Severe and Mild Depression

SOCIOCULTURAL FACTORS, SOCIOLOGY OF KNOWLEDGE, AND DEPRESSION

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Table of Contents

PART ONE: SOCIOCULTURAL FACTORS, SOCIOLOGY OF KNOWLEDGE, AND DEPRESSION

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Introduction

It is a well-established fact that sociological and cultural factors are relevant to the study of psychiatric conditions. Here are some of the questions commonly asked. Are these factors political, religious, economic, dietary, ideological, related to the culture in its totality, or to some of its specific, salient, or secondary characteristics? Are they etiologically essential for the particular disorder which is being considered? Do they facilitate its occurrence or make its occurrence more difficult? What does historical inquiry reveal to us when we study the incidence of a psychiatric condition over a long period of time? And what does anthropology add to our understanding?

This field of research is vast indeed, even when it is confined to the psychiatric syndromes of depression.

Bemporad and I had our training in psychiatry and psychoanalysis, and we do not claim professional expertise in the other fields which I have just mentioned. Therefore we have limited ourselves to discussing in this chapter the few areas which we could investigate with a certain depth. Although our selection of topics is arbitrary, we hope to demonstrate that the issues raised are all very relevant. We are fully aware that much more work has to be done in these areas and we hope that other authors will continue this type of inquiry.

At this point I wish to indicate that a cognitive approach lends itself better than any other to the integration of psychiatry and sociocultural studies. A cognitive approach stresses the importance of ideas, and most of a person's ideas derive from the sociocultural environment. Although a large number of thoughts and habits of thinking are acquired in childhood from the members of one's family, the family members are carriers of the culture to which they belong. Later the individual continues to acquire ideas and systems of ideas from different people in his sociocultural milieu and from the various institutions and media which the culture provides.

The branch of sociology called sociology of knowledge is of particular relevance to a cognitive approach. It is the branch of sociology that studies the relation between thinking and society. Since the Greek classical era, it has been known that social circumstances shape the psyche of the human being.

In the early eighteenth century Giambattista Vico was the first great writer to demonstrate that every phase of history has its own mode of thought. In much more recent times Emile Durkheim, Karl Mannheim, and Max Scheler have made important contributions which are beyond the scope of this book to review. What is important to stress, because it is more closely related to the theme of this book, is that the human psyche is never concerned with more than a sector of reality. This sector is to a large extent chosen by society. A society is attuned to certain ideas and values which consequently predispose or inhibit other feelings, ideas, and actions. Here it is important to study how a special sector of social awareness and concern is related to the occurrence of depression.

Before proceeding, it is appropriate to mention that some sociologists and philosophers attribute a less important role to ideas in the shaping of human life. One of the major sociologists, and an exponent of the non-cognitive point of view, is Vilfredo Pareto: according to him, the human being acts first and thinks of reasons for his actions afterwards. He calls these reasons “derivations,” that is, they are derived from the instincts or quasi-instincts which determine modes of human behavior, and through them, human modes of thought. This position is not distant from the Freudian stance. That a considerable part of human life consists of simple actions, quasi-instinctive in origin, is undeniable, but to see the whole or most of human life as a derivation of these simple actions and physiological functions

is a reductionistic approach which does not do justice to man's infinite symbolic possibilities. It is true, as Pareto says, that man acts first and thinks of plausible reasons to justify his actions and feelings only afterwards, but these "reasons" are only rationalizations. At a human level the real reason or motivation is not necessarily instinctual but is very often the result of complicated cognitive constructs which have become unconscious. Pareto is thus correct only to the extent that he considers some levels of the psyche, but not others. In other words, in analyzing this phenomenon Pareto goes much further than the man in the street inasmuch as he realizes that the "reason" is an *a posteriori* (after-the-fact) rationalization. However, he does not go far enough because, like the man in the street, he is unaware of the unconscious cognitive constructs which determine many human actions and feelings.

When we take feelings rather than actions into consideration, we find that many authors have made similar errors. As an example, I shall mention the philosopher Miguel De Unamuno who, in his book *The Tragic Sense of Life,* rightly explains how human life is predominantly emotional. Man is said to be a reasoning animal but he should be defined as an affective or feeling animal. Unamuno is right but, like the many authors who have made similar statements since ancient times, he does not understand the psychological origin of most human emotions. Unamuno tells us, for instance, that it is not "usually our ideas that make us optimists or pessimists, but it is our optimism

or our pessimism, of physiological or perhaps pathological origin, as much the one as the other, that makes our ideas." In other words, the mood of sadness or elation selects our ideas and our conclusions. Any observer who remains at this level of investigation would agree with Unamuno. In our psychiatric practice we see many examples which at first seem to confirm this philosopher's point of view.

The following report seems a joke; actually it is a vignette similar to many others encountered in a psychiatrist's daily dealings with depressed patients. A depressed woman reported to me that she felt very melancholy, especially since she had seen a very depressing movie full of misery, unhappy events, and a tragic ending which reminded her of what her life had been and probably would continue to be. She vowed never to see an unhappy movie again. A few days later she reported that she had gone to see a very frivolous and happy movie, full of jokes and laughter. When I asked her whether that movie had made her feel better, she replied, "On the contrary, I left the movie more miserable than ever. The movie reminded me of how life could be; it made me see that there are people who laugh and are happy. How different all that is from my personal situation!" This vignette seems to confirm Unamuno's point of view. The patient's a priori pessimism (an emotional state) made her interpret all external events in a pessimistic way. Like Pareto, however, the Unamuno type of interpretation remains at the level of consciousness. Although it is true that the patient's pessimism (or basic

emotional tonality) made her think in a negative way, irrespective of the nature of the external event, it is also true that her pessimism was based on a cognitive substratum, perhaps a very large constellation of thoughts and memories, of which she was totally or almost totally unconscious.

One could argue that even an unconscious cognitive substratum is a derivative of a primitive emotional, quasi-intuitive state, or in a Freudian sense, derivative of a purely instinctual life. Again, our basic assumption is that the appearance of the cognitive-symbolic level in the human mind makes such a revolutionary transformation into animal psychology as to change life itself in the most drastic way.

Returning to our major topic, the relation between sociocultural factors and depression, the following issues will be discussed in the first part of chapter 16:

I. The greater incidence of depression in women.

II. Affective psychoses, and inner-directed or other-directed society.

III. Depression and literature, with special emphasis on tragedy.

IV. Our contemporary period as an era of depression.

V. Socio-philosophical premises of the psychotherapist of depression.

In the second part of this chapter Bemporad discusses methods of child-rearing in relation to depression.

Greater Incidence of Depression in Women

There is no doubt that depression, especially in its severe forms, occurs much more frequently in women than in men. Statistics collected in several parts of the world confirm this marked difference. In the United States, Winokur and his collaborators (1971) found a greater incidence of depression in women in relatives of 129 probands. Helgason (1966) in Iceland found a much greater risk of affective psychoses in women. McCabe (1975) in Denmark found that women admitted to hospitals for affective psychoses were much more numerous than men (male to female ratio was 0.64). In an excellent article, Weissman and Klerman (1977) reviewed the evidence for the different rates of depression between the sexes in the United States and elsewhere during the last forty years. In the United States they consistently found a 2:1 female-to-male ratio for depression, and in all the other industrialized Western countries the ratio was about the same. Among highly industrialized countries, only in Finland and Norway was the preponderance of female depressives, although still present, not as marked. In a small number of developing countries (India, Iraq, New Guinea, and Rhodesia) there seems to be a preponderance of male depressives.

Weissman and Klerman (1977) asked the pertinent question of whether the reported preponderance of female depressives was an artifact. According to this hypothesis, women perceive, acknowledge, report, and seek help for depressive stress and symptoms more than men. This attitude and habit would account for the sex ratio findings. Reviewing data from the pertinent literature, the authors were able to exclude the importance of these attitudes, and they reached the conclusion that the female preponderance is real and not due to an artifact. Weissman and Klerman reaffirmed the possibility of a genetic factor in the etiology of depression, but concluded that "currently the evidence from genetic studies is insufficient to draw conclusions about the mode of transmission or to explain the sex differences."

Weissman and Klerman (1977) proceeded to examine whether the longstanding disadvantaged social status of women has had psychological consequences that lead to depression. Two main hypotheses have been proposed. The first, which the authors call the "social status hypothesis," refers to social discrimination against women. Social discrimination and inequities would lead to legal and economic helplessness, dependency on others, low self-esteem, low aspirations, and eventually clinical depression. The second hypothesis, which the authors call "learned helplessness," states that "socially conditioned, stereotypical images produce in women a cognitive set against assertion, which is reinforced by societal expectations.... The classic 'femininity' values are redefined as a variant of 'learned helplessness',

characteristic of depression."

Weissman and Klerman (1977) discuss marriage in relation to depression. They quote many authors and in particular Gove (1972, 1973), who concluded that whereas being married has a protective effect for men, it has a detrimental effect for women. In each of the following categories women have a lower relative rate of mental illness than men: single, divorced, widowed. Only married women have a higher incidence than married men. Weissman and Klerman's paper offers other data which leave no doubt about the preponderance of depression in women. (The authors also summarize other interpretations which cannot be reported here: the reader is referred to the original source.)

According to prevailing concepts of modern psychiatry, psychiatric conditions are multi-determined. Thus the presence or absence of specific social factors may be the decisive factor in the adoption or avoidance of specific pathogenetic patterns. It seems plausible to me that most of the important psychodynamic patterns leading to depression which have been illustrated in the previous chapters, especially in chapters 6, 9, 11, and 12, are for sociocultural reasons much more likely to occur in women. Let us examine, for instance, the following mechanisms: the experience of having sustained a loss or been threatened by loss, with the consequent adoption of a pattern of submissiveness to a dominant other; the pattern of living for the

sake of the dominant other, or for obtaining approval and gratification from the dominant other; the pattern of dependency; the pattern of living in which romantic love is a dominant goal; and so on.

The first important mechanism is the childhood experience of loss, which is generally interpreted as loss of mother's love or threat of such loss, and it seems to occur equally in boys and girls. If there is a difference, it has so far received no reliable confirming evidence from available data. I can only postulate in the most hypothetical way that in families which practice gender prejudice, and in which a girl has already been born, the birth of a boy is experienced with great joy and leads to neglect of the older girl. A great deal of attention is devoted to the newborn boy and the girl experiences the trauma of the loss of love. Although this hypothesis may be purely speculative, it is not at all speculative that cultural factors predispose more strongly in girls than boys all the other mechanisms and interpersonal relations that lead to depression. In many environments it is possible to recognize a relation of transmitted duty between mothers and daughters. Daughters feel the transmitted sense of obligation more strongly than sons, and consequently tend to become duty-bound. Submissiveness to a male-dominant other is also favored by the patriarchal character of our society. It seems natural to a woman to affiliate herself with a male-dominant other. Jean Baker Miller (1976) and other writers have illustrated how it is commonly expected that a woman will serve others' needs and to be tied to

the destiny of a man, and how much more difficult it is for her than for a man to become an authentic self.

I could say that culture at large enters into a conspiracy with the woman's private conflicts, so that it is easier for her than for the male partner to give up self-determination and personal power, and to indulge in masochism. The conspiracy on the part of the culture consists in diverting the woman from becoming aware of the abnormality of her situation. As I had the opportunity to say elsewhere (Arieti, 1974b), it is not only the patient who represses the abnormality of some interpersonal relations and the accompanying cognitive constructs, but society as well. In *The Will To Be Human* (1972), I wrote:

> The individual has a double burden to repress: his (her) own and that of society. How does society repress? By teaching the individual not to pay attention to many facts (selective inattention); by masking the real value of certain things; by giving an appearance of legality and legitimacy to unfair practices; by transmitting ideas and ideals as absolute truths without any challenge or search for the evidence on which they are supposed to be based; by teaching certain habits of living, etc. The defense against objectionable wishes which Freud described in the individual (for instance, repression, reaction formation, isolation, and rationalization) can be found in society, too. (Pp. 45-407).

In a patriarchal society the woman often represses the sorrow, the anger, and the frustration which accompany her subordinate way of living. The repression, however, in the best circumstances leads to neurotic

defenses; in the worst, to facilitating serious mental disorders, especially depression. Although it is true that the very beginning of a pattern of female dependency can be traced back to the first two or three years of life, it is also true that this pattern would not persist and become ingrained in many cases if society at large did not promote it.

Femininity in some social classes becomes confused with being dependent. Self-assertiveness substitutes for reliance in a “strong” man. The man often depicts himself as the pillar, the ruler, or the direction-maker to the point of fostering a state of helplessness in the woman in his life. And yet later this very state of helplessness which has been fostered by men becomes bitterly criticized by them. As a rule, only in the areas of motherhood and homemaking is the woman allowed to assert herself fully. Homemaking, however, is decreasing in value in modern society, and many functions which in a preindustrial society were entrusted to the woman are now relegated to other agencies. The nursery school, the kindergarten, the grammar school, the church, the restaurant, the laundry, the clothing store, and many other institutions are taking over the functions of the home. Many wives feel relieved, but the problem remains that the woman has very little to do which she can consider stimulating. Therefore she feels dissatisfied. Society has prevented her from developing according to the male model. If she decides at a certain point to pursue a career, she feels left behind by contemporary men. Thus it becomes difficult for her to muster enough courage to pursue a career

with initial disadvantages.

The acquired state of dependency and submission makes the woman more prone to the developments described in chapter 6. Her dependency also makes her less able to help herself and more vulnerable to certain events which become precipitating factors to psychopathology. A person who relies more on his/her own inner resources and ability is less intensely affected by adverse circumstances. The feeling of helplessness and the inability to find alternative paths may evoke the return of an original experience of irreparable loss or impending loss.

One would expect that the depression which follows the realization of not having achieved the dominant goal is very common in women. We know in fact that especially in the past, but even in our own time, women have had fewer opportunities than men to become part of the high-level hierarchy of political parties, government institutions, churches, corporations, universities, industry, hospitals, and so forth. Undoubtedly many women suffer on account of this discrimination. However, as far as I can determine from my personal experiences, this discrimination does not lead to severe depression as frequently as one would expect.

