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**PSYCHOTHERAPY OF
SEVERE DEPRESSION**

Severe and Mild Depression

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PSYCHOTHERAPY OF SEVERE DEPRESSION

Silvano Arieti

Choice of Treatment

Four major therapeutic approaches or combinations of them are presently available for the treatment of severe depression: psychotherapy, drug therapy, shock therapy, and hospitalization and milieu therapy.

The therapist must have a knowledge of their range of applicability in order to decide which one or which combination to use with a specific patient. Because of the special scope of this book, a discussion of methods other than psychotherapy will be limited to a few remarks.

In the last several years, drug therapy for the treatment of depression has received a great deal of attention even in the press. Often it is the patient himself who asks to be treated pharmacologically. Generally it is easy for him to accept the idea that a pill can relieve him of depression just as a codeine pill can relieve him of a toothache. However, in severe cases of depression characterized by a feeling of hopelessness and the belief that everything is futile, it may be difficult to convince the patient to accept even drug therapy.

Drug therapy is generally started with administration of one of the tricyclics, the best known of which is imipramine (Tofranil®). The patient is informed that improvement will not occur overnight and that it may take two or three weeks before he notices a difference in the way he feels. As a rule, the decrease in intensity of the feeling of depression is preceded by increase in appetite and improved sleep patterns. If no sign of improvement is noticed within a month, the treatment generally is switched to a MAO inhibitor.

According to my observations, amelioration of symptoms treated with drug therapy occurs in many cases, but not in the most severe. Moreover even when the patient improves, he inwardly remains the person he was before starting drug therapy; that is, he retains the same psychological equipment, potentialities, and vulnerabilities unless other types of treatment are given or unexpected propitious circumstances occur. At best, drug therapy must be considered a moderately effective symptomatic treatment. Nevertheless pharmacotherapy should not be rejected or even belittled on account of its limited effect. Many cases of severe depression cause terrible suffering for the patient. Anything that can even partially relieve the mental pain is to be welcomed unless it produces undesirable collateral effects. To my experience and knowledge, drug therapy which consists of the common antidepressants (tricyclics and MAO inhibitors) does not produce damaging psychological effects or conditions which would prevent psychotherapy unless massive doses are used, at times in conjunction with neuroleptics. With the use of the

MAO inhibitors, dietary restrictions must of course be imposed and careful vigilance exerted for hypertensive crises, which occur on rare occasions. Lithium therapy is effective in the treatment of manic episodes, but only rarely helps depressed patients or prevents recurrence of attacks.

In conclusion, antidepressant drugs are effective in the treatment of severe depressions, but only to a moderate degree. They seem less effective than neuroleptics are in the symptomatic treatment of schizophrenia.

Whenever drug therapy is completely ineffectual and psychotherapy cannot be obtained, or whenever there are urgent reasons for bringing about an immediate change (in such contingencies as concomitant physical illness, high suicidal risk, or extreme suffering), electric shock treatment is indicated. Whereas ECT has practically no effect on mild (or reactive) depressions, it is quite effective in many cases of primary severe depression. The treatment may be beneficial even if the patient has been sick for many years, as demonstrated by successfully treated cases of involuntal melancholia. However, not all patients respond to ECT, and many refuse to undergo this type of treatment. In manic patients ECT is less effective than lithium.

In my experience, ECT treatment does not make a patient less accessible to psychotherapy. However, many patients who are quickly relieved of their suffering with ECT unfortunately no longer feel motivated to embark upon

long psychotherapy which necessitates reconsidering aspects of their life that they wish to forget. They generally do not accept any additional treatment until another attack ensues.

Hospitalization must be considered especially when there is danger of suicide. However, we must realize that a suicidal risk exists in practically every patient suffering from a severe form of depression. It is up to the psychiatrist to assess whether the risk is great, moderate, or minimal, and there are no infallible methods for making such a distinction. The danger is generally greater in people who are single, widowed, separated, or divorced, for two reasons. First, their life history more easily leads them into a feeling of hopelessness and helplessness. Second, surveillance is less available; often they live alone and therefore, if seized by sudden destructive impulses, are much less likely to be prevented by others from carrying out these impulses.

If the danger is deemed great and the patient cannot be kept under proper surveillance at home, hospitalization becomes necessary. Often it is more difficult to convince the relatives than the patient that he should be hospitalized. The very depressed patient, perhaps in a masochistic spirit, at times is ready to enter the hospital whereas the relatives would prefer to send him on vacation. It is more difficult to hospitalize a manic, as he himself prefers to take trips and to escape into action. When the risk is moderate or minimal, the decision is more difficult. At times the risk is worth taking in

view of the fact that long psychodynamic psychotherapy is not available in many hospitals, and also because the possibility of suicide is not completely eliminated even in a hospital setting. Moreover, in some cases a certain amount of risk remains for an indefinite but prolonged period of time because the patient does not benefit from therapy even in a hospital milieu. Thus he would have to be hospitalized for an indefinite period of time, with great damage to his self-image and increased feelings of hopelessness. All these possibilities should be discussed openly with the members of the family. The responsibility for the decision must be made in a spirit of collaboration and, if possible, unanimity among patient, family, and therapist.

