope. She was hospitalized for a few days and on her discharge she learned that her husband had already moved out of the house.

Rose said that she had been depressed for a long time, mostly because of her husband. He was unreliable, would not pay debts, would make

promises which he did not fulfill, and did not respect her.

An underlying sense of inadequacy and inability to assert herself had characterized Rose's whole life. A fear of being abandoned had existed since childhood when, after the birth of her brother, she felt her mother would cease to love her and possibly go away. During the first ten years of marriage she tried to devote herself entirely to her husband and two children. She tried to please the members of the family as well as she could. At a certain point in her life she came to the realization that her marital situation could not improve. She had several attacks of depression, but did not seek treatment. At the level of consciousness she did everything she could to cling to her husband, and to keep the marriage going. She was terrified at the idea of remaining alone. She felt unattractive and the possibility of finding another man seemed to her nonexistent. On another level—that is, without realizing the implications of her actions—she did things to antagonize her husband, to render herself unattractive, and to urge him to seek the companionship of other women. During treatment she became aware of the role she had played. She accepted the divorce without a sense of panic and started gradually to rebuild a life for herself.

Mrs. Lucille O., Frances R., and Marie P. had almost identical life histories. The three of them each developed in childhood and adolescence a relation of submissiveness and dependence on their mothers, who became

the dominant other. All three married self-assertive men who were moderately successful in their business activities and were good providers, but rather callous and insensitive to family relations. The three patients put their husbands in the position of being the dominant other after they had succeeded at least partially in removing the mother from that position. In one case, the mother retained a very strong role although not quite comparable to that of the husband. The three patients gave up whatever career ambitions they had once nourished and devoted themselves entirely to the family. One of the three had been a music teacher, one a business woman, and the third a secretary. They became increasingly depressed; the former music teacher also developed suicidal ideas. Hospitalization, however, was not necessary for any of them. The three insisted that their marriages were happy and their husbands were wonderful men, good providers, and excellent fathers.

The course of treatment revealed the rancor of these patients toward their husbands, the marital situation, their condition of submission, and their frustration. The three of them responded to intensive psychotherapy with complete recovery. A large part of the treatment of these patients was devoted to the study of their marital situation. They all understood the relation between the role the mother had once played and the role the husband was playing at present. After the first stage of treatment, the husbands were invited to participate in a certain number of sessions and these marital therapy sessions had excellent results. Both spouses in each of

the three couples understood the roles that they had played in assuming the respective positions of dependency and the dominant other. In one of these cases the husband was at first rigid in his ways and unwilling to change but, with the help of individual psychotherapy from another therapist, he acquired insights into his own subtle behavior and the way his wife related to him.

Quite different is the case of Louise S., a single woman and a registered nurse, who started treatment with me at the age of forty-three, after having been treated at various times by six previous therapists. Louise had had several attacks of severe depression. The first one occurred at the age of twenty-two, after her graduation. She was hospitalized then and received twenty-two electric shock treatments. At the age of thirty, she had a second hospitalization which lasted seven months. After having changed many therapists who had treated her with psychotherapy and drug therapy, she requested treatment with me.

The patient lost her father at a young age. She was brought up by her mother, a perfectionistic and rigid woman who never gave her approval or comfort. Louise left her home town and came to work in New York, but it was obvious that she was more interested in finding a husband than in pursuing a nursing career. She was told that she was an excellent nurse but this appraisal did not comfort her. As a woman she felt unattractive and unable to keep men interested in her. They only wanted to use her sexually. Every time she looked

at herself in the mirror, she was horrified by her appearance. Nobody ever proposed to marry her. When she came for treatment she was very despondent. Nobody would marry her or find her desirable: she would never become a mother. Even as a nurse she was no longer good. The head nurse in her department was constantly criticizing her. The patient felt that her work was deteriorating. Occasionally a man would still sleep with her, but it was always a one-night stand.

Two events caused an exacerbation of her condition. A gynecologist whom she consulted found an enormous fibroma and recommended hysterectomy. After she consulted a second gynecologist who made the same recommendation, the operation was performed. Louise recovered very quickly but became seriously depressed and suicidal. For her, the hysterectomy was the coup de grace to her femininity. Now it was definite that she would not become a mother. Although she was forty-three, she had always clung to the idea of becoming a mother one day, and now any last hope had dissipated. This part of her history seems typical of involutional melancholia (see chapter 12), but the history of previous attacks of depression ruled out this diagnosis.

The second event which exacerbated her depression was of an entirely different kind. In the hospital where she worked, an elderly doctor started to pay attention to her. He propositioned her and made definite proposals to

her. He had an invalid, terribly crippled wife whom he could not divorce. He wanted Louise to become his girl friend, mistress, and spiritual companion. He would do anything for her except marry her. Louise's answer was a flat refusal. This was her reply to him as she reported it to me: "You offer me a piece of pie, and I am entitled to the whole pie." She became very despondent, also angry at the whole world, including me as her present therapist, and suicidal. Since she refused hospitalization, her mother had to be summoned. Louise went back to her home town with her mother, where she received another series of electric shock treatments. I heard that she did not improve.

Some Conclusions

The patients described in this chapter, and those reported in detail in chapters 11 and 12, constitute a group of twelve patients who were treated with intensive psychotherapy for a period extending from eighteen months to three years. In these cases, diagnoses other than severe depression (such as schizophrenia, organic condition, and so on) could definitely be excluded. Any patient who after the second session manifested the desire to continue psychotherapy was accepted for treatment. A preliminary report of these case studies has already appeared in the literature (1977). In that report it was stated that full recovery with no relapses was obtained in seven patients, marked improvement in four, and failure in one. That statement was to be corrected to some extent because since then one patient (Mrs. Fullman) had a

relapse.

I consider the overall result to be more than satisfactory. Of course, this type of treatment has to be tried with many more patients. The treatment that we have started but not yet completed with several other patients seems also very promising. The failure in the treatment of Louise S. is not difficult to understand. The events of her life made it impossible for her, in spite of psychotherapy, to disentangle herself from the cognitive constructs which perpetuated her feeling of hopelessness.

It is worth considering the moral issues which quite often emerge in these cases of depression. The therapist must of course respect the moral decisions made by the patient even if he personally happens to disagree with them. In the case of Sandra Carquois, her decision to embark on a promiscuous life was something to which we may object. Incidentally, I have seen similar occurrences in some recovering schizophrenics, in which a promiscuous stage (at times accompanied by definite psychopathic traits) is of brief duration and by no means so disturbing or incorrigible as the asocial behavior of typical nonschizophrenic psychopaths. The limited number of similar developments in the cases of depression which have come to my attention do not permit me to draw any conclusion.

Almost opposite is the case of Louise S., who refused “the piece of pie”

offered by the elderly doctor. Another person would have considered that piece of pie sweet and nourishing enough to be seen not necessarily with contempt, especially since the elderly doctor also was in a very precarious and unhappy circumstance and felt he could not offer anything more. The position Louise S. took certainly was tenable and to be respected, but unfortunately it became integrated and reinforced into a framework of hopelessness and depression.

Notes

[1] All names of patients in this book are fictitious and identifying data have been altered. Homonyms are purely coincidental.

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