In chapter 6 it was shown that in absolute figures even the type of depression which is connected with the realization of not having achieved the

dominant goal is more common in women than men. We must remember, however, that it is because the dominant goal of many women is connected not with a career but with the pursuit of love. It is in the area of love that many women feel disappointed. Thus, often it is difficult to categorize their depression, that is, if it is connected with the relation with a dominant other, or with the dominant goal of love achievement. It is not difficult to understand why this is so. Many women since early in life have not been encouraged to pursue a career, but have been subtly or openly directed toward the aims of motherhood and housekeeping. This prospect was made to appear very desirable to them because it was connected with the realization of dreams of romantic love. Love is of course very important and has to be pursued by everybody, men and women, but when romantic love becomes the only concern or aim in life and takes the place of any other aim including the pursuit of other types of love, then life becomes unduly restricted in rigid patterns for which it will be difficult to find alternatives later.

In men, depression caused by the realization of failure to achieve the dominant goal generally concerns a career. Inasmuch as a larger number of women are now diverting their aim from the traditional one to that of pursuing a career, it is possible to predict that a larger number of woman will become frustrated as a consequence of not achieving this aim, especially if discrimination against working women persists. It is more probable,

however, that society will move more and more toward giving equal opportunities to women, and consequently this type of depression in women will decrease. Up to now the depression which follows the realization of not having achieved the dominant goal has put women in a state of double jeopardy. Inasmuch as many women become affiliated with a male dominant other through marriage, they feel unfulfilled not only when they themselves do not achieve the dominant goal, but also when their husbands do not. Unfortunately, and purely for sociological reasons, the married woman's happiness depends more on her husband's feeling of fulfillment than the husband's happiness depends on his wife's sense of fulfillment.

At this point it is worthwhile to reconsider the theory which from time to time has appeared in classic psychoanalytic literature, that a castration complex can explain the greater occurrence of depression in women. I think it is easier to affirm that depressed women are more likely to mourn not for the castration of their penis, which would be pure fantasy on their part, but because they really have been castrated—although in a metaphorical sense. The symbolic penis of which they have been deprived is the male role in the world, including all opportunities connected with that role, from becoming president of the United States to being the director of a small bank. In *Creativity: The Magic Synthesis* (1976) I explained how the fact that women have played a less important role than men in various fields of creativity is the result of social conditions rather than of different biological endowments.

Here I wish to add that in addition to being hindered in cultivating the great fields of creativity, women have found it more difficult to grow in several aspects of life because only the husbands have had access to a large number of stimuli such as intellectual exchange with others, the practice of special occupations, trades, and so on.

Being denied the possibility of growth in many areas, some women have found it easy to regain power through functions which wrongly have been considered to pertain more to femininity than masculinity: sex appeal, the art of seduction, love. Many women who are afraid to lose these functions at the time of menopause are easy candidates for involutional melancholia. Fortunately, these tendencies are now being rapidly reversed.

Although society has made progress in changing the conditions which make it more likely for a woman to become depressed, the present situation is far from satisfactory. First, abolition of double standards and unequal opportunities has not taken place as much as would be desirable. Second, even though some changes have occurred at a behavioral level, the old cognitive constructs and accompanying feelings still operate in contemporary people. Moulton (1973) wrote, " . . . the unconscious of modern woman contains many remnants of the conscious misconceptions of her grandmother .... [The human being's] adaptive powers are remarkable for their ultimate versatility, but rarely for their speed. A culture in flux offers an apparent

breadth of choices, but effects are unpredictable . . .” We could add that the unconscious of modern man also contains many remnants of the conscious misconceptions of his grandfather. Moreover at the level of consciousness old and new concepts and guidelines are mixed, and the result is confusion.

In the last third of the twentieth century, many people are still under the influence of ideas which prevailed in the nineteenth century and at the beginning of this century. I have found it interesting to draw conclusions on the conceptions about women which prevailed in these historical periods by focusing on a form of art from that period which continues to affect us. I am referring to operas, and specifically to how women are represented in them. Although works of art generally accentuate certain traits and special characters are selected as heroes and heroines, this accentuation and choice are not haphazard but represent the ideas of the time in which these works appeared. My conclusion (which I will illustrate) is that if women were in situations as depicted in the lyric operas or if they were conceived of as they were in operas, they had good reason to be sad and were certainly facilitated in a trend toward depression. To the extent that these ideas continue in our conscious or unconscious, women are still affected in this way.

Before I proceed with my exposition, I wish to inform the reader that I believe I have no prejudice against operas. I have loved them since my childhood, and for decades I have had a regular subscription at the

Metropolitan Opera House. Nevertheless, I must reluctantly admit that in our day quite often we must make a strong effort to reconcile sublime overtures, melodious arias, and enrapturing intermezzos with the absurd ideological contents of the librettos. As to the way women are represented in most librettos, I can differentiate six major categories.

I. Women are victimized, exploited, insulted, and brutalized by men; and they are prevented by society from redeeming themselves.

II. Women are sick or frail.

III. Women are infantile, vain, and dependent.

IV. Women are loose and promiscuous.

V. Women are mechanical, insincere, and untrustworthy.

VI. Women are beautiful and lovely when young, but their youth is of brief duration.

Often the woman is in a situation in which she fulfills several of these categories at the same time.

The first category is the most common and states that men are brutal toward women, and the conclusion is a very pessimistic one from the point of view of the woman. If we consider all six categories, we can conclude that either woman's life is made miserable by men and therefore she is right in

being depressed, or she is regarded by men in such a negative way as to justify being in a state of despondency. A few significant examples will illustrate the points made. I shall start with the sixth category, which fosters the belief that youth is very important and at the age of the menopause a woman is finished. In Puccini's *Madama Butterfly* the heroine is fifteen when she develops a love which becomes tragically unattainable. In Strauss's *Der Rosenkavalier* the most touching point concerns the Marschallin, who at the age of thirty-two mourns her past youth. In the magnificent mirror aria she laments that she is no longer the beautiful young girl she used to be. Thinking about the inexorable flow of time, she prophetically concludes that her lover Octavian will leave her for a much younger girl.

The list of heroines to be included in the first category is long indeed. Madama Butterfly is abandoned by her husband, and she kills herself. In Donizetti's *Lucia di Lammermoor,* Lucia is victimized by her brother who forces her to marry Arturo, a man she detests. Edgardo, with whom Lucia is in love, rushes in just after the ceremony and curses her for betraying him. Lucia becomes insane, kills Arturo, and then sings the beautiful "mad scene."

In Tchiakovsky's *Eugene Onegin,* the heroine Tatiana dares to do the inconceivable for a Russian woman. She writes a letter to Onegin, revealing her love for him. This action brings about a series of misfortunes. And yet in writing the letter, Tatiana asks for mercy and understanding. In Verdi's

Rigoletto the heroine Gilda is victimized by the Duke of Mantua who seduces her, and by her father Rigoletto who keeps her in a state of dependency and infantilization. Rigoletto tells the housekeeper to watch Gilda and take care of her as if she were a beautiful flower. After Gilda's seduction, revengeful Rigoletto hires a man to kill the Duke, but Gilda offers herself in place of the Duke and is killed by her father's hired assassin. In Verdi's *La Traviata* Violetta, a high-class courtesan, finally finds real love and attempts to revise her life drastically. But society cannot forget her past, and she is doomed. The libretto, taken from Dumas's *La Dame Aux Camelias,* portrays a familiar theme in French literature: the *demi-mondaine* or loose woman who, in the French bourgeois environment, is not given a chance to redeem herself.

Loose women appear quite often in operas as main characters (for instance, Thai's, Manon) or as foils to the heroine (Musetta in Puccini's *La Boheme,* Maddalena in *Rigoletto,* and Lola in *Cavalleria Rusticana* by Mascagni). Sick women appear just as frequently, for instance, Violetta in *La Traviata,* Mimi in *La Boheme,* and Antonia in *The Tales of Hoffmann.*

It is true that in some rare operas there are women who do not belong to the six categories that have been mentioned, but who are rather strong and active promoters of a good outcome. This is the case with Minnie in *La Fanciulla del West* by Puccini. It is worth mentioning, however, that Puccini had the least success with this female character. Although Puccini was a

master at depicting the woman as victim (Butterfly, Tosca, Suor Angelica, Liu), sick (Mimi), or sexually loose (Musetta, Manon), he did not do such a good job with Minnie.

The most comprehensive picture of how women are portrayed in the world of opera probably appears in *The Tales of Hoffmann* by Offenbach. Hoffmann, a poet, offers to tell the story of his life's three great loves to a group of students. The first woman he loves is Olympia, the daughter of the great scientist Spalanzani. But alas! He discovers that she is not a real woman but a mechanical doll, an automaton which is finally smashed to pieces. The second of Hoffmann's loves is the Venetian high-class prostitute Giulietta, who causes a lot of trouble to others and to herself. Hoffmann's third love is Antonia, the daughter of a musician. Antonia is also in love with Hoffmann, but she loves her musical career more. She is warned not to sing because of her frail health, but she does sing, and dies. Hoffmann is disappointed again. In the end he decides that neither human love nor earthly woman is for him; his real love is for the Muse of poetry.

This unusual libretto cannot be taken literally. It has obvious symbolic meanings. We can easily agree with Hoffmann that he had better stick to the ivory tower of poetry since he is so maladroit in practical life and in his choice of women. However, he professes to demonstrate something philosophical, perhaps that love in unattainable on earth. Love may inspire human beings, as

the notes of Olympia's waltz do, and as the famous barcarolle sung by Giulietta and Antonia make us envision, but all this is not to be trusted; it is only illusion. Love is really impossible to find. Although as psychiatrists we cannot adhere to this point of view, we can respect it as a philosophical conception. Even the great Schopenhauer thought so. But what is objectionable to our modern ears, in spite of the beautiful melodies, is the way women are depicted. The three loves of Hoffmann are prototypes of women described in many operas and in other works of art from the nineteenth century and even later. Olympia is not a real human being, but a mechanical creature, made by men and very fragile. Giulietta is a high-class prostitute, and Antonia is a very frail human being.

In summary, in a world which sees women in the role of victim, or as sick, gullible, and naive, or loose, as a prostitute, it is no wonder women are bound to feel despondent about their lot and more inclined than men to become melancholic. One could argue that the melodrama represents special cases which are in fact selected because they are special. But special cases attract attention only because they accentuate or exaggerate common views. Most of the librettos derive from popular novels or plays which reflected the prevailing views of society at the time they were written. It could also be said that the librettos present the prevailing views only of the nineteenth and early twentieth centuries, views which are no longer shared in our time. It is true that these views are rapidly disappearing, but not so extensively as one

would hope. There is still a great deal of the cognitive structure (sociology of knowledge) of the nineteenth and early twentieth centuries in our own time. Moreover, many of our patients of today were brought up when these ideas were still accepted, especially in certain milieus. Mrs. Fullman (described in chapter 10) and Mrs. Carls (described in chapter 12) retained many features of the operatic heroine.

Although the present attitude of society toward women is still short of our desires, the future seems promising. We can hope in the years to come that there will be less discrepancy in the incidence of depression between women and men. And yet we cannot make predictions with strong convictions. New and unexpected social factors may develop, causing the same discrepancy to persist, to be altered in the reverse order, or to increase in incidence for both sexes.

Affective Psychoses and Inner-Directed or Other-Directed Society

From the time of Kraepelin to the early 1930s, affective psychoses (manic-depressive psychosis, psychotic depression, involutional melancholia) received an amount of consideration equal or almost equal to that of schizophrenia (dementia praecox). However, from the thirties to the beginning of the seventies there has been a progressive disinterest in these conditions.

As I reported elsewhere (1959, 1976) the decline of interest seems due to a decline in the frequency of serious affective disorders. The present revival of interest in manic conditions is probably connected to the enthusiasm with which lithium has been recently used in the treatment of manic states. Actually, Cade's introduction of lithium in the treatment of manic patients goes back to 1949 but at the time of its introduction it was considered dangerous, and only in the 1960s did it become a popular form of treatment. The recent interest in depression or in manic states does not rule out the persistence of a low incidence of the typical biphasic manic-depressive psychoses, characterized by full-fledged manic episodes and severe attacks of the self-blaming type of depression.

In 1928, in New York state there were 10 new hospital admissions of manic-depressive patients per 100,000 inhabitants, and in 1947 this incidence had decreased to 3.7 per 100,000. The percentage of first admissions of manic-depressive patients in 1928 was 13.5 percent of all admissions, and in 1947 the percentage was reduced to 3.8. Thus in a period of twenty years, the incidence of manic-depressive patients admitted to New York state hospitals decreased to approximately one-third, and has shown no tendency to increase since then. Similar statistical trends are obtained in most of the other states. The statistics point out that a definite decrease of this psychosis has taken place. However, interpretating the statistics is difficult because, as in all cases of psychiatric vital statistics, there are many variables

involved. Beliak (1952) offered three possible explanations: an actual lessening of the relative frequency of this disease; greater toleration by the healthy population of milder cases of manic-depressive psychosis; and changing diagnostic trends.

To these three hypotheses a fourth and a fifth can be added. The fourth hypothesis is that new therapeutic methods administered at the beginning of the illness produce such improvement or recovery that the patients do not need to be hospitalized. One thinks in particular of electric shock treatment which is capable of rapidly ending a manic-depressive attack, especially in the depressive phase. But this hypothesis does not withstand close examination. The first reports on electric shock by Cerletti and Bini appeared in 193S. Electric shock was introduced into the United States in 1939, but it did not receive wide application, especially in private offices with nonhospitalized patients, until the year 1942-43. On the other hand the statistics indicate that the decline in first admissions of manic-depressive patients started in 1928. What I have said in reference to electric shock treatment can be reported with even more emphasis for antidepressant drug therapy or lithium therapy in manic cases. These therapies were introduced long after a marked decrease in the incidence of affective psychoses had taken place. Before examining a filth hypothesis, it is worthwhile to discuss in detail Ballak's three hypotheses.

Beliak's third hypothesis, that changing diagnostic trends are

completely responsible for this decrease, is difficult to sustain. It is correct that many patients with a mixed symptomatology have been classified since the 1930s not as cases of manic-depressive psychosis, but as cases of reactive depression, senile depression, schizophrenia, schizo-affective psychosis, obsessive-compulsive psychoneuroses, etc. The pertinent question here is: Why has the diagnosis of manic-depressive psychosis been made with great reluctance?