Contrary to what can be said in reference to schizophrenia or other psychiatric conditions, hospitalization is not a good milieu therapy for most depressed patients. The main and often the only advantage of hospitalization lies in decreasing the danger of suicide and in making certain that the patient will receive adequate drug therapy or electric shock treatment. Hospitalization also may be advisable for severely depressed, but nonsuicidal patients who live alone, have no relatives or friends, and are unable to take care of themselves.

Although I recognize that my theoretical inclination and my personal clinical experience are influencing me, I think that I can make the following statements with a fair degree of objectivity.

- I. Indications for psychotherapy exist in every case of primary severe depression.
- II. The intensity of the depression should not deter the therapist from making psychotherapeutic attempts.
- III. Concomitant or prior drug therapy does not make the patient less accessible to psychotherapy, except in cases in which antidepressants or a combination of antidepressants and neuroleptics are used in massive doses.
- IV. Drug therapy may have much more rapid action than psychotherapy in ameliorating the distressing symptoms, but it does not modify the basic structures of the personality which render the patient highly vulnerable to depression.
- V. Prior use of electric shock treatment does not make the patient less accessible to psychotherapy. However, during the period of forgetfulness, mild confusion, and other organic effects which follow ECT treatment, psychotherapy cannot and should not go beyond a superficial supportive role.
- VI. Psychotherapy is strongly recommended in patients who are hospitalized.
- VII. Psychotherapy becomes a necessity when drug therapy and electric shock therapy have been ineffective, when the syndrome keeps recurring in spite of these treatments, or when the patient refuses to try physical therapies again.
- VIII. Psychotherapy also should be instituted in patients whose acute

attacks have ended spontaneously. In these cases the aim is to make recurrence of the attacks less likely.

In spite of a great increase of interest in depression, the literature on the psychotherapy of severe cases is still in the pioneer stage. Many recent books on depression either omit this topic entirely or offer only a few and cursory indications. There are several reasons for this relative neglect. Mild depressions are easier to treat with psychotherapy and have received the focus of attention by psychotherapists. On the other hand, the lure of quick results has converged the interest of many therapists onto drug therapy, even in cases of severe depression. Although it is true that, unlike cases of schizophrenia, patients with severe affective disorders have been treated psychoanalytically since early in the history of psychoanalysis, it is also true that these patients have been very few and as a rule were treated in the intervals between depressive attacks. Important books on depression by distinguished authors have taken into consideration only special problems resulting from the psychoanalytic treatment of specific cases.

Beginning of Psychotherapy

The initial stage of the treatment is the most difficult and the most crucial. As a matter of fact, we can say generally that unless an immediate and intense rapport is established at the beginning of the treatment, the likelihood of having a successful therapy is considerably reduced. At the beginning of

treatment verbal contacts are hard to make, not because the patient is withdrawn as many schizophrenics are, but because he is absorbed in his seemingly everlasting mood. The patient is retarded in every action and does not always succeed in finding words which express his feelings. The effort he has to make in order to communicate appears enormous to him and, what is more important, futile. He seems possessed and overwhelmed by feelings of futility, helplessness, and desperation.

The therapist assumes an active role from the beginning. He is a firm person who makes clear and sure statements and asks very few questions or none. He is compassionate, but not in a way that can be interpreted by the patient as an acknowledgment of his helplessness. Unless the patient voluntarily explains why he is depressed, no effort should be made to compel him to justify his depression. If he is severely depressed, he is not able to answer and the renewed awareness of this inability would make him even more discouraged and depressed. On the contrary, the therapist may initiate the conversation by saying, "Most probably you do not know why you are depressed. But in my professional work I have found without exception that there are reasons for every depression. The depression does not come out of the blue. The anguish and the suffering stem from sources that a person like you, at a certain period of life, cannot find out by himself. He needs help."

When the therapist succeeds in establishing rapport and proves his

genuine desire to reach, nourish, and offer hope, he will often be accepted by the patient, but only as a dominant third—a third entity or person in addition to the patient and the dominant other (or goal). Immediate relief may be obtained because the patient sees in the therapist a new and reliable love object.

Although this immediate relief may be so pronounced as to be mistaken for a real cure, it is only a temporary expedient. It may be followed by another attack of depression if and when the patient realizes the nature and limitation of this relation. The procedure of leaning on a dominant third may arouse objections on theoretical grounds as well. In fact, we have seen how often the difficulty of the depressed patient stems from his dependence on a dominant other. And now we would encourage him to substitute for the dominant other a dominant third; in other words, we would not encourage him to assume an independent role. However, we must be aware that—similar to what we do in the treatment of schizophrenia—at the beginning of therapy of the severely depressed, the therapist cannot disregard the demands of the illness and act as if it did not exist. The first meaningful rapport with the patient must be made only through the mechanisms that the illness puts at our disposal. To do otherwise would not only be useless, it also would be likely to increase the pathology of the patient. Treatment would be immediately experienced by the patient as dangerous and would therefore be rejected before meaningful therapeutic relatedness had been established.