It can be argued justifiably that this reluctance is not merely due to caprice, but has been determined by the fact that for a long time the typical or severe manic-depressive features played only a secondary role in many cases which needed hospitalization, whereas in the past they played a predominant role. I have also mentioned (chapter 3) that in the last few years an increase of cases has been noticed in which depression follows a typical initial schizophrenic symptomatology. In these cases preference obviously is given to the initial, and much more marked, symptomatology. Moreover, schizophrenic residues are often detectable in these cases even when the depressive features prevail.

Relevant information has been gathered in other parts of the world. Gold (1951) found a relatively larger incidence of manic-depressive psychoses than schizophrenic psychoses in the lands of the Mediterranean basin, as well as in Ireland. He reported that in Oriental countries, especially

where Hinduism and Buddhism prevail, manic-depressive psychosis is much less common, but in the Fiji Islands manic-depressive patients are numerous. He added that whereas in India, where the incidence of manic-depressive psychosis is low and schizophrenia is higher, the reverse is true for the Indians who have emigrated to Fiji. Immediately after the Second World War classical or pure manic-depressive patients were more numerous in Italy than in the United States. I11 1949, in the United States the rate of admissions was 4.7 for manic-depressives and 16.1 for schizophrenics; In Italy it was 10.0 for manic-depressives and 8.2 for schizophrenics.[1] Italian psychiatrists, however, state that since the late 1940s, in Italy the incidence of the classical type of manic-depressive psychosis also has decreased approximately as much as in the United States.

Another important point to consider concerning diagnostic trends is whether the differentiation of such categories as involutional paranoid state and involutional melancholia, used in the last few decades, is responsible for the statistical differences. In other words, patients previously diagnosed as manic-depressive might have been diagnosed as suffering from the involutional syndromes. Here again it is difficult to evaluate all the factors. Involutional patients previously might have been diagnosed as having paranoid conditions or paraphrenia, for example. It is only in cases of pure involutional melancholia that competition with the diagnosis of manic-depressive psychosis exists. It is doubtful whether the cases of pure

involutional melancholia, if added to the official figures of manic-depressive cases, would reverse the decline or explain the difference between the rate of first admissions of schizophrenia and of manic-depressive psychosis. Again the trend is shown sharply by the statistics. Beliak reported that of first admissions to New York civil state hospitals for the year ending March 1947, 27.7 percent were diagnosed as dementia praecox, 7.0 percent as involutional psychosis, and 3.8 percent as manic-depressive psychosis. (Involutional and manic-depressive combined were 10.8 percent.)

Beliak's second hypothesis is that the healthy population has more tolerance for milder cases. Beliak states that the "full of pep and energy" salesman type of person has become an accepted type. He is correct, but— in spite of some similarities—this person corresponds not to the cyclothymie hypomanic who is liable to become manic-depressive, but to the "marketing personality" of Fromm (1947) and the "other-directed" personality of Riesman (1950). This second hypothesis of Beliak, however, implies a corollary: milder cases have been much more common in recent decades. I believe this to be the case. But an explanation for the difference will be discussed when the fifth hypothesis is examined.

These observations and considerations seem to lead to the conclusion offered by Beliak's first hypothesis: the decline in the number of manic-depressive patients, at least of those who are so seriously ill as to require

hospitalization, is real and not apparent. Although this decline is not universal, it seems to affect many countries and especially Western countries, but not with the same speed.

It would appear that understanding the reasons for this decline in number or the lessening of the symptomatology of manic-depressive psychosis could lead to conclusions relevant to the field of mental hygiene in particular, and of psychiatry in general.

What David Riesman called the inner-directed personality and culture may be related to typical manic-depressive psychosis with the self-blaming type of depression. When this type of personality and culture tend to disappear, this psychosis tends also to disappear.

Riesman explained that the establishment of the inner-directed society is the result of demographic and political changes. At certain times in history, a rapid growth of population determines a diminution of material goods and a psychology of scarcity. This type of society has occurred several times in history. The society with direct relevance for us had its beginning at the time of the Renaissance and developed during the Reformation. Fromm (1941) wrote that in this period of history, the security that the individual had enjoyed in the Middle Ages by virtue of membership in his closed class system was lost, and he was left alone to rely on his own efforts. The religious

doctrines of Luther, and indirectly those of Calvin, gave the individual the feeling that everything depended on his own efforts. Deeply felt concepts of responsibility, duty, guilt, and punishment, which had existed in the early Middle Ages but became confined to a few religious men, reacquired general acceptance and tremendous significance and came to color every manifestation of life. This type of culture, which originated during the Renaissance and developed during the Reformation, sooner or later permeated all Western countries: only in the third or fourth decade of this century has it faced replacement by another type of culture, the other-directed.[2] In some countries such as the United States, this replacement has taken place at a rapid rate; in others, it is still taking place but at a slower pace.

In the inner-directed society, the parent is duty-bound and very concerned with the care of the newborn child. It is this duty-bound care, and later burdening the child with responsibilities and a sense of duty and guilt, which may permit the child to develop the strong introjective tendencies that play such a prominent role in the development of manic-depressive psychosis.

The typical manic-depressive and the typical inner-directed person have the following characteristics in common:

1. Very early in the life of the child, the duty-bound parent gives such

tremendous care to the child as to determine strong introjective tendencies in him.

2. A drastic change occurs later, when the child is burdened with responsibility. This change produces the trauma of the paradise lost.

3. The individual feels responsible for any possible loss. He reacts by becoming compliant, working hard, and harboring strong feelings of guilt. Life becomes a purgatory.[3]

4. This tremendously burdened life leads to depressive trends, or to inactivity, which leads to guilt feelings, or as a reaction to activity which appears futile. These negative states and feelings are misinterpreted as proof of one's unworthiness, and they reactivate the expectancy of losing the paradise again, this time forever. A vicious circle is thus formed.

Other social studies point out a relation which is more than coincidental between manic-depressive psychosis and inner-directed society. The research by Eaton and Weil on the Hutterites (1955*a*, *b)* may throw additional light on this hypothesis, although these authors did not use the term inner-directed society. The Hutterites are a group of people of German ancestry who settled in the Dakotas, Montana, and the prairie provinces of Canada. Their life is very concerned with religion and their birth rate is very high, with the average family having ten children. This society seems to be typically inner-directed. In a population of 8,542 people Eaton and Weil found

only 9 persons who at some time in their life had suffered from schizophrenia, and 39 who suffered from manic-depressive psychosis. In other words, manic-depressive psychosis among the Hutterites was 4.33 times more frequent than schizophrenia, whereas in the general population of the United States, the incidence of schizophrenia by far exceeded that of manic-depressive psychosis. In the second part of this chapter Bemporad discusses child-rearing among the Hutterites and its relevance to the incidence of affective disorders.

Other historical facts point to a relation between inner-directed society and manic-depressive psychosis, but these facts although suggestive are by no means reliable or scientifically proved. For instance, among the physicians of the pre-Christian era, Hippocrates in particular seemed concerned with cases of mania and melancholia. It is possible to assume that his experience with such cases was extensive, making it probable that their incidence was high. Significantly, Riesman's theories postulated that Athenian culture at that time was inner-directed.

What has been discussed in this section should not be interpreted as if I were suggesting that inner-directed culture is "the cause of" manic-depressive psychosis. I only advance the hypothesis that this type of culture tends to elicit family configurations and interpersonal conflicts which generally lead to severe forms of manic-depressive psychosis with the self-

blaming type of depression.

A fifth hypothesis concerns the possibility of a change in the symptomatology of many cases of depression, including the depressions which are part of manic-depressive psychosis. This change would result in a different symptomatology of milder intensity which often does not require hospitalization. That a change has occurred has already been seen in chapter 3, when the manifest symptomatology was discussed, and in subsequent chapters. I have described the claiming type of depression, which as a rule is less severe than the self-blaming type.

The relation that has just been illustrated between inner-directed culture and a self-blaming type of depression cannot be repeated for the claiming type. A person who tends to rely on others for autonomous gratification has since early childhood resorted to the external environment for most kinds of stimulation and has been less prone to internalize or conceive distant values and goals. He is likely to be other-directed. In Reisman's conception (1950), the other-directed person uses peers as models rather than the older generation. A person whose major orientation is not inward or toward himself but toward the external world is more inclined to claim from others than to expect from himself. He also has less inclination to blame himself.

Again, according to Riesman, the other-directed types of culture and personality have increasingly replaced the inner-directed types. It can thus be postulated that at present a larger proportion of the claiming type of depressions tend to occur. Although the claiming type is less severe than the self-blaming type and does not require hospitalization as frequently, it is still to be considered a rather serious type of disorder and should not be confused with what is called neurotic or reactive depression.

Literature and Depression: Tragedy

Since sadness and depression are such common states, it is no wonder that these emotions have been described in the literature since ancient times. In some particular historical eras, however, the literary involvement with melancholy has been much more intense than in others. It is difficult to say whether the culture has stimulated accounts of melancholy in the literature or whether the literature has contributed to create a cultural climate of sadness by giving particular stress to this emotional state. Probably a vicious circle often is established between what is called the *Weltschmerz* (melancholy pessimism of some authors) and the *Weltanschauung,* or sadness of some eras. It is also important for us to evaluate whether the general cultural climate of sadness or the literary trends of melancholy favor the onset of individual depression.

A rapid excursion from the world of antiquity to our day will reveal various representations of sadness and depression in the literature. The field is immense, and any selection is certainly arbitrary.

According to Koerner (1929), the earliest record of depression in Indo-Germanic cultures is the melancholia of Bellerophon in the *Iliad.* In the Bible (Samuel I) the depression of King Saul, terminating with his suicide, is dramatically reported. In the classical Greek era we have the writings of Aristotle, who followed the Hippocratic school in believing that melancholia was due to an abnormal mixture of the black bile. In *Problemata,* Aristotle asks a question which is said to have inspired the painter Durer to make his famous painting of Melancholia First nineteen centuries later. Aristotle asks: "Why are all men who excel in philosophy, politics, poetry, or arts definitely melancholy, and some of them in such a way as to be really affected by the morbid manifestations which derive from the black bile?" Thus Aristotle implies that many creative people are not just melancholy, but morbidly so.

Joannes Cassianus was a fourth-century monk who spent some years as an ascetic in the Egyptian deserts. In his long book *De institutio coenobiorum* he describes two types of depression: the rational, to be accepted; and the irrational, to be rejected. The Spaniard Isidore of Seville (560-636), who for over forty years was bishop of Seville and eventually was sanctified by the Catholic church, wrote that hopelessness and depression derive from

sinfulness. He advised that confession and atonement would help. Alcuin, originally Ealhwine or Albinus (735—804), an advisor of Charlemagne, wrote *The Vices and Virtues* in which he anticipates some modern views of depression. He considers melancholia to be a loss of hope of salvation. He also describes the depressed person as one who hates himself and wishes his own death.

Throughout the Middle Ages depression was seen as something negative, probably associated with sinfulness or with some kind of disease, as Hippocrates and Aristotle had thought.

The medieval literature does not portray a pervasive atmosphere of sadness, as what we know about Dark Ages would lead us to expect. It is fair to assume that people were indeed saddened by the state of the world then, but they either were not allowed to express or were incapable of expressing their negative feelings. To do so would have been interpreted as a rebellion or revolt against the divine order. People were allowed to express discontent only when they could do so in theological terms. Actually, it is safe to assume that in a cultural atmosphere where despotic feudalistic power prevailed, where the concepts of sinfulness and atonement reigned, and where contempt was preached for earthly life, sadness and depression should have been rampant, unless neutralized by fanatic faith.

Some historians who have studied the Middle Ages used to believe that a large percentage of people living in that period had interpreted the New Testament as predicting the world would perish in the year 1000. Thus they stopped being active, and literature, arts, and works of any kind languished and were reduced to a minimum. After the year 1000, when people realized that the world had survived that fatidic date, hope for the future was renewed and people moved toward the innovating spirit of the Renaissance. This theory was later discarded by historians. The fact remains, however, that the Middle Ages contributed much less to Western civilization than the classic world of antiquity and the period of time which started with the Renaissance. Undoubtedly, complex historical, political, and sociocultural factors are responsible but they are beyond the scope of this book to investigate. However, I would like to suggest another hypothesis for consideration: at a cultural level a climate of depression prevailed during the several centuries of the Middle Ages that slowed the activities of entire generations of men. Relatively little was accomplished in literature, art, and science.

Melancholy makes its official entrance into the philosophy and literature of the modern world with Marsilio Ficino, a Platonist-humanist (1434-1499). Developing a trend which had already entered the Christian literature with St. Augustine, and the Italian literature with Petrarch, Ficino rehabilitated melancholia. Melancholia was no longer considered to be exclusively a negative state, as it had been since Aristotle. According to Ficino

the human being lives in exile, in a world to which he does not belong, since he still retains a divine spark. Melancholia is the emblem of the Christian. Love stimulates in the human being a state of perennial dissatisfaction, a constant craving and anxiety, a thirst of knowledge which is never quenched. Thus love leads to disappointment, fatigue, and consequently to melancholia. But melancholia will rekindle the desire for love.

According to Ficino, melancholia is a restless and uneasy state of mind which typifies inner experience. It is not a paralyzing sadness that leads to renunciation, but a desire to lift oneself from a vulgar existence; it is the pain of the soul which aspires toward higher and immaterial places. If I understand Ficino correctly, it is the sorrow of the human being for being human, and for being so distant from the divine to which he aspires.

Ficino retained the conception that melancholia derives from one of the four humors of the organism. According to him it has an astrological meaning, too: those who are subjected to the influence of Saturn tend to be melancholy.

Lorenzo the Magnificent (1449-1492), the Florentine prince, statesman, and poet, was very much influenced by Ficino. He was both a man of action and a man given to contemplative life. In a celebrated sonnet he describes how Death is the teacher who shows how any hope is vain, any plan is futile, and the world of men is full of ignorance. Lorenzo does not have the faith in a

better world which animated Ficino. For him, death is the end. Thus in the most celebrated of his poems he reminds people of the beauty of youth which ever flies; there is no certainty in tomorrow; let him be glad who will be.

A more complete literary rendition of melancholia is provided in the Italian literature by the poet Iacopo Sannazzaro (1456-1540). He mourns for Arcadia, the world he has lost. Here is a passage from one of his descriptions.

> Our Muses are extinct; withered are our laurels. Our Parnassus is ruined. The woods are mute, and pain has deafened the valleys and the mountains. No longer are nymphs or satyrs to be found in the forest; the shepherds have lost their songs and the flock hardly grazes the grass .... Everything is lost, every hope has failed, every comfort is dead. [Translation mine.]

The climate of melancholia spread from Italy to the rest of Europe. It is found in Albrecht Durer (1471-1528), the painter who portrayed the concept of melancholia in fine art. In England *The Anatomy of Melancholy* by Robert Burton appeared in 1621 under the author's pseudonym, Democrites Junior. Burton repeated the idea that melancholia is a state of the organism resulting from the perturbation of one of the four primary humors. The work is preceded by a prologue which explains and justifies the selection of the topics and the system of exposition. The book is divided into three parts: two deal with melancholia in general; the last with melancholia as related to love and religion. This work is a huge compilation and a strange conglomeration of disparate quotations. It offers hardly anything original about melancholia

from a philosophical, psychological, and psychiatric point of view. However, it had some influence in English literature—especially on Milton, Sterne, Byron, and Lamb.

It is beyond the purpose of this book to discuss the complex problem of how melancholia gained ground in the European literature and finally emerged in the literary movement called romanticism. Romanticism is permeated by a philosophy of pessimistic idealism. The romantic writers advocated not a practical utilitarian morality, but an absolute one which never triumphed because of either adverse fate or human flaws. Often the Romantic hero was depressed, but not so much because of the suffering inflicted on him or the defeats to which he was subjected. He was not like the religious martyr who disregards lack of success on earth because he aspires only to eternal values and superior goodness; his pain and rancor, which made him utterly depressed, came from not being understood and appreciated by other humans. His great suffering often derived from the fact that he could not in good faith respect those who were not able to recognize his value. He finds himself in a state of despair in which he must reconcile himself to the tragic fatality of human existence as it is now, in his present milieu, and as it probably always will be. Suffering and disappointment often lead the romantic hero to suicide, as in Goethe's *The Sorrows of the Young Werther,* a book imitated by many authors in various languages. This book, and its imitators, were said to have caused an epidemic of suicides in Europe.

In this depressed climate the French poet Lamartine wrote in a poem dedicated to Byron:

Plus je sonde l'abime, hélas! plus je m'y perds.
Ici-bas la douleur à la douleur s'enchaine,
le jour succède au jour, et la peine à la peine.
Borné dans sa nature, infini dans ses voeux,
l'homme est un dieu tombé qui se souvient des cieux.

The more I plumb the abyss, alas! the more lost I become.
Here on earth, pain is bound to pain;
As day follows day, sorrow follows sorrow.
Limited in his nature, infinite in his desire,
Man remains a fallen god with memories of Heaven.

[My translation]

Victor Hugo represents man as a blind giant who travels in the darkness of the night and sustains himself on a special cane: his sorrow. Musset, in his well-known sonnet "Tristesse," assesses his life which craves joy but is full of disappointments, and he concludes with these verses:

Dieu parle, il faut qu'on lui répond;
le seul bien qui me reste au monde
est d'avoir quelquefois pleuré.

God speaks, and I must answer;
The only wealth left to me in this world
Is that of having sometimes cried.

[My translation]

The Italian poet Giacomo Leopardi, in a poem written on the occasion of the wedding of his sister Paolina, reminds her that she will add an unhappy family to unhappy Italy.

Whether it is transformed into realism or decadence, romanticism continues to exert an influence even today, and it possibly facilitates the occurrence of depressive thoughts. For instance, the realist Thomas Hardy viewed the human being as the victim of destiny and uncontrollable forces. Disappointment and sadness pervaded the poets in the 1930s (W. H. Auden, Louis MacNeice, Stephen Spender, Cecil Day Lewis, William Empson, and many others).

I have taken examples from several literary genres, without yet taking into consideration the one which probably portrays more intensely than any other genre the oceanic feeling of despair and melancholia. I am referring to the tragic situation as portrayed in literature in the form of tragedy. This is a vast issue, and only books of literature and philosophy can deal adequately with it in its many parts. I shall only refer to what is particularly relevant in connection with the psychiatric understanding of depression.

Can the state of the tragic hero be compared to that of the severely depressed patient? In some respects, yes. The hero finds himself in a situation which is tragic insofar as it is inevitable, irreversible, and unwanted to an

extreme degree, like the irreparable failure of one's mission, life plan, or lifelong hope, and the renunciation of life itself for the sake of the ideal. The hero is at the mercy of uncontrollable forces or he is responsible for deeds which he carried out without being aware of them; if he was aware of them, he was not conscious of their significance and their possible consequences. He is supposed to have no faults, like a god, but he is a human being and has flaws. Oedipus is unable to "see the truth," Othello is jealous, Lear is proud and arrogant, and Hamlet is unable to make decisions. The hero's flaws in and of themselves would not be sufficient in some instances to bring about the catastrophe if other circumstances had not worked together toward the tragic end, for instance, if Othello had not been misguided by Iago, if Macbeth had not been enticed by the witches, and so forth. Often a group of circumstances seems to conspire against the human being who, no matter how much he towers in his human dimensions, is still too little to cope with the gigantic situation which confronts him.

We can recognize a hero in our depressed patient, too, and more frequently a heroine, who lives a tragic drama. He or she is the protagonist, but often obscure circumstances have set the stage, fie or she seems at the mercy of uncontrollable forces, but the patient's flaws also play determining roles: not recognizing the rigidity of the selected patterns of living; the unwillingness to change life goals and find alternatives; and the total commitment to a cause, in spite of repeated subliminal warnings that the

patient should change his or her ways of thinking and feeling.

The literary tragedy is in some respects a human protest. It mirrors the terror the human being has to face at times, the injustice he has to suffer, the anguish he feels. The protest is against whoever is responsible—the gods, fate, historical or social circumstances—or the limitations of human nature. The patient's depression also is a protest, but he often seems to lack the grandeur which is inherent in the ultimate acceptance of the tragic hero. He may even seem to lose his dignity at times and to indulge in a personal melodrama. And yet we must see him or her in an even more tragic light than the tragic hero; because unless he is successfully treated, he cannot maintain his own belief in himself or in his ideas, and he has contempt even for his own depression, for his own protest.

Literary tragedy often portrays the struggle between man and fate, which ends with the defeat of man and the victory of fate. But as Schlegel wrote (1818), the moral victory is with man. The depressed patient is not concerned with moral victory; he or she does not want to be heroic or a person who challenges the power of destiny, but only a happy human being.

A common conception of tragedy was originally presented by Schiller (1796), who interpreted the tragic conflict as being between the ideal to which the human being aspires and the real world. The depressed person also

sees a big discrepancy between what he aspired to in terms of human relations and life goals and what he can achieve in this meager reality. He cannot solve the conflict. What is available is not acceptable to him, and what would be acceptable he cannot grasp. He experiences the tragic situation of having no choice.

For Schopenhauer, tragedy as a literary form portrays what to him is the terrible essence of life, "the unspeakable pain, the wail of humanity, the triumph of evil, the scornful mastery of chance, and the irretrievable fall of the just and innocent" (Schopenhauer, 1961). The original sin is the sin of being born at all. Many patients at the nadir of their depression would echo Schopenhauer if they were endowed with his style and vocabulary. Other conceptions of tragedy are probably closer to those that a psychotherapist would accept. For example, Aristotle saw literary tragedy as a catharsis or purgation of the spectator through pity and fear. For Goethe (1827), the catharsis had to be understood as expiation or reconciliation on the part of the hero, rather than as purgation of the spectator. Goethe in his maturity changed the points of view he held earlier in life. I have already mentioned that young Goethe had his first hero, young Werther, commit suicide, and in the first part of *Faust* he had his protagonist sell his soul to the devil, an act which in the Christian tradition is an absolute form of suicide. But in the second part, written after a long interval, Faust undergoes purgation and obtains salvation.

Contemporary feelings of tragedy and depression, as they have occurred in the literature and other media, are discussed in another section of this chapter. A theme which has recurred in several periods of history is similar in its negativity to that of Schopenhauer. It has appeared frequently in literary forms and even in the common expressions of people. Any human being is a tragic figure: he finds himself on earth for no reasons that he initiated, coming from nobody knows where, and going toward indefinite paths. Only one thing is sure, that he will die and will have to face death. As tragic as this portrayal of man seems, the depressed patient does not experience his predicament in these terms. His protest is a personal one. He does not speak for Man or Woman, but for John Doe or Mary Smith.

The therapist who wishes to help the depressed patient must be a person who assumes that the human being could do a great deal to change the otherwise tragic circumstances of his life. Obviously our destiny is not entirely in our hands, but we ourselves are one of the major forces which mold our existence.

The therapist must admit, however, that there are tragic situations which the human being cannot change at all. What then? What can the therapist do to help? If the individual cannot change the tragic situation after having done his utmost to change it, his position becomes heroic, and he must learn to accept the heroic stand both for himself and as a spiritual example to

others. Let us remember, however, that as our rapid survey may have indicated, there is not only one type of tragedy, but two, and the second is more frequent than the first. The first follows the Greek paradigm, in which the human being is the ineluctable victim of destiny and as such is ineluctably predestined to suffer and perish. Ananke—necessity or fate—which at times works in conjunction with other human beings, is the cruel puppeteer who pulls the strings. If this is the human situation, the heroic position is in seeing the heroism of the puppet.

But there is a second type of tragedy, the tragedy of the Judeo-Christian tradition. It is the tragedy of having to sacrifice one's own beloved son, Isaac, the tragedy of Joseph being sold by his own brothers, the tragedy of Job, the tragedy of Christ—wherever the tragedy leads to the triumph of the human spirit. It is the tragedy in which the heros are not *les petites marionettes,* but where they themselves pull the strings which at times move the world, not necessarily in a direct way or during their lifetime, but through their legacy. The tragedy that ends with the triumph of the spirit may be called a spiritual or divine "comedy," as it was called by those who interpreted Dante's allegoric journey.

Our Era As the Age of Depression

Depression is acknowledged as being so common in our time that some

people are ready to classify our era as the age of depression.

Since I have been in the field of psychiatry, I have heard periods of time, stretching up to about a decade each, being referred to with psychiatric terms. In the 1940s we repeatedly heard that we were living in an age of anxiety; in the 1950s, in the age of alienation; in the 1960s, in an era of anger; and in the 1970s, in the age of depression. Is there any truth to these affirmations?

First of all, we must remember that these terms—anxiety (and/or fear), alienation (and/or detachment), anger (and/or hostility and violence), sadness (and/or depression)—are the basic negative emotional states that affect the human being. These basic negative feelings have existed since man made his appearance on this troubled planet. It is true, however, that one basic mood is felt more intensely than the others in particular periods of time. It is also true that periodical cultural trends make the human being as an individual and the whole society more sensitive to one particular mood than to another.

Anxiety has always been man's companion, but psychoanalysis has focused on this emotion and has made us recognize that it is a practically constant affective tonality. The popularity of psychoanalysis in the 1940s and the experiences of the Second World War have made us more aware of

anxiety and more ready to respond to it. The triumph of technology, mechanization, industrialization, corporation, and bureaucracy in the 1950s made us aware of our rampant alienation and brought about a revival of theories about this human status, which were originally formulated by Hegel, Marx, and others. The revolt against the Establishment, manifested by the students' confrontation and rebellion and by the increase in crime in the 1960s, made us think of an age of anger and violence.

But what about the 1970s, and why depression? What accumulation of facts had made sadness (or depression) more common, or increased our awareness of it, or made us more responsive to it? I have already mentioned that in some psychiatric circles the hypothesis has been advanced that since Cade discovered the beneficial effect of lithium in manic-depressive psychosis, we have focused on what we are able to treat and therefore on our manic and depressive trends. So many assumptions have to be packed into this hypothesis as to put its credibility in serious doubt. Lithium is an effective symptomatic treatment in some manic patients, not in depressed patients. It is also difficult to see how the enthusiasm of a few pharmacotherapists could influence the whole culture. We have seen that eras of depression have recurred throughout history. First in the early Middle Ages and then after the Reformation it was enhanced by the prevailing concepts of sin, guilt, damnation, retribution, and unworthiness. In our time depression, at least at a cultural level, seems to be connected with the loss of traditional values and

the inability to replace them with new ones. A state of meaninglessness, reminiscent of that which is experienced by the severely depressed patient, permeates contemporary culture. Our contemporary literary tragedy is best represented by the theatre of the absurd. It conveys the premise that God is dead, and with the death of God all hope is dead; life is meaningless and essentially absurd, unfit to its surroundings, disharmonious, and purposeless.

The significant writings of some authors who actually had started to write in this vein in the 1930s and 1940s has finally permeated the spirit of the culture. When the present literature—especially the novel and the theatre in their most eloquent representations—portrays the tension between the forces of growth and the forces of dissolution, it ends with the victory of the negative forces. Already in 1942 Camus in *The Myth of Sisyphus* asked why man should not commit suicide, since life has lost its meaning. Echoing with modern themes the quoted verses of Lamartine (page 381) he writes ". . . In a universe that is suddenly deprived of illusion and of light, man feels a stranger. His is an irremediable exile, because he is deprived of memory of a lost homeland as much as he lacks the hope of a promised land to come." In *Waiting for Godot,* Beckett says "Nothing happens, nobody comes, nobody goes, it's awful" [1959]. The awfulness is the state of meaninglessness in this cultural climate, in which a considerable number of people feel that they have lost their ideals and have not replaced them with new ones. Many persons no longer see themselves as part of a worthwhile whole, as part of either society

or an ideological group. In some cases cynicism, distance-making, and alienation of all kinds are not strong enough antidotes to the state of meaninglessness; and despondency and depression ensue, often as a chronic, anxious sadness or as an apathetic form of depression.

Some sociologists and psychiatrists have asked themselves whether the terrible events which have happened in our century—the First World War with millions of people killed on the battlefield and the massacre of millions of civilian Armenians, the Second World War, with the Holocaust of the Jews and the atomic bombing of Hiroshima—have engendered a feeling of overwhelming hopelessness in generations of young people, culminating with a pervasive feeling of sadness and meaninglessness about mankind and life in general. Studies of this type are difficult to make on a large scale. Conclusions drawn from answers in response to questionnaires seem inadequate to the depth of the inquiry. I can only speak for myself and express the conclusions that I have reached from my studies of both depressed patients and patients belonging to other clinical categories whom I have treated since the end of the Second World War. I am fully aware that the limitation of my inquiries and my personal biases may have led me to wrong conclusions. Nevertheless, I must dare to express my tentative feelings.