After the first stage of treatment, however, the therapeutic approach must be characterized by a therapeutic relation in which the therapist is no longer a dominant third, but a *significant third*, a third person with a firm, sincere, and unambiguous type of personality who wants to help the patient without making threatening demands or requesting a continuation of the patient's usual patterns of living. Whereas the dominant other was experienced as a rigid and static person, the significant third will change rapidly and will appear eventually as a person who shares life experiences without aiming to control and dominate. He may indicate alternative possibilities but he does not demand their implementation.

The only demand the therapist makes is that the patient become part of a *search team*, a group of two people committed to finding the cause of the depression and to altering or making it harmless. I personally use the term search team rather than therapeutic alliance, which to my ears smacks of militarism. We are together in the search, but of course we have different roles. The nebulosity, uncertainty, hesitation, and discouragement of the patient are compensated by the guidance that the therapist gives with a sense of assurance. When the patient realizes that the therapist is oriented in the right direction, he acquires hope. The more the obscurity diminishes, the more faith increases. The patient will tend again to lean on the therapist and make him a dominant third. Sooner or later, however, the patient will trust the therapist fully and see him as an accepting, not disapproving, and

basically undemanding person. The therapist will only demand that if the patient wants understanding and possible guidance, he must give information about his past and present life.

How can the therapist offer guidance and interpretation which, by being recognized as accurate, will reassure the patient that he can trust the effect of therapy? The therapist will be able to orient the patient in the right direction if he has mastered the psychodynamic development illustrated in chapters 5 and 6. For expository reasons its salient features are summarized here.

- I. The range of life possibilities has undergone a gradual narrowing throughout the history of the patient, who has come to follow a rather rigid pattern of living with specific attitudes toward himself and others, and set ideas and aims.
- II. A rupture of the pattern occurs because of either some inner reevaluation or given events and contingencies which externally impinge upon the patient. This rupture is experienced as a loss of vital importance, a loss which may reactivate the feelings experienced from a loss sustained early in life.
- III. This rupture produces sadness, but sorrow work is not possible. The patient feels helpless and hopeless, and depression ensues.

When the therapist has established a good rapport with the depressed

patient, he must aim at a quick discovery and understanding of the patient's basic drama. What is really the loss that the patient has experienced and which has threatened him so much? Has the loss disrupted a life pattern so that the patient no longer is able to sustain himself on habits, attitudes, ideas, feelings on which he had always relied? The loss may not consist of actual things or be connected with definite events, but may pertain to the symbolic values attributed to these things and events. The event may seem insignificant to others and yet the patient may have attached to it the meaning of loss of a hope or a fantasy, nourished consciously or unconsciously, that had filled a great part of his psychological life.

Many therapists who are convinced that so-called endogenous depressions are the result only of biochemical disorders are not attuned to detecting the occurrence of previously stressful events or, if they are, they look only for facts and not for symbols. On the other hand, we must realize that even when a stressful event has taken place, the event becomes important only in the context of the patient's background, history, and special psychological picture. This point must be emphasized: just as there are a large number of therapists and patients who deny the importance or occurrence of precipitating events, there are also a conspicuous number of therapists and patients who give exclusive importance to them. They focus on the precipitating event and do not investigate adequately the course of life as it unfolded prior to the occurrence of the specific event. The death of a person

very important to the patient (generally the death of the dominant other) may seem sufficient in itself to cause a depression. However, even in these cases we must explain to the patient—in terms that he will easily understand and at a time when he seems receptive to explanations—that the sorrow, although justified, is different from depression and not the only cause of it. Whereas sorrow and sadness are appropriate, consonant with the situation, and even adaptive, depression is inappropriate and maladaptive.

The therapist must be aware that the crucial problem is in the inability of the patient to sustain sorrow work after the event. For understanding this crucial inability, a longitudinal study of the patient's life is required.

The recognition of the specific precipitating event generally will indicate to the therapist the kind of depression from which the patient most likely suffers. For instance, depression following the death of the spouse points to a depression based on the relation with the dominant other. When depression follows the loss of a position or the failure to satisfy a particular ambition, it will suggest that most probably we are dealing with a depression based on the relation of the patient with a dominant goal.

When the therapist has determined which of the major psychodynamic patterns of living the depressed patient has followed, he will orient the treatment in specific ways, try to retrace the course of events that were

illustrated in chapter 5, and offer therapeutic alternatives which will enable the patient to do successful sorrow work. First I will describe in detail the treatment of the patient who has followed a pattern of submission toward the dominant other. In the treatment of other categories of severely depressed patients, only the differential modalities will be described.