None of my patients have seemed concerned at more than a superficial level with the effects and meaning of the Holocaust and Hiroshima, unless

they had some relatives or friends caught in these tragic events. The massacre of the Armenians has practically been forgotten by everybody except the Armenians. I expected people to be concerned about these terrible events, but they were not. I could not conclude that the concern was deeply repressed and I did not catch it because I have included in my inquiry only people who were adequately and deeply analyzed. If repression existed, it was to an extent that could not be overcome with the usual therapeutic procedures.

Alexander and Margarete Mitscherlich (1975), two well-known German analysts, have described the inability of the German people to mourn for what their fellow citizens had done during the Second World War. But we could extend the Mitscherlichs' regret to the whole world and say that people in general have not been able to mourn adequately for the Armenian massacre, for the Holocaust, and for Hiroshima. They could not do sorrow work, nor did they fail to do adequate sorrow work as described in chapter 5 of this book because they did not feel the need to mourn. They did not experience adequate sorrow in the first place. A sad or depressed reaction would have been more adequate, and probably would have made them experience a salutary sense of tragedy. Perhaps a longer interval of time for a thoughtful appraisal of historical events is necessary. In any case I cannot attribute the present cultural mood of depression directly to the tragedies of our century or relate depression to them in a sequence of linear causality. Perhaps the lack of adequate emotional response has contributed to the feeling of lost

values and meaninglessness which may be responsible for this state of aimless despondency and vulnerability to depression. Nothing matters in a world reputed to be aimless, amoral, and deprived of personal or cosmic harmony.

Instead of finding reconstructive inspiration from the historical tragedies of our time, some of which were of a magnitude never before conceived, literature has contributed to this feeling of meaninglessness and abolition of values. Unfortunately, we must subscribe to John Gardner's view when he writes of "death by art" or death by cultural influences. He says, "Some men kill you with a six-gun, some men with a pen"(1977).

In defending writers of the absurd, some critics indicate that by pointing out the meaninglessness of the world and the destructive tendencies of everything, such writers want to help people and to stimulate the emergence of constructive forces. This does not seem to me to be the case, because writers of the absurd identify very well with these negative forces, feel them very strongly, and with the greatest sincerity point out what seems to be their inevitability and irreversibility.

Socio-Philosophical Premises of the Psychotherapist of Depressed Patients

Not everything is negative, however. We have made progress in some areas, for instance, in the way women are treated.

The task of the psychotherapist of depressed patients is made more difficult in a cultural climate in which the meaninglessness of everything is advocated. I have mentioned, however, that the patient who feels very sick is seldom concerned with anything that transcends his private predicament. The therapist has to find his own identity and pave his own way, but if he shares the feeling that any waiting is a waiting for Godot, how can he help the patient to wait for recovery, and to reacquire hope in himself and life? Rather, he must think that waiting in a passive way and doing nothing else, while the earth continues to rotate on its axis, is not enough. The patient must move too, with open eyes, toward various possibilities. I cannot make generalizations which will be satisfactory for every psychotherapist, since specific issues enter into the dealings of each individual. I will nevertheless attempt to formulate guidelines which may help the therapist of depressed patients to do his work. These guidelines obviously also derive from our culture, and they can be seen as common denominators of the philosophical premises on which psychotherapy is based:

1. A psychotherapist assumes that a person does not need to become depressed if he is able to focus not on the daydreams which did not come to pass, but on those which were realized. The fewer the actualized dreams, the more valuable they are and the more they should be cherished.

2. Because of the infinite cognitive, emotional, and volitional functions of the psyche, the patient's age, sex, physical appearance, and

intellectual ability may decrease but—with rare exceptions—they do not extinguish his human possibilities. It is not necessary for the individual to feel trapped in certain patterns of living as if they were indelible imprintings. He can preserve a mobility consonant with life's array of alternatives.

3. A therapist cannot adhere to the concept that life is meaningless, or therapy becomes meaningless too. Two possibilities exist: (a) the therapist feels that there is a transcendental order and consequently a meaning in the universe and in life. But this is an act of faith, and we cannot prescribe it on demand to the therapist who cannot experience it. (b) The therapist shares the idea that even if there is no preordained order in the universe, and even if man and human affairs are random and inexplicable occurrences, an order and consequently a meaning can evolve in the human environment. Thus a purpose can still be given to one's life.

PART TWO: DEPRESSION AND METHODS OF CHILD-REARING

Jules Bemporad

In attempting to delineate the etiological factors that culminate in adult depression, some information might be obtained by scrutinizing the methods of child-rearing in those societies or subcultures that produce a high number of depressed adults. As with family studies of depression in our own culture, such reports are very scarce although some data exist and will be presented here. However, child-rearing methods cannot easily be separated from the cultural context in which they occur. Cultural beliefs permeate all areas of the individual's existence, just as these beliefs influence the parents and, in particular, the ideology that they impart to their offspring. Therefore more than simple child-rearing practices are involved. The whole cultural system of beliefs which are handed down through the parents, and which continue to shape the individual after childhood, must also be considered.

The importance of cultural beliefs was highlighted in a comparative study of neighboring Ojibwa and Eskimo tribes reported by Parker (1962). He found that although these two peoples shared common ecological hardships of cold winters and poor food supply, the Ojibwa tribe had a high rate of

depression together with anorexia, paranoid ideation, and obsessiveness; and the Eskimos demonstrated frequent hysterical attacks and some conversion reactions, but essentially no depressive disorders.

The reason for this difference may of course reflect different genetic pools, but this explanation is difficult to support in that both groups exhibited changes in symptomatology as their contact with Western culture increased. Rather, the discrepancy in types of pathology seemed to result from basic tribal beliefs which in turn affected the mode of child rearing. The Eskimos are, or were, a communal people who believed in total sharing and equality. It was difficult to discern any leadership structure, and there was no emphasis on social rank or individual accomplishment. They exhibited a confident attitude toward the supernatural, expecting their gods to grant them the necessities for survival. In times of hardship, they banded together and shared what little food could be obtained. Also, if any one member of the tribe transgressed some taboo, the community as a whole assumed responsibility so that there was essentially no concept of individual sin, or perhaps even of individual guilt. Those who came in contact with the Eskimos described them as exuding an atmosphere of joviality, friendship, camaraderie, and modesty. They openly expressed their emotions and were not ashamed to ask each other for help or to admit weakness.

In contrast, the Ojibwa Indians were described as boastful, sullen,

competitive, and secretive. They were hypersensitive to criticism and nursed grudges for inordinate periods of time. In times of hardship they lived apart, in closely knit, small family units that competed and were suspicious of each other. The Ojibwa showed a masochistic attitude toward their gods; they humbled themselves and begged for pity from spiritual powers. They also tried to propitiate their gods by personal suffering. This religious attitude may have been based on their belief that impersonal causes were never the reason for misfortune. Someone was always responsible and had to mollify the gods by personal sacrifice for guilt which was not shared by the others. Their gods were appeased only by suffering and even children were required to suffer in order to insure the gods' favoritism.

As regards child-rearing, the practice of the two neighboring peoples were also different. The Eskimos believed that a child was the repository of the soul of a recently departed family member. Unless the child was treated kindly and prevented from suffering, they feared that the protective soul would leave the child's body and the child might become sick or die. Therefore the Eskimo baby was welcomed into the tribe as the return of a departed loved one. He was satisfied in every way, even being nursed on demand until four years of age. Any sign of discomfort was appeased by food, distraction, or engaging the child in a pleasurable activity. There was complete dependency gratification without the expectation that the child had to work in order to deserve the love given him. In general, there were few

restrictions on behavior, with great tolerance for bowel and bladder accidents or sexual curiosity. Around puberty the child was gradually initiated in the adult role with great patience.

In marked contrast, the Ojibwa believed that the neonate was an empty vessel who was vulnerable to the myriad evil powers that filled the world. In order to protect the child from misfortune, he was disciplined early and "toughened" to prevent being seduced by evil spirits. Early in life the child was introduced to the gloomy pessimism of the Ojibwa; for example, he was regularly starved to prepare him for periods of food shortage. As with the cultural belief system, he was made to feel responsible for his misfortunes and that salvation was possible only through self-induced suffering. Finally, the child was given a goal that he had to achieve in his later life: he was expected to have a vision during an intensely painful rite of passage which would show him his future path. Therefore, he later felt obligated to achieve the goal revealed to him in his "vision."

Parker concluded that the Eskimo's need for immediate gratification and the easy reliance on the community to fulfill his every need may have predisposed him to public histrionics in times of deprivation. On the other hand, the Ojibwa's consistent shame over dependency needs, his lack of community support, his belief that gratification could be achieved only through self-induced suffering, and his need to achieve in order to feel worthy

might have accounted for the selection of depression as a common expression of conflict and stress.

Another anthropological study which may shed some light on the psychogenesis of depression is Eaton and Weil's (1955b) report of the self-contained Hutterite community in the northern United States. As mentioned earlier, this is a highly puritanical and duty-oriented community which has been found to have an extremely high rate of depressive disorders. The values of this community may be summarized as follows: to deny oneself (or others), to shun (and be ashamed of) hedonistic or aggressive tendencies, to have complete loyalty to the group, and to seek rewards for self-denial and hard work in an afterlife.

Child-rearing procedures differ markedly from the neighboring American communities. For example, babies are delivered at home by natural childbirth, families have ten to twelve children (since birth control is considered sinful), and there is communal mothering after the infant is two months of age. From the age of roughly thirty months, each child spends most of the day in a nursery school, and from this point on his entire life becomes group-oriented with ever-increasing ties to the community. Eaton and Weil comment that there is a great deal of identification with the peer group and a strong need for conformity. Education is described as colored by "a continuous, uniform, but general rote form of religious indoctrination" (p.

31). Furthermore, the children are taught an absolute value system with a clear code of admissible behavior, the only justification for which is tradition. The children are told that they are superior to their decadent and spiritually contaminated neighbors and they are expected to lead exemplary lives. Competition between children is not encouraged, but everyone is expected to do his utmost and to try his hardest in any endeavor.

In Eaton and Weil's study one is struck with the lack of freedom, spontaneity, and even privacy allowed to the growing child. While there is a great deal of community support and security, these comforts appear to be achieved at the price of individuality. In addition, there appears to be a constant fear that one has failed by insufficient effort and will be liable to judgment from peers or from God.

The effects of these pressures on Hutterite children was clearly noticeable to the authors and to their non-Hutterite teachers. The Hutterite elders had remarked that there were no maladjusted children in their community, while the teachers believed that about two-thirds of the children demonstrated some degree of psychopathology. Ironically, the behavior thought to be pathological by American teachers was approved by Hutterite religious teachers, and the behavior encouraged by the American teachers was judged as bad by the Hutterites. For example, impulsive and spontaneous behavior was criticized by the Hutterites. On the other hand, extremely

inhibited, submissive, obedient behavior was applauded by the Hutterites to the dismay of the American teachers.

A vignette described by Eaton and Weil epitomizes the atmosphere that surrounds the Hutterite child.

> A young staff member, who was very spontaneous with children, started to play tag with a group that had gathered around him. The tagging progressed into hitting, and our field worker was soon preoccupied with warding off shouting boys and girls who were competing in the effort to get a lick at him. The staff member enjoyed the 'game' and encouraged it. Suddenly the shrill voice of an elderly lady came out of an entrance door of the communal kitchen across the courtyard: 'Gebt Heim!' (Go home). As if hit by lightning, the children froze, stopped, and dispersed. One remark from a respected adult was enough to curb them, although the woman was not the parent of any of them. Later, she and several other adults apologized profusely to the staff member for the behavior of the youngsters explaining: 'They are awfully bad.' (Pp. 132-133).

Nevertheless, while the child is highly disciplined, he is also given much love. Children are the only wealth a Hutterite may call his own and so they are prized by their parents. This counterforce may protect them from severe psychopathology in childhood, but the stern system of beliefs that is indoctrinated shows up in adult life as an inordinate propensity for depression.

For the Hutterite as for the Ojibwa child, life experience is channelled by strong taboos against spontaneity or fun. There is an everpresent sense of

inhibition and a fear of letting go. Furthermore, there is an equally pervasive atmosphere of sin, accountability, and self-denial. The world is seen as a place full of evil temptation from which the child is to be protected by stern discipline. The Hutterites temper this severity with love, but this parental love must be won by hard work. The Ojibwa seem to make a virtue of suffering and to show their love for their offspring by preparing him for the harsh difficulties of adult life. While the Ojibwa child seems to be allowed more freedom and individuality than the conformist Hutterites, he is burdened with a sense that he must accomplish his visionary goal and that others cannot be counted on to help in this endeavor. These differences might account for the variations in secondary symptoms seen in the respective depressive episodes. Finally, both cultures view outsiders with suspicion and consider themselves to be both different and superior.

These studies, while limited in number, confirm the fundamental thesis that the predisposition to adult depression results from the individual's early relationships and from cognitive structures that are internalized. In reading the accounts of child-rearing among the Ojibwa or the Hutterites, one sees many areas of similarity in the accounts of the childhoods of depressives in our own society. Our cultural mores do not strengthen or amplify the family beliefs and transactional styles that predispose to later depression. However, the early learning of these beliefs or the child's early experiences (such as those described by Cohen and co-workers, 1954) appear sufficient to mold

the individual's way of thinking and behaving so that he is later impervious to healthier modes of adaptation. In our society, specific subcultures do exist whose values tend to produce depression-prone individuals. However, the lack of general cohesion in current American society may allow for a pathological belief system of even one nuclear family to be sufficient to create a depressive vulnerability in childhood.

Notes

[1] Italian statistics were kindly provided by Professor Francesco Bonfiglio of Rome. To be exact, first admissions of schizophrenics in Italy were 3,541 in the year 1947, 3,780 in the year 1948, and 3,854 in 1949. First admissions of manic-depressives were 4,298 in 1947, 4,562 in 1948, and 4,791 in 1949. The rate of admission per 100,000 citizens represents the annual average of the triennial period 1947-1949.

[2] Do not confuse the other-directed culture and personality, described by Riesman, with what I have described as outer-directed personality. The outer-directed personality is a hypomaniclike defense against, or a reaction formation to, the inner-directed personality. Riesman's other-directed personality is basically a different type of personality, occurring predominantly in an other-directed society.

[3] At this point many manic-depressive patients deviate from the inner-directed personality; instead they develop an excessively dependent or hypomaniclike outer-directed personality.

REFERENCES

Abraham, K. 1960 (orig. 1911). Notes on the psychoanalytic treatment of manic-depressive insanity and allied conditions. In *Selected papers on psychoanalysis.* New York: Basic Books. Pp. 137-156.

_____. 1960 (orig. 1916). The first pregenital stage of the libido. In *Selected papers on psychoanalysis.* New York: Basic Books. Pp. 248-279.

_____. 1960 (orig. 1924). A short study of the development of libido, viewed in the light of mental disorders. In *Selected papers on psychoanalysis.* New York: Basic Books. Pp. 418-501.

Adler, K. A. 1961. Depression in the light of individual psychology. *Journal of Individual Psychology* 17:56-67.

Akiskal, H. S., and McKinney, W. T. 1975. Overview of recent research in depression. Integration of ten conceptual models into a comprehensive clinical frame. *Archives of General Psychiatry* 32:285-305.

Annell, A. L. 1969. Lithium in the treatment of children and adolescents. *Acta Psychiatria Scandinavia* Suppl. 207:19-30.

Annell, A. L., ed. 1971. *Depressive states in childhood and adolescence.* New York: Halsted Press.

Ansbacher, II. L., and Ansbacher, R. R. 1956. *The Individual psychology of Alfred Adler.* New York: Harper.

Anthony, E. J. 1967. Psychoneurotic disorders. In A. M. Friedman and H. I. Kaplan, eds. *Comprehensive textbook of psychiatry.* Baltimore: Williams & Wellsing.

_____. 1975a. Childhood depression. In E. J. Anthony and T. Benedek, eds. *Depression and human existence.* Boston: Little, Brown.

_____. 1975*b.* Two contrasting types of adolescent depression and their treatment. In E. J. Anthony and T. Benedek, eds. *Depression and human existence.* Boston: Little, Brown.

Anthony, E. J., and Scott, P. 1960. Manic-depressive psychosis in childhood. *Child Psychology and Psychiatry* 1:53-72.

Arieti, S. 1950. New views on the psychology and psychopathology of wit and of the comic. *Psychiatry* 13:43-62.

_____. 1959. Manic-depressive psychosis. In S. Arieti, ed. *American handbook of psychiatry,* First ed., Vol. I. New York: Basic Books. Pp. 419-454.

_____. 1960. The experiences of inner states. In B. Kaplan and S. Wapner, eds. *Perspectives in psychological theory.* New York: International Universities Press. Pp. 20-46.

_____. 1962. The psychotherapeutic approach to depression. *American Journal of Psychotherapy* 16:397-406.

_____. 1967. *The intrapsychic self.* New York: Basic Books.

_____. 1970a. Cognition and feeling. In A. Magda, *Feelings and emotions.* New York: Academic Press.

_____. 1970b. The structural and psychodynamic role of cognition in the human psyche. In S. Arieti, ed. *The world biennial of psychiatry and psychotherapy,* Vol. I. New York: Basic Books, Pp. 3-33.

_____. 1972. *The will to be human.* New York: Quadrangle. (Available also in paperback edition. New York: Delta Book, Dell Publishing Co., 1975.)

_____. 1974a. *Interpretation of schizophrenia,* Second ed. New York: Basic Books.

_____. 1974b. The cognitive-volitional school. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. I. New York: Basic Books. Pp. 877-903.

_____. 1974c. Manic-depressive psychosis and psychotic depression. In S. Arieti, ed. *American handbook of psychiatry,* Vol. III. New York: Basic Books.

_____. 1976. *Creativity: the magic synthesis.* New York: Basic Books.

_____. 1977. Psychotherapy of severe depression. *American Journal of Psychiatry* 134:864-868.

Aronoff, M., Evans, R., and Durell, J. 1971. Effect of lithium salts on electrolyte metabolism. *Journal of Psychiatric Research* 8:139-159.

Baastrup, P. C., and Schou, M. 1967. Lithium as a prophylactic agent against recurrent depressions and manic-depressive psychosis. *Archives of General Psychiatry* 16:162-172.

Baldessarini, R. J. 1975. The basis for the amine hypothesis in affective disorders. *Archives of General Psychiatry* 32:1087.

Beck, A. 1967. *Depression: clinical, experimental, and theoretical aspects.* New York: Paul B. Hoeber.

_____. 1970. The core problem in depression: the cognitive triad. In J. Masseman, ed. *Science and Psychoanalysis* 17. New York: Grune & Stratton.

_____. 1976. *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Becker, E. 1964. *The revolution in psychiatry.* New York: Free Press.

_____. 1969. Kafka and the Oedipal complex. In *Angel in armor.* New York: Braziller.

Beckett, S. 1959. *Waiting for godot.* London: Faber & Faber.

Beliak, L. 1952. *Manic-depressive psychosis and allied conditions.* New York: Grune & Stratton.

Bemporad, J. R. 1970. New views on the psychodynamics of the depressive character. In S. Arieti, ed. *The world biennial of psychiatry and psychotherapy,* vol. I. New York: Basic Books.

_____. 1973. The role of the other in some forms of psychopathology. *Journal of the American Academy of Psychoanalysis* 1:367-379.

_____. 1976. Psychotherapy of the depressive character. *Journal of the American Academy of Psychoanalysis* 4:347-372.

Bender, L., and Schilder, P. 1937. Suicidal preoccupations and attempts in children. *American Journal of Orthopsychiatry* 7:225-243.

Beres, D. 1966. Superego and depression. In R. M. Lowenstein, L. M. Newman, M. Scherr, and A.]. Solnit, eds. *Psychoanalysis—a general psychology.* New York: International Universities Press.

Berg, J., Hullin, R., and Allsopp, M. 1974. Bipolar manic-depressive psychosis in early adolescence. *British Journal of Psychiatry* 125:416-418.

Berman, H. H. 1933. Order of birth in manic-depressive reactions. *Psychiatric Quarterly* 12:43.

Berner, P., Katschnig, H., and Poldinger, W. 1973. What does the term "masked depression" mean? In Kielholz, P., ed. *Masked depression.* Bern:Huber.

Bertalanffy, L. von. 1956. General system theory. In Bertalanffy, L. von, and Rapaport, A., eds. *General system yearbook of the society for the advancement of general system theory.* Ann Arbor: University of Michigan Press.

Bibring, E. 1953. The mechanism of depression. In P. Greenacre, ed. *Affective disorders.* New York: International Universities Press.

Bieber, I., and Bieber, T. B. (In press.) Postpartum reactions in men and women. *Journal of the American Academy of Psychoanalysis* 6 (1978).

Bierman, J. S., Silverstein, A. B., and Finesinger, J. E. 1958. A depression in a six-year-old boy with poliomyelitis. *Psychoanalytic Study of the Child* 13:430-450.

Bigelow, N. 1959. The involutional psychosis. In S. Arieti, ed. *American handbook of psychiatry,* First ed., Vol. I. New York: Basic Books. Pp. 540-545.

Binswanger, L. 1933. *Uber ideenflucht.* Orrele-Fusseler.

_____. 1963. Heidegger's analytic of existence and its meaning for psychiatry. In *Being-in-the-world.* New York: Basic Books.

Bonhoeffer, K. 1910. *Die symptomatischen psychosen im gefolge von akuten infektionem und inneren erkrankungen.* Leipzig: Deutieke.

Bonime, W. 1960. Depression as a practice. *Comparative Psychiatry* 1:194-198.

_____. 1962. *The clinical use of dreams.* New York: Basic Books.

_____. 1962. Dynamics and psychotherapy of depression. In J. Masserman, ed. *Current psychiatric therapies.* New York: Grune & Stratton.

_____. 1976. The psychodynamics of neurotic depression. *Journal of the American Academy of Psychoanalysis* 4:301-326.

Bonime, W., and Bonime, E. (In press.) Depressive personality and affect reflected in dreams: a basis for psychotherapy. In J. M. Natterson, ed. *The dream in clinical practice.* New York: Aronson.

Bowlby, J. 1958. The nature of the child's tie to his mother. *International Journal of Psycho-Analysis* 39:350-373.

_____. 1960a. Grief and mourning in infancy and early childhood. *The Psychoanalytic Study of the child* 15:9-52. New York: International Universities Press.

_____. 1960b. Separation anxiety. *International Journal of Psycho-Analysis* 41: 89-113.

Boyd, D. A. 1942. Mental disorders associated with child-bearing. *American Journal of Obstetrics and Gynecology* 43:148-163; 335-349.

Braceland, F. J. 1957. Kraepelin, his system and his influence. *American Journal of Psychiatry* 114:871.

_____. 1966. Depressions and their treatment. In J. J. Lopez Ibor, ed. *Proceedings IV,* Part 1. Madrid: World Conference on Psychiatry. p. 467.

Brand, H. 1976. Kafka's creative crisis. *Journal of the American Academy of Psychoanalysis* 4:249-260.

Brenner, B. 1975. Enjoyment as a preventative of depressive affect. *Journal of Comparative Psychology* 3:346-357.

Brill, H. 1975. Postencephalitic states or conditions. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. IV. Pp. 152-165.

Brod, M. 1973. *Franz Kafka: a biography.* New York: Schocken Books. (Paperback.)

Brown, F. 1968. Bereavement and lack of a parent in childhood. In E. Miller, ed. *Foundations of child psychiatry.* London: Pergamon.

Buber, M. 1937. *I and thou.* Edinburgh: Clark.

Bunney, W. E., Carpenter, W. T., and Engelmann, K. 1972. Brain seratonin and depressive illness. In T. A. Williams, M. M. Katz, and J. A. Shield, Jr., eds. *Recent advances in the psychobiology of the depressive illnesses.* Department of Health, Education, and Welfare: Publication No. (HSM) 70—9053.

Burton, R. 1927. *The anatomy of melancholy.* New York: Tudor.

Cade, J. F. 1949. Lithium salts in the treatment of psychotic excitement. *Medical Journal of Australia* 2:349-352.

Cadoret, R. J., and Tanna, V. L. 1977. Genetics of affective disorders. In G. Usdin, ed. *Depression.* New York: Brunner/Mazel. Pp. 104-121.

Cameron, N. 1944. The functional psychoses. In J. Mev. Hunt, ed. *Personality and behavior disorders,* Vol. 2. New York: Ronald Press.

Camus, A. 1942. *Le myth de sisyphe.* Paris: Gallimard. (Quoted in Esslin, 1969).

Carver, A. 1921. Notes on the analysis of a case of melancholia. *Journal of Neurology and Psychopathology* 1:320-324.

Cerletti, V., and Bini, L. 1938. L'elettroshock. *Archivi generali di neurologia, psichiatria e psicoanalisi* 19:266.

Charatan, F. B. 1975. Depression in old age. *New York State Journal of Medicine* 75:2505-2509.

Chertok, L. 1969. *Motherhood and personality, psychosomatic aspects of childbirth.* London: Tavistock.

Chodoff, P. 1970. The core problem in depression. In J. Masserman, ed. *Science and Psychoanalysis,* Vol. 17. New York: Grune & Stratton.

_____. 1972. The depressive personality. *Archives of General Psychiatry* 27:666-677.

Choron, J. 1972. *Suicide.* New York: Scribner's.

Cohen, M. B., Blake, G., Cohen, R. A., Fromm-Reichmann, F., and Weigert, E. V. 1954. An intensive study of twelve cases of manic-depressive psychosis. *Psychiatry* 17:103-38.

Committee on Nomenclature and Statistics of the American Psychiatric Association. 1968. *DSM—II: diagnostic and statistical manual of mental disorders,* Second ed. Washington: American Psychiatric Association.

Cooperman, S. 1966. Kafka's "A Country Doctor"—microcosm of symbolism. In Manheim, L. and Manheim, E., eds. *Hidden Patterns.* New York: Macmillan.

Coppen, A., Shaw, D. M., and Farrell, J. P. 1963. Potentiation of the antidepressing effect of a monoamine oxidose inhibition by tryptophan. *Lancet* 11:79-81.

Covi, L., Lipman, R. S., Derogatis, L. R., et al. 1974. Drugs and group psychotherapy in neurotic depression. *American Journal of Psychiatry* 131:191-198.

Coyne, J. C. 1976. Toward an interactional description of depression. *Psychiatry* 39: 28-40.

Cytryn, L., and McKnew, D. H., Jr. 1972. Proposed classification of childhood depression. *American Journal of Psychiatry* 129:149.

Davidson, G. M. 1936. Concerning schizophrenia and manic-depressive psychosis associated with pregnancy and childbirth. *American Journal of Psychiatry* 92:1331.

Da Vinci, M. N. 1976. Women on women: the looking-glass novel. *Denver Quarterly* 11:1-13.

Dennis, W., and Najarian, P. 1957. Infant development under environmental handicap. *Psychology Monographs* 71:1-13.

Despert, L. 1952. Suicide and depression in children. *Nervous Child* 9:378-389.

Dublin, L. I. 1963. *Suicide: a sociological and statistical study.* New York: Ronald Press.

Durand-Fardel, M. 1855. Etude sur le suicide chez les enfants. Annals of Medicine 1:61—79.

Durell, J., and Schildkraut, J. J. 1966. Biochemical studies of the schizophrenic and affective disorders. In S. Arieti, ed. *American handbook of psychiatry*, First ed., Vol. III. New York: Basic Books.

Easson, W. II. 1977. Depression in adolescence. In S. C. Feinstein and P. Giovacchini, eds. *Adolescent psychiatry,* Vol. 5. New York: Aronson.

Eaton, J. W., and Weil, R. J. 19550. *Culture and mental disorders.* Glencoe: Free Press.

_____. 1955b. The Mental health of the Hutterites. In A. M. Rose, ed. *Mental health and mental disorders.* New York: Norton.

Engel, G., and Reichsman, F. 1956. Spontaneous and experimentally induced depressions in an infant with gastric fistula. *Journal of the American Psychoanalytic Association* 4:428-456.

English, II. B., and English, A. C. 1958. *A comprehensive dictionary of psychological and psychoanalytic terms.* New York, London, Toronto: Longmans, Green and Co.