Therapy of the Patient with a Pattern of Submission to the Dominant Other

In self-blaming types of depression, one of the first therapeutic challenges consists of ascertaining the person with whom the patient is most involved. Soon the existence of the dominant other is revealed. Often the patient will try to protect the dominant other, saying that there is nothing wrong with this person. Whatever is wrong is to be blamed on the patient himself. But once the therapist has been able to gather enough information, the relation with the dominant other must be interpreted to the patient. The recommendations which are given in this section may seem direct, quick, and incisive. This impression is due only to expository reasons. In practice the interpretations have to be given slowly and cautiously, lest they be vehemently rejected. Even when a specific precipitating event (like the discovery of a clandestine love of the spouse or the spouse's announcement that he wants a divorce) easily reveals the failure of the relation on which the patient sustained himself, the depressed patient may find reason to exonerate the other and to blame himself. What is clear to the therapist is not

necessarily clear to the patient, who continues to repress feelings and facts. Our caution must be even more pronounced when the depression was precipitated by the death of the dominant other. The guilt experienced in these cases and the possible idealization of the departed make it very difficult for the patient to learn to visualize in a different way his past relation with the dominant other.

Step by step we must clarify to the patient that he does not know how to live for himself. He has never listened to himself or been inclined to assert himself, but cared only about obtaining the approval, affection, love, admiration, or care of the dominant other. For the sake of the dominant other he has conformed to the wishes of others and denied his own, and he has even led himself to believe that the wishes of the others are his own. At times the fault of the other has been transformed by the patient into his own fault or flaw. For instance, the extreme thriftiness of the dominant other has been transformed into the patient's alleged largesse; the carelessness of the other has become the patient's fastidiousness or his obsessive behavior. In cases of married couples, the dominant other's lack of sexual desire has become an exaggerated sexual appetite in the patient, or vice versa; the immoderate demands of the dominant other are interpreted in terms of the so-called frigidity or quasi-frigidity of the patient.

With the permission of the patient, in some cases it is important to

discuss with the dominant other the general climate of the relationship and the possibility of some environmental changes. The dominant other may be shown by the therapist how he can relieve the patient's feeling of having to bear a heavy yoke of guilt, responsibility, or feelings of unaccomplishment and loss. The dominant other, because of repressed hostility or because of perfectionistic, ultramoralistic, or obsessive-compulsive attitudes, quite often unwittingly increases the patient's feeling of guilt, duty, and self-denial. Such sentences as, "You are too sick to do the housework now," or, "For many years you took care of me; now I will take care of you," increase the guilt feeling of the patient. The patient must be guided by the therapist to become aware of his personal wishes and the meaning he wants to give to his own life. This is not easy to do because the patient has denied and repressed his own wishes for so long. In many cases we have to reevoke the daydreams, aspirations, and fantasies of childhood and adolescence in order to figure out what the patient expected from his life, what his life claim was. As has already been mentioned, the dominant other is not necessarily a person, but may be the whole family or a special group, organization, or firm. The patient's relation to them must be reevaluated and possibly changed.

After the therapist has made some headway into the patient's psyche, several developments may occur. The patient may become less depressed but angry at either the dominant other or the therapist, whom he would like to transform into a dominant thud. The anger and hostility toward the dominant

other (most frequently the spouse) at times is out of proportion. Once repressed or unconscious ideations come to the surface, the dominant other may be seen as a tyrant, a domineering person who has subjugated the patient. At this point the therapist has a difficult task in clarifying the issues involved. At times the dominant other really has been overdemanding and even domineering, taking advantage of the placating, compliant qualities of the patient. However, it is often the patient himself who has allowed certain patterns of life to develop and persist by being unable to assert himself and by complying excessively. Now, when he wants to change these patterns, he attributes the responsibility for them to the dominant other. No real recovery is possible unless the patient understands the role that he himself has played in creating the climate and pattern of submissiveness.

I have so far referred to the patient as he or him, and shall continue to do so. However, I would again remind the reader that approximately two-thirds of the patients belonging to this category are women and, if the language required referring to the most common sex involved, I would use the pronouns she or her. Undoubtedly the improved attitude of society toward women's rights and needs will change the cultural climate or at least the frequency of certain developments. At the present time, the still-prevailing patriarchal character of society makes it easier for a woman to assume an attitude of dependency on a male dominant other, or even on a female dominant other. By tradition many more women than men have been

trained overtly or in subtle ways to depend on others for support, approval, and appreciation. Some of these women actually live a vicarious life.

The fact that society and culture have facilitated these developments does not exonerate the female patient from recognizing the role she has played. By omission or commission the patient has allowed the dominant other to assume that specific position in her life. Many husbands, certainly helped by the prevailing patriarchal character of society, are not even aware of playing the role of a dominant other. When they come to such a realization, they may try to deny certain facts, become busy in defending themselves as if they stand accused, and may require psychotherapy (or family therapy with the patient). The same remarks can be made, although less frequently, for dominant others other than husbands.

The realization of these factors by the patient does not yet relieve the depression, although in most cases it is diminished. Generally the patient continues to be depressed because: (1) He broods over what he did not have. (2) He has a feeling of self-betrayal. By accommodating to the dominant other, he has not been true to himself. (3) He has some sort of realization that many of the gratifications he once desired in life were given up. (4) He has a feeling of hopelessness about remedying or retrieving what he has lost, the opportunities he did not grasp.

As mentioned in chapter 6, ideas of this type are not kept in consciousness for long. The ensuing depression covers up these cognitive components. The therapist must train the patient to catch himself in the act of having these ideas, or in an attitude in which he expects to become depressed. If the patient becomes aware of these ideas and consequently of expecting to be depressed, he can stop the depression from occurring or at least from reaching its previous intensity. Then he must discuss with the therapist these depression-prone cognitive components. If the patient understands that he had a role in this dynamic complex, he will abandon a state of helplessness and hopelessness. Both in the present and in the future he may act differently by learning to assert himself and to obtain what is really meaningful and gratifying to him. Any feeling of loss or disappointment is no longer translated into self-accusation or guilt.

With the help of the therapist, the patient must obviously change his way of living and interrelating with the dominant other. The patient cannot devote his life to the dominant other or live vicariously through him. On the other hand, the patient may be afraid of going overboard and being too hostile and angry at the dominant other. However, this stage will be outgrown when the dominant other is recognized as not what the patient consciously saw him to be in recent years, but as the early childhood situation made the patient envision him. In other words, the trauma over the alleged or real loss of love sustained in childhood, and the mechanisms adopted in an attempt to

reobtain this love or its equivalents (admiration, approval, affection, care) have led to a series of events in which the patient had to create or choose as a mate a person who would fit the role of dominant other. The patient has also misperceived some attributes of the dominant other in order to see him in that role. When the patient is no longer concerned with the dominant other in his recent role, and concentrates instead on his childhood situation, treatment will be at an advanced stage. The patient realizes more and more that he has not lived for himself or even for the world, but for an audience which often has been limited to one person, the dominant other. There will be a gradual abandonment of the stereotyped way of living and a progressive enlargement and embracing of life's possibilities.

However, even at this point the patient may become easily depressed since depression has been his fundamental mode of living. Depressive thoughts should not be allowed to expand into a general mood of depression, but must retain their discrete quality and content in order to be analyzed. The patient learns that because of this pattern of depression, even innocent thoughts at times have the power to elicit a depression. Little disappointments or losses which lead the patient to self-accusation, guilt, or severe depression are actually symbolic of an earlier, greater disappointment or of lifelong disappointment. But now the early or the recurring losses are unlikely to be repeated because the patient is learning to assert and fulfill himself.

It is not possible to eliminate historically the original traumas of childhood, but it is possible to change the pattern by which the patient tries to remedy or undo the original traumas. The original traumas and these patterns finally will lose their power and the compulsive qualities that caused their persistence or recurrence.

The handling of irrational guilt feeling is important in the treatment of self-blaming cases of depression, not only at the beginning of therapy but also at advanced stages. Fits of strong guilt feeling tend to recur. The patient has learned and repeated for many years of life the following pattern: guilt feeling —> atonement —> attempted redemption. Guilt about what? Originally the child attributed the responsibility for the original traumatic loss to himself. He was naughty, terrible, and evil. By atonement—that is, placating, obeying, working hard, doing his duty, denying himself, wanting peace at any cost—he felt he could obtain the love, approval, or admiration that he desired. But if he did not get it, he felt guilty again for not having done enough, for not having atoned enough. If some energy is left, it must be used for self-punishment. The patient continues to feel, although in a rather vague way, that enough punishment will make him acceptable to others and will restore a self-image acceptable to himself. The cycle thus repeats itself.

The guilt feeling is often experienced for hating (consciously or unconsciously) the dominant other in a way which is reminiscent of the

sadistic trends that Freud (1917) described as directed by the depressed patient against the incorporated love object. Thus the greatest relief from guilt occurs when the patient has drastically changed his relation with the dominant other. However, since this pattern of guilt is so ingrained in many patients with the self-blaming type of depression, other psychological mechanisms are often transformed to fit into this guilt complex. Often breaking habits elicits guilt. For example, the patient does not go to church on Sunday or does not accompany his child to grammar school. Now the patient has something to feel guilty about. In many instances anxiety is transformed into guilt feeling. As painful as the guilt feeling is, the patient is aware that the possibility of suffering and thus of redeeming himself is in his power, whereas with anxiety he is at a loss; he does not know what to do about it.

The obsessive-compulsive symptoms which complicate a minority of cases of severe depression are attempts to channel guilt feelings and to find measures for relieving them so that the lost love or approval will be reacquired. They actually aggravate the situation instead of solving it. For instance, the patient may be obsessed with thinking about something profane or sacrilegious, or about the coming death of a relative, and feel guilty about having such thoughts. Similarly, compulsions may obligate the patient to perform actions condemned by the rituals of his religion, and consequently he feels guilty.