English, O. S. 1949. Observations of trends in manic-depressive psychosis. *Psychiatry* 12:125.

Erikson, E. H. 1959. *Identity and the life cycle. Psychological Issues,* Vol. 1. New York: International

Universities Press.

_____. 1963. *Childhood and society.* New York: Norton.

Esslin, M. 1969. *The theatre of the absurd,* rev. ed. Garden City: Anchor Books, Doubleday.

Faris, R. E. L., and Dunham, II. W. 1939. *Mental disorders in urban areas.* Chicago: Univ. of Chicago Press.

Feinstein, S. G, and Wolpert, E. A. 1973. Juvenile manic-depressive illness. *Journal of the American Academy of Child Psychiatry* 12:123-136.

Fenichel, O. 1945. *The psychoanalytic theory of neurosis.* New York: Norton.

Fieve, R. R., Platman, S., and Plutehik, R. 1968. The use of lithium in affective disorders. *American Journal of Psychiatry* 125:487-491.

Forrest, T. 1969. The combined use of marital and individual therapy in depression. *Contemporary Psychoanalysis* 6:76-83.

Frazier, S. II. 1976. Changing patterns in the management of depression. *Diseases of the Nervous System* 37:25-29.

Freud, A. 1953. Some remarks on infant observation. *The Psychoanalytic Study of the Child* 8:9-19.

_____. 1960. Discussion of Dr. J. Bowlby's paper. *The Psychoanalytic Study of the Child* 15:53-62.

____. 1970. The symptomatology of childhood. *The Psychoanalytic Study of the Child* 25:19-41.

Freud, S. 1957 (orig. 1900). The interpretation of dreams. *Standard Edition* 4, 5. London: Hogarth Press.

____. 1957 (orig. 1917). Mourning and melancholia. *Standard Edition* 14:243-58. London: Hogarth Press.

____. 1957- (orig. 1921). Croup psychology and the analysis of the ego. *Standard Edition* 18.

London: Hogarth Press.

____. 19S7 (orig. 1923). The ego and the id. *Standard Edition* 19. London: Hogarth Press.

____. 1957 (orig. 1927). Fetishism. *Standard Edition* 21. London: Hogarth Press.

____. 1969. (orig. 1933). *New introductory lectures on psycho-analysis. Standard Edition* 22. London: Hogarth Press.

____. 1957 (orig. 1938). Splitting of the ego in the defensive process. *Standard Edition* 23. London: Hogarth Press.

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

____. 1947. *Man for himself.* New York: Rinehart.

Frommer, E. A. 1968. Depressive illness in childhood. In A. Coppen and A. Walk, eds. Recent developments in affective disorders. *British Journal of Psychiatry*, special publication no. 2. Pp. 117-136.

Fromm-Reiehmann, F. 1949. Discussion of a paper by O. S. English. *Psychiatry* 12: 133.

Gardner, J. 1977. Death by art. some men kill you with a six-gun, some men with a pen. *Critical Inquiry* 3(5).

Geisler, L. S. 1973. Masked depression in patients suspected of suffering from internal diseases. In Kielholz, 1973.

Gero, G. 1936. The construction of depression. *International Journal of Psycho- Analysis* 17:423-461.

Gibbons, J. L. 1967. Cortisal secretion rate in depressive illness. *Archives of General Psychiatry* 10:572.

Gibson, R. W. 1958. The family background and early life experience of the manic- depressive patient: a comparison with the schizophrenic patient. *Psychiatry* 21: 71-90.

Goethe, W. 1827. *Nacldese zu Aristotcles Poetik*.

Gold, II. R. 1951. Observations on cultural psychiatry during a world tour of mental hospitals. *American Journal of Psychiatry* 108:462.

Goodwin, F. K., and Bunney, W. E, 1973. A psychobiological approach to affective illness. *Psychiatric Annals* 3:19.

Gove, W. R. 1972. The relationship between sex roles, marital status, and mental illness. *Social Focus* 51:36-66.

____. 1973. Sex, marital status, and mortality. *American Journal of Sociology* 79: 45-67.

Green, A. W. 1946. The middle-class male child and neurosis. *American Sociological Review* 11:31-41.

Greenspan, K., Aronoff, M., and Bogdansky, D. 1970. Effect of lithium carbonate on turnover and metabolism of norepinephrine. *Pharmacology* 3:129-136.

Group for the Advancement of Psychiatry. 1975. *Pharmacotherapy and psychotherapy: paradoxes, problems and progress,* Vol. IX. New York.

Cutheil, E. A. 1959. Reactive depressions. In Arieti, S., ed. *American handbook of psychiatry,* First ed. Vol. I. New York: Basic Books. Pp. 345-352.

Guyton, A. C. 1972. *Structure and function of the nervous system.* Philadelphia: W. B. Saunders.

Hall, C. S., and Lind, R. E. 1970. *Dreams, life, and literature: a study of Franz Kafka.* Chapel Hill: University of North Carolina Press.

Hauri, P. 1976. Dreams in patients remitted from reactive depression. *Journal of Abnormal Psychology* 85:1-10.

Helgason, T. 1964. Epidemiology of mental disorders in Iceland. *Acta Psychiatrica Scandanavia* 40.

Hempel, J. 1937. Die "vegetativ-dystone depression." *Nervenarzt* 10:22.

Hendin, M. 1975. Growing up dead: student suicide. *American Journal of Psychotherapy* 29:327-338.

Herzog, A., and Detre, T. 1976. Psychotic reactions associated with childbirth. *Diseases of the Nervous System* 37:229-235.

Hinsie, L. E., and Campbell, R. J. 1960. *Psychiatric dictionary.* New York: Oxford University Press.

Horney, K. 1945. *Our inner conflicts.* New York: Norton.

____. 1950. *Neurosis and human growth.* New York: Norton.

Jacobson, E. 1946. The effect of disappointment on ego and superego formation in normal and depressive development. *Psychoanalytic Review* 33:129-147.

____. 1954. The self and the object world. *Psychoanalytic Study of the Child* 9:75.

____. 1961. Adolescent moods and the remodeling of psychic structures in adolescence. *Psychoanalytic Study of the Child* 16:164-183.

____. 1971. *Depression.* New York: International Universities Press.

____. 1975- The psychoanalytic treatment of depressive patients. In E. J. Anthony and T. Benedek, eds. *Depression and human existence.* Boston: Little, Brown.

Janouch, G. 1953. *Conversations with Kafka.* London: Derek Verschoyle.

Jaspers, K. 1964. *General psychopathology.* Chicago: University of Chicago Press.

Jelliffe, S. E. 1931. Some historical phases of the manic-depressive synthesis. In *Manic-depressive psychosis,* Applied research in nervous and mental disease, Vol. XI. Baltimore: Williams & Wilkins.

Joffe, W. G., and Sandler, J. 1965. Notes on pain, depression, and individualism. *Psychoanalytic*

Study of the Child 20:394-424.

Jones, E. 1955. *Sigmund Freud: life and work,* Vol II. New York: Basic Books.

Kafka, F. 1949. *Diaries.* Vol. 1: 1910-1913. Vol. 2: 1914-1923. New York: Schockcn.

____. 1971. *The complete stories.* New York: Schocken.

____. 1973. (orig. 1919) *Letter to his father.* New York: Schocken.

Kasanin, J., and Kaufman, M. R. 1929. A study of the functional psychoses in childhood. *American Journal of Psychiatry* 9:307-384.

Katz, S. E. 1934. The family constellation as a predisposing factor in psychosis. *Psychiatric Quarterly* 8:121.

Kennedy, F. 1944. Neuroses related to manic-depressive constitutions. *Medical Clinics of North America* 28:452.

Kielholz, P., ed. 1972. *Depressive illness.* Bern: Huber.

____. ed. 1973. *Masked depression.* Bern: Huber.

Kierkegaard, S. 1954. (orig. 1843 and 1849). *Fear and trembling* and *The sickness unto death.* New York: Doubleday (Anchor).

Klaus, M. II., and Kennell, J. H. 1976. *Maternal-infant bonding.* St. Louis: Mosby.

Klein, D. F. 1974. Endogenomorphic depression. *Archives of General Psychiatry* 31: 447-454.

Klein, M. 1948 (orig. 1940). Mourning and its relation to manic-depressive states. In M. Klein, ed. *Contributions to psychoanalysis,* 1.921-1945. London: Hogarth Press.

Klerman, G. L., Dimaseio, A., Weissman, M. et al. 1974. Treatment of depression by drugs and psychotherapy. *American Journal of Psychiatry* 131:186-191.

Koerner, O. 1929. *Die aerztliche Kenntnisse in llias und Odysse.* (Quoted in Jelliffe, 1931)

Kohlberg, L. 1969. Stage and sequence: the cognitive-developmental approach to socialization. In D. A. Goslin, ed. *Handbook of socialization theory and research.* Chicago: Rand McNally.

Kolb, L. C. 1956. Psychotherapeutic evolution and its implications. *Psychiatric Quarterly* 30:1-19.

____. 1959. Personal communication

Kovacs, M. 1976. Presentation in working conference to critically examine DMS-111 in midstream. St. Louis: June 10-12.

Kraepelin, E. 1921. *Manic-depressive insanity and paranoia.* Edinburgh: Livingstone.

Kuhn, T. S. 1962. *The structure of scientific revolutions,* 2d ed. Chicago: University of Chicago Press.

Kurland, H. D. 1964. Steroid excretion in depressive disorders. *Archives of General Psychiatry* 10:554.

Kurland, M. L. 1976. Neurotic depression: an empirical guide to two specific drug treatments. *Diseases of the Nervous System* 37:424-431.

Landis, C., and Page, J. D. 1938. *Society and mental disease.* New York: Rinehart.

Laplanehe, J., and Pontalis, J. B. 1973. *The language of psychoanalysis.* New York: Norton.

Leeper, R. W. 1948. A motivational theory of emotion to replace "emotion as disorganized response." *Psychiatric Review* 55:5-21.

Lemke, R. 1949. Uber die vegetativ Depression. *Psychiat. Neurol, Und Psychol.* 1:161.

Lesse, S., ed. 1974a. *Masked depression.* New York: Aronson.

____. 1974b. Psychotherapy in combination with antidepressant drugs in patients with severe

masked depression. *American Journal of Psychotherapy* 31:185-203.

Levine, S. 1965. Some suggestions for treating the depressed patient. *Psychoanalytic Quarterly* 34-37-45.

Levy, D. 1937. Primary affect hunger. *American Journal of Psychiatry* 94:643-652.

Lewinsohn, P. M. 1969. Depression: a clinical research approach. (Unpublished manuscript, cited in Coyne, 1976.)

Lewis, A. 1934. Melancholia: a historical review. *Journal of Mental Science* 80:1.

Lindemann, E. 1944. The symptomatology and management of acute grief. *American Journal of Psychiatry* 101:141.

Loevinger, J. 1976. *Ego development.* San Francisco: Jossey-Bass.

Lopes Ibor, J. J. 1966. *Las neurosis como enfermedadcs del animo.* Madrid: Gedos.

____. Masked depression and depressive equivalents. (Cited in Kielholz, P. *Masked Depression* Bern: Huber 1972.)

Lorand, S. 1937. Dynamics and therapy of depressive states. *Psychoanalytic Review* 24:337-349-

Lorenz, M. 1953. Language behavior in manic patients. A qualitative study. *Archives of Neurology and Psychiatry* 69:14.

Lorenz, M., and Cobb, S. 1952. Language behavior in manic patients. *Archives of Neurology and Psychiatry* 67:763.

Luria, A. R. 1966. *Higher cortical functions in man.* New York: Basic Books.

____. 1973. *The working brain. An introduction to neuropsychology.* New York: Basic Books.

McCabe, M. S. 1975. Demographic differences in functional psychosis. *British Journal of Psychiatry* 127:320-323.

McConville, B. J., Boag, L. C., and Purohit, A. P. 1973. Three types of childhood depression. *Canadian Psychiatric Association Journal* 18:133-138.

MacLean, P. D. 1959. The limbic system with respect to two basic life principles. In M. A. B. Brazier, ed. *The central nervous system and behavior.* New York: Macy.

Magny, C. E. 1946. The objective depiction of absurdity. In A. Flores, ed. *The Kafka problem.* New York: New Directions.

Mahler, M. 1961. Sadness and grief in childhood. *Psychoanalytical study of the child* 16:332-351.

____. 1966. Notes on the development of basic moods: the depressive affect. In

R. M. Lowenstein, L. M. Newman, M. Schur, and A. J. Solnit, eds. *Psychoanalysis— a general psychology.* New York: International Universities Press. Pp. 152-160.

____. 1968. *On human symbiosis and the vicissitudes of individuation.* New York: International Universities Press.

Malmquist, C. 1971. Depression in childhood and adolescence. *New England Journal of Medicine* 284:887-893; 955-961.

Malzberg, B. 1937. Is birth order related to incidence of mental disease? *American Journal of Physical Anthropology* 24:91.

____. 1940. *Social and biological aspects of mental disease.* Utica, New York: State Hospital Press.

Mandell, A. J., and Segal, D. S. 1975. Neurochemical aspects of adaptive regulation in depression: failure and treatment. In E. J. Anthony and T. Benedek, eds. *Depression and human existence.* Boston: Little, Brown.

Maranon, C. 1954. Climacteric: the critical age in the male. In A. M. Krich, ed. *Men: the variety and meaning of their sexual experiences.* New York: Dell.

Mattson, A., Sesse, L. R., and Hawkins, J. W. 1969. Suicidal behavior as a child psychiatric emergency. *Archives of General Psychiatry* 20:100–109.

Mendels, J. 1974. Biological aspects of affective illness. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. III. New York: Basic Books. Pp. 491-523.

Mendels, J., Stern, S., and Frazer, A. 1976. Biological concepts of depression. In D. M. Gallant and G. M. Simpson, eds. *Depression.* New York: Spectrum Publications. I5P. 19-76.

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

Messina, F., Agallianos, D., and Clower, C. 1970. Dopamine excretion in affective states and following LijCo3 therapy. *Nature* 225:868-869.

Meyer, A. 1908a. The role of the mental factors in psychiatry. *American Journal of Insanity* 65:39.

____. 1908*b.* The problems of mental reaction—types, mental causes and diseases. *Psychological Bulletin* 5:265.

Miller, J. B. 1976. *Toward a new psychology of women.* Boston: Beacon Press.