In most cases it will be possible to show the patient how he tends to translate anxiety into guilt and depression. He will finally learn to face anxiety rather than to reproduce the sequence which leads to depression. He also will recognize the cognitive components which lead to anxiety. If the therapeutic climate established with the therapist is a sound one, the patient will realize that he can manifest and consequently share his anxiety with the therapist. His anxiety—that is, his negative attitude toward what is uncertain or what is about to come—will progressively change into a hopeful attitude.

The therapist eventually will learn to handle little relapses, to understand and explain little psychological vicious circles which are formed, or stumbling blocks which are encountered and tend to reestablish a mood of depression. For instance, the patient may become depressed over the fact that he so easily does become depressed by any little disappointment which triggers off the state of sadness or guilt. Again, he has to be reminded that the little disappointment is symbolic of a bigger one. Another difficulty consists of the fact that some clusters of thought seem harmless to the therapist and are allowed to recur: they actually lead to depression because of the particular connections that they have in the patient's frame of reference. Eventually, however, the emotional pitch of the therapist becomes more and more attuned to that of the patient.

We must also remember that the patient who is familiar only with the

mood of depression will search for reasons to be depressed and succeed in finding seemingly plausible ones. They are negative appraisals of the self, the world, and the future, and they constitute the cognitive triad described by Beck (1967). The therapist involved in deep psychodynamic therapy should not be easily sidetracked. These negative appraisals are part of the manifest symptomatology and their significance and use must be explained to the patient. The therapist must also realize, however, that these ideas may accrue a superficial layer of depression over the deep-rooted disposition to become depressed.

The Treatment of Claiming Depression

The treatment of the claiming type of depression is also difficult. Before starting therapy the patient has become more and more demanding of the dominant other, but he also feels more deprived. Any unfulfilled demand is experienced as a wound—a loss—and increases the depression. When treatment starts, the patient wants to find in the therapist a substitute for the dominant other who has failed. To the extent that the patient's demands are plausible or realistic, the therapist should try to go along with these requests and satisfy some of the needs for affection, consideration, and companionship. Even clinging and nagging have to be accepted.

Kolb (1956, 1959), English (1949), and Cohen (1954) emphasized this

excessive clinging as one of the main problems encountered in intensive psychotherapy with manic-depressives. Some patients do not want to leave at the end of the hour; they suddenly remember many things they must say, plead for help, and attempt to make the therapist feel guilty if they are not improving. As Kolb described, these patients have learned proper or apparently suitable social manners and, with pleading and tenacity, they are often capable of eliciting in the therapist the reaction they want.

Occasionally we have to prolong the session for a few minutes because at the last minute the patient feels the urge to make new demands or to ask "one more question." The recommended attitude may seem too indulgent, but especially at the beginning of treatment we cannot expect the patient to give up mechanisms he has used for a long time.

Many patients, especially at the beginning of the session, are not able to verbalize freely and should not be requested to explain their feelings in detail or to go into long series of associations. On the contrary, the therapist should take the initiative and speak freely to them even about unrelated subjects. As a patient of Thompson (1930) said, the words of the analyst are often experienced as gifts of love by the depressed person. By following the suggestions made by Spiegel (1959, 1960) the therapist will soon learn to communicate with the depressed, in spite of his lack of imagery and the poverty of his verbalizations. It is in the feeling itself, rather than in verbal

symbols, that the patient often expresses himself.

When this immediate craving for acceptance is somewhat satisfied, the claiming depression will diminish considerably but will not disappear. The depression will no longer appear in the form of a sustained mood, but in isolated discrete fits. At this stage it is relatively easy to guide the patient into recognizing that the fit of depression comes as a result of the following conscious or unconscious sequence of thoughts or their symbolic equivalents: "I am not getting what I should → I am deprived → I am in a miserable state." The patient is guided to stop at the first stage of this sequence, "I am not getting what I should," because these words mean "I would like to go back to the bliss of babyhood. I do not want to be a person in my own right, with self-determination." Can the patient substitute this recurring idea and aim for another one, for instance, "What ways other than aggressive expectation and dependency are at my disposal in order to get what I want?" In other words, the patient is guided to reorganize his ways of thinking so that the usual clusters of thought will not recur and will not reproduce the old sequence automatically and tenaciously. The psychological horizon will enlarge, and new patterns of living will be sought. The patient will be able to activate these changes in himself only if the new relationship with the therapist has decreased his feeling of deprivation and suffering. More and more frequently he will make excursions into paths of self-reliance. At the same time, the therapist will put gradual limitations on the demands that the patient makes

on him. Once the fits of depression have disappeared, the treatment will continue, giving special importance to the exploration of the past. The patient will learn to recognize the basic patterns of living which led him to the depression, and the special characteristics of his early interpersonal relationships which led to the organizations of these patterns. Such characteristics as superficiality, insensitivity, marked extroversion covered by depression, recurrence of clichés, and infantile attitudes such as “Love me like a baby” will be recognized as defense mechanisms and will disappear.

Treatment of Depression Following Failure to Reach the Dominant Goal, and of Depression with Mixed Patterns

When the therapist has ascertained that the depression follows the patient’s realization that he has failed to reach the dominant goal or is hopelessly going to fail, the psychodynamic inquiry following the initial state of treatment is focused on why such a realization had such a strong impact. The psychological integrity of the patient has depended only on the fulfillment of a life claim. But it is only a narcissistic integrity. Deprived of it, the patient feels mortally wounded and deeply depressed.

Therapist and patient must come to a full understanding of how important the fantasied achievement was. How many conscious and unconscious ramifications did it have? How big a place did the patient allow the fantasy to occupy in his psyche? Is it true that life without that particular

fantasy has no meaning? The patient must be helped to find alternative paths. Is it really necessary to be a singer, a dancer, a successful politician, or a big businessman in order to find a meaning in one's life? The patient will answer, yes, at least for him. In many other instances he will say that intellectually he knows that he should say no, but with the depth of his emotions he feels that the achievement of that particular goal is necessary in his case. From his subjective point of view he is correct, as we have seen in chapter 6. His self-esteem and self-identity have depended on the goal, and he now feels cheated of his dream. We must help him to realize that he has started with a great demand upon life. Whatever the origin, this demand has become a false pride or hubris from which he has to be relieved. But his life is certainly more valuable than an ill-founded illusion, a fantasy which has reached a stage of pathetic naivete. The disillusionment must actually be seen as an awakening, as a recognition of unfounded values, and as the start of a search for new and stable values.

In many cases we succeed in ascertaining a specific and very important reason for which the patient gave supremacy to the achievement of a particular goal, and this reason must be explained to him. In middle childhood the patient came to envision the achievement of a particular goal as a way of recapturing the love, affection, or approval of the mother or whoever else was in the role of the significant other. Later in life the patient saw the attainment of that goal as the only occurrence which would make him worthy of love and

approval and make him feel worthwhile. His life previously was experienced not beautifully, but like a long tunnel with only one exit, one commitment.

Treatment entails a call for a different integration of values and habits and for a considerable change in character. Thus it may be difficult. Just as patients belonging to the previously described categories had to enlarge their involvement with people and change their attitude toward the former dominant other, this category of patients must acquire a latitude of choice toward life claims. Many of the modalities recommended for patients with a pattern of submission or of claiming dependency also apply to patients in this category.

The same modalities also can be applied to a large number of patients who do not fit into the previously mentioned categories either because they represent a mixture of them, or because their patterns of living seem different from those which are commonly encountered. Particularly difficult are cases which had an insidious, slow course. Some of these patients at first seem to suffer from relatively severe depressive characters. Eventually they are recognized as being affected by severe depression. No single episode can be recognized as a precipitating factor. The patient lives in the mood of an existence whose only meaning seems to be suffering. Conversely, in some cases a single and in itself not important episode is recognized as the precipitating factor, but only because the patient has given it an unusual

interpretation. For instance, for a person who previously appeared well-adjusted, an illness which is not serious at all becomes the signal that life is going to end, and that life has been wasted.

Many of these cases eventually can be understood as the acute or slow realization by the patient that he has never developed a meaningful interpersonal bond based on love or affection and neither has he achieved any meaningful goal. We must help the patient to reevaluate his life and find alternatives, in the same manner as with the previous categories of patients.

As was mentioned at the end of chapter 6, the patient may feel that the meaning he has given to his life is inappropriate or unworthy but if he renounces that meaning, his life becomes meaningless. We must help the patient understand that his sorrow over the loss of meaning in his life actually indicates how much life means to him. In other words, implicit in his sorrow is the affirmation that his life—a human life—is very meaningful, as something that transcends its mere factual circumstances. If the patient's sorrow is real and meaningful, life is too. If his sorrow is authentic then life can be authentic too, but up to now he has lived an unauthentic life in pursuit of an unauthentic goal.

The therapist helps the patient become aware that his great sorrow implicitly reaffirms the authenticity and value of life. The therapist also helps

him to make authentic choices and to retrieve a sense of purpose. Even if life has not delivered what it promised, it is not meaningless. The patient feels helpless and hopeless because his patterns of living have prevented him from switching to alternative behaviors. As we do with the other categories of severe depressions, we help the patient become aware again of the cognitive structures that have caused his sorrow and to look again at the array of life's infinite possibilities. The task will be made easier if the patient understands the meaning of his sorrow, that it implicitly asserts how much he attributes to life.

Advanced Stage of Treatment

At an advanced stage of treatment with any type of depression, therapy consists of repeatedly going over the patient's life patterns and explaining how his present dealings with life situations are often in accordance with the old psychogenetic mechanisms. Sooner or later the patient, who by now has understood the psychodynamics of his life history, learns to avoid the old ways because he recognizes them to be pseudosolutions, futile defenses, and vicious circles. In some patients the old mechanisms tend to recur even after they have been completely understood. As a matter of fact, even discussion of them may evoke strong emotions which are not congruous with the gained insight, but which demonstrate the usual affective components of the original symptoms. Even after the patient has understood the meaning of his

symptoms and behavior patterns, it is sometimes much easier for him to repeat the old patterns.