Miller, W. R., and Seligman, M. E. P. 1976. Learned helplessness, depression, and the perception of reinforcement. *Behavioral Research and Therapy* 14:7-17.

Minkowski, E. 1958. Findings in a case of schizophrenic depression. In R. May, ed. *Existence.* New York: Basic Books.

Mitscherlich, A., and Mitscherlich, M. 1975. *The inability to mourn.* Translated by B. R. Placzek. New York: Grove Press.

Moulton, R. 1973. Sexual conflicts of contemporary women. In E. G. Wittenberg, ed. *Interpersonal explorations in psychoanalysis.* New York: Basic Books.

Munn, N. L. 1946. *Psychology: the fundamentals of human adjustment.* New York: Houghton-Mifflin.

Murphy, II. B. M., Wittkower, E. D., and Chance, N. A. 1967. Cross-cultural inquiry into the symptomatology of depression: a preliminary report. *International Journal of Psychiatry* 3:6-15.

Nagy, M. II. 1959. The child's view of death. In H. Feifel, ed. *The meaning of death.* New York: McGraw-Hill.

Neal, J. B., ed. 1942. *Encephalitis: a clinical study.* New York: Grune & Stratton.

Neider, C. 1948. *The frozen sea: a study of Franz Kafka.* New York: Oxford University Press.

Odegard, O. 1963. The psychiatric disease entitites in the light of genetic investigation. *Acta Psychiatrica Scandanavia* (Suppl.) 169:94-104.

Olds, J., and Milner, P. 1954. Positive reinforcement produced by electrical stimulation of septal area and other regions of rat brain. *Journal of Comparative Physiology and Psychology* 47:419-427.

Oswald, I., Brezinova, J., and Dunleavy, D. L. F. 1972. On the slowness of action of tricyclic antidepressant drugs. *British Journal of Psychiatry* 120:673.

Palmer, II. D., and Sherman, S. H. 1938. The involutional melancholic process. *Archives of Neurology and Psychiatry* 40:762-788.

Papez, J. W. 1937. A proposed mechanism of emotion. *Archives of Neurology and Psychiatry* 38:725-743.

Parkes, C. M. 1964. The effects of bereavement on physical and mental health: a study of the case records of widows. *British Medical Journal* 2:276.

____. 1965. Bereavement and mental illness. *British Journal of Medical Psychology* 38:1-25.

____. 1972. *Bereavement: studies of grief in adult life.* New York: International Universities Press.

____. 1973. Separation anxiety: an aspect of the search for the lost object. In R. J. Weiss, ed. *Loneliness. The experience of emotional and social isolation.* Cambridge: MIT Press.

Parker, S. 1962. Eskimo psychopathology in the context of eskimo personality and culture. *American Anthropologist* 64:76-96.

Perris, C. 1966. A study of bipolar (manic-depressive) and unipolar recurrent depressive psychosis. *Acta Psychiatrica Scandanavia* (Suppl.) 194:42.

____. 1976. Frequency and hereditary aspects of depression. In D. M. Gallant and G. M. Simpson, eds. *Depression.* New York: Spectrum Publications.

Piaget, J. 1932. *The moral judgment of the child.* New York: Free Press.

____. 1951. *Play, dreams, and imitation in childhood.* New York: Norton.

____. 1952. *The origins of intelligence in children.* New York: International Universities Press.

Politzer, II. 1966. *Franz Kafka: parable and paradox,* Second ed. Ithaca: Cornell University Press.

Pollock, II. M., Malzberg, B., and Fuller, R. G. 1939. *Hereditary and environmental factors in the causation of manic-depressive psychosis and dementia praecox.* Utica, New York: State Hospital Press.

Poznanski, E., and Zrull, J. P. 1970. Childhood depression: clinical characteristics of overtly depressed children. *Archives of General Psychiatry* 23:8-15.

Poznanski, E. O., Krahenbuhl, V., and Zrull, P. 1976. Childhood depression: a longitudinal perspective. *Journal of the American Academy of Child Psychiatry* 15:491-501.

Prange, A. J., Jr., Wilson, I. C., and Rabon, A. M. 1969. Enhancement of imipramine antidepressant activity by thyroid hormone. *American Journal of Psychiatry* 126:457.

Prange, A. J., Jr., and Wilson, I. C. 1972. Thyrotropin Releasing Hormone (TRH) for the immediate relief of depression: a preliminary report. *Psychopharmacology* 26 (Suppl.).

Prange, A. J. Jr. 1973. The use of drugs in depression: its theoretical and practical basis. *Psychiatric Annals* 3:56.

Protheroe, C. 1969. Puerperal psychoses: a long-term study 1927-1961. *British Journal of Psychiatry* 115:9-30.

Rado, S. 1956. (orig. 1927). The problem of melancholia. In Rado S. *Collected papers*, Vol. I. New York: Grune & Stratton.

___. 1951. Psychodynamics of depression from the etiologic point of view. *Psychosomatic Medicine* 13:51-55.

Raskin, A. 1974. A guide for drug use in depressive disorders. *American Journal of Psychiatry* 131:181-185.

Redmond, D. E., Mass, J. W., and King, A. 1971. Social behavior of monkeys selectively depleted of monoamines. *Science* 174:428–431.

Rennie, T. A. L. 1942. Prognosis in manic-depressive psychosis. *American Journal of Psychiatry* 98:801.

Rie, M. E. 1966. Depression in childhood: a survey of some pertinent contributions. *Journal of the American Academy of Child Psychiatry* 5:653-685.

Riesman, D., Glazer, N., and Denney, R. 1950. *The lonely crowd.* New Haven: Yale University Press.

Roehlin, G. 1959. The loss complex. *Journal of the American Psychoanalytic Association* 7:299-316.

Rosenthal, S. II. 1968. The involutional depressive syndrome. *American Journal of Psychiatry* (Suppl.) 124:21-35.

___. 1974. Involutional depression. In S. Arieti, ed. *American handbook of psychiatry*, Second ed. Vol. III. New York: Basic Books. Pp. 694-709.

Russell, B. 1967. *The autobiography of Bertrand Russell: the early years.* New York: Bantam.

Sachar, E., Heilman, L., and Gallagher, T. F. 1972. Cortisal production in depression. In T. A. Williams, M. M. Katz, and J. A. Shield, Jr., eds. *Recent advances in the psychobiology of the depressive illnesses.* Department of Health, Education, and Welfare: Publication No. (HSM) 70-9053.

Sapirstein, S. L., and Kaufman, M. R. 1966. The higher they climb, the lower they fall. *Journal of the*

Canadian Psychiatric Association 11:229-304.

Salzman, L., and Masserman, J. H. 1962. *Modern concepts of psychoanalysis.* New York: Philosophical Library.

Sandler, J., and Joffe, W. G. 1965. Notes on childhood depression. *International Journal of Psychoanalysis* 46:88-96.

Schilder, P., and Weschler. D. 1934. The attitudes of children toward death. *Journal of Genetic Psychology* 45:406-451.

Schildkraut, J. J. 1965. The catecholamine hypothesis of affective disorders: a review of supporting evidence. *American Journal of Psychiatry* 122:509-522.

____. 1975. Depression and biogenic amines. In D. Hamburg and II. K. H. Brodie, eds. *American handbook of psychiatry,* Vol. 6. New York: Basic Books.

Schlegel, F. 1818. *Lectures on the history of literature, ancient and modern.* Edinburgh.

Schoenberg, B., Gerber, I., Wiener, A., Kutscher, A. H., Peretz, D., and Carrac, eds. 1975. *Bereavement: its psychological aspects.* New York: Columbia University Press.

Schopenhauer, A. 1961. *The world as will and idea.* Translated by R. B. Haldane and J. Keint. New York: AMS Press.

Segal, Hannah. 1964. *Introduction to the work of Melanie Klein.* London: Heinemann.

Seiden, R. H. 1969. *Suicide among youth. Bulletin of Suicidology.* (Suppl.).

Seligman, M. E. P. 1975. *Helplessness.* San Francisco: W. H. Freeman.

Seligman, M., and Maier, S. 1967. Failure to escape traumatic shock. *Journal of Experimental Psychology* 74:1-9.

Shaffer, D. 1974. Suicide in childhood and early adolescence. *Journal of Child Psychology and Psychiatry* 15:275-291.

Shambaugh, B. 1961. A study of loss reactions in a seven-year-old. *Psychoanalytic Study of the Child* 16:510-522.

Shimoda, M. 1961. Uber den fraaruorbideu charakter des manish-depressiven irreseius. *Psychiatria et Neurologia Japonica* 45:101.

Silverberg, W. 1952. *Childhood experience and personal destiny.* New York: Springer.

Slipp, S. 1976. An intrapsychic-interpersonal theory of depression. *Journal of the American Academy of Psychoanalysis* 4:389-410.

Smith, A., Troganza, E., and Harrison, G. 1969. Studies on the effectiveness of antidepressant drugs. *Psychopharmacology Bulletin* (Special issue).

Smythies, J. 1973. Psychiatry and neurosciences. *Psychological Medicine* 3:267-269.

Sperling, M. 1959. Equivalents of depression in children. *Journal of Hillside Hospital* 8:138-148.

Spiegel, R. 1959. Specific problems of communication in psychiatric conditions. In S. Arieti, ed. *American handbook of psychiatry,* First ed. Vol. I. New York: Basic Books. Pp. 909-949.

____. 1960. Communication in the psychoanalysis of depression. In J. Massemian, ed. *Psychoanalysis and human values.* New York: Grune & Stratton.

____. 1965. Communication with depressive patients. *Contemporary Psychoanalysis* 2:30-35.

Spitz, R. 1946. Anaclitic depression. *Psychoanalytic Study of the Child* 5:113-117.

Strecker, E. A., and Ebaugh, F. 1926. Psychoses occurring during the puerperium. *Archives of Neurology and Psychiatry* 15:239.

Strongin, E. I., and Hinsie, L. E. 1938. Parotid gland secretions in manic-depressive patients. *American Journal of Psychiatry* 96:14-59.

Sullivan, H. S. 1940. *Conceptions of modern psychiatry.* New York: Norton.

____. 1953. *The interpersonal theory of psychiatry.* New York: Norton.

Szalita, A. B. 1966. Psychodynamics of disorders of the involutional age. In S. Arieti, ed. *American handbook of psychiatry,* First ed., Vol. III. New York: Basic Books. Pp. 66-87.

____. 1974. Grief and bereavement. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. I. Pp. 673-684.

Taulbee, E. S., and Wright, II. W. 1971. A psychosocial-behavioral model for therapeutic intervention. In C. D. Spielberger, ed. *Current topics in clinical and community psychology,* Vol. 3. New York: Academic Press.

Tellenbach, II. 1974. *Melancholic problemgeschichte-endogenitat-typologie-putho- genese-klinik.* Berlin: Springer-Verlag.

Thomas, A., Chess, S., and Birch, H. G. 1968. *Temperament and behavior disorders in children.* New York: New York University Press.

Thompson, C. M. 1930. Analytic observations during the course of a manic-depressive psychosis. *Psychoanalytic Review* 17:240.

Thompson, R. j., and Schindler, F. H. 1976. Embryonic mania. *Child Psychiatry and Human Development* 7:149-154.

Titley, W. B. 1936. Prepsychotic personality of involutional melancholia. *Archives of Neurology and Psychiatry* 36:19-33.

Toolan, J. M. 1962. Depression in children and adolescents. *American Journal of Orthopsychiatry* 32:404-15.

Tupin, J. P. 1972. Effect of lithium and sodium and body weight in manic-depressives and normals. In T. A. Williams, M. M. Katz, and J. A. Shield, Jr., eds. *Recent advances in the psychobiology of the depressive illnesses.* Department of Health, Education, and Welfare: Publication No. (HSM) 70-9053.

Veith, Ilza. 1970. Elizabethans on melancholia. *Journal of the American Medical Association*

212:127.

Wainwright, W. H. 1966. Fatherhood as a precipitant of mental illness. *American Journal of Psychiatry* 123:40-44.

Warneke, L. 1975. A case of manic-depressive illness in childhood. *Canadian Psychiatric Association Journal* 20:195-200.

Weinberg, W. A., Rutman, J., and Sullivan, L. 1973. Depression in children referred to an educational diagnostic center: diagnosis and treatment. *Journal of Pediatrics* 83:1065-1072.

Weiner, I. B. 1970. *Psychological disturbance in adolescence.* New York: Wiley.

Weiss, J. M. A. 1957. The gamble with death in attempted suicide. *Psychiatry* 20:17.

____. 1974. Suicide. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. III. Pp. 763-765.

Weissman, M. M., and Klerman, L. 1977. Sex differences and the epidemiology of depression. *Archives of General Psychiatry* 34:98-111.

Weissman, M. M., Klerman, G. L., Payhel, E. S., et al. 1974. Treatment effects on the social adjustment of depressed patients. *Archives of General Psychiatry* 30:771-778.

Weissman, M. M., Prusoff, B. A., and Klerman, G. 1975. Drugs and psychotherapy in depression revisited. *Psychopharmacology Bulletin* 11:39-41.

Werner, H. 1948. *The comparative psychology of mental development.* New York: International Universities Press.

Whittier, J. R. 1975. Mental disorders with Huntington's chorea. Clinical aspects. In S. Arieti, ed. *American handbook of psychiatry,* Second ed., Vol. IV. New York: Basic Books. Pp. 412-417.

Wilson, E. 1962. A dissenting opinion on Kafka. In D. Gray, ed. *Kafka.* Englewood Cliffs: Prentice-

Hall.

Winnicott, D. W. 1953. Transitional objects and transitional phenomena. *International Journal of Psycho-Analysis* 34.

Winokur, G. 1973. Depression in the menopause. *American Journal of Psychiatry* 130: 92-93.

Winokur, G., Cadoret, R., Dorzab, J., and Baker, M. 1971. Depressive disease. A genetic study. *Archives of General Psychiatry* 25:135-144.

Wolfgang, M. E. 1959. Suicide by means of victim-precipitated homicide: *Journal of Clinical and Experimental Psychology* 20:335-349.

Wolman, B. B. 1973. *Dictionary of behavioral science.* New York: Van Nostrand.

Woodworth, B. S. 1940. *Psychology.* New York: Holt.

Zetzel, E. R. 1965. Depression and its incapacity to bear it. In M