For example, it must constantly be pointed out to the patient that he should learn to ask himself what he wants, what he really wishes. Quite often his attempted answer will be only a pseudo-answer. He may say, "First of all, I wish peace. Then I wish the happiness of my children." He must learn—and relearn—that peace at any cost implies satisfying others before himself and that even the happiness of children, although a natural wish of every parent, is not a wish predominantly related to the individual himself.

In other words, the patient must learn to listen to himself and to reduce the overpowering role of the "Thou." At the same time he must make a voluntary effort to develop inner resources. In the attempt to imitate others or even to surpass others in proficiency and technique, some patients do not rely on their own individuality. They cannot be alone (unless they are depressed), and when alone they cannot do anything that gives them satisfaction: they must work for the benefit of others or escape into common actions. They must learn that they too may have artistic talents. As a matter of fact, some very depressed persons have become able to transform their conflicts into high forms of creativity. Creative upsurges in apparently uncreative, conventional depressive personalities are a good prognostic sign. Transient feelings of depression will be tolerated at this point, indicating as

Zetzel (1965) put it, a measure of the ego strength.

As has already been mentioned, the therapist must be alert to spot early signs of depressions which at times are precipitated even by trivial disappointments or chance associations of ideas. Jacobson (1954) and Kolb (1959) emphasize that the recurring depression must immediately be related by the therapist to its precipitating cause.

At the same time the patient must learn new patterns of living which will lead to his own independence, individual growth, and self-fulfillment. Learning new patterns will reduce the tendency of the old ones to recur.

Other secondary recommendations may be useful in the treatment of the depressed. Except during the time when the depression is very severe, the patient must be encouraged to be active. Inactivity fosters depressive trends. He must assign himself graded tasks. A daily program can be structured with the therapist until the patient is able to structure one by himself. He must often be reminded that, contrary to what he believed at the beginning of his illness, life changes, the depression lifts, and gusto for life comes back. He must be told that the worst moment is generally in the morning when he wakes up and the depressogenic thoughts tend to emerge fully, soon to be repressed and replaced by a general depressive mood.

Another characteristic which occurs quite frequently is the acquisition

of a personality characteristic or trait opposite to the one that the patient has relinquished. For instance, a formerly submissive patient is now assertive to a degree which is beyond the tolerance not only of family members but of what social customs require. With the new fervor and zest with which he tries not to be submissive anymore, the formerly depressed patient may become somewhat obtrusive, abrasive, and quite angry. At times he is prone to give too much importance to events that should not make him as angry as he is. This anger is often misplaced anger which has accumulated through years of submission or frustration in attempts to attain impossible goals. It is often exaggerated, at times inappropriate, and likely to put distance between the patient and others. When the patient becomes aware of these mechanisms, he will be in a better position to control them. On some occasions the members of the family who do not adjust well to the new self-assertive personality of the patient become angry at him and in their turn arouse his anger.

In other cases a very dependent, clinging patient tends to assume a degree of independence which is unrealistic. Again, with therapeutic intervention this trait is easily changed.

Orthodox psychoanalytic procedure with the use of the couch and free association is not indicated in the treatment of severe depression even during the interval periods. Many failures in the treatment of these patients have been due to the adoption of the classical psychoanalytic technique. Today

many therapists feel that retarded and hyperactive patients generally should be treated with less frequent sessions—from one to three a week. Many patients, especially elderly ones, seem to do well with one session a week. The therapist must play a relatively active role, not one that conveys to the patient the feeling that he is being pushed or under pressure, but not one in which the passivity of the therapist is too much in contrast with the natural extroversion of the patient. Whenever the therapist feels that he has succeeded in reaching some conclusions or in understanding the feelings of the patient, he should express them freely. Often the patient prefers to keep quiet, not because he is unable to put things together as in the case of the neurotic or the schizophrenic, but because he feels guilty or ashamed to express his feelings of rage, hostility, and—paradoxically—even guilt and depression. Dream interpretations are very useful and portray the major conflicts of the patient as well as the general mood of pessimism. Many severely depressed patients have great difficulty in recalling dreams.

The treatment of hypomanic episodes is far more difficult, as the flight of ideas prevents any significant contact. An opposite procedure is to be followed: the patient is asked to cut out details, so that irritation and rage are purposely engendered; or he is reminded that he must talk about certain subjects—the subjects that are liable to induce depression. Conversion to a mild depression is therapeutically desirable.

Treatment of the severely depressed patient requires a change in his psychological make-up which is substantial and difficult to implement. Of course we do not ask him to give up his identity; rather, whatever lie or impossible value has become connected with an unauthentic identity. We do not help a human being to lose a sense of commitment, but only the commitment that seduces and saps the self.

Although difficult, the treatment may be successful and rewarding for both patient and therapist. It is hard to imagine something more gratifying than the fading of a seemingly endless sorrow and the dissolution of a pattern of living which had drastically narrowed a human existence, or to imagine something more uplifting than the restored ability to look with hope at the array of life's infinite possibilities.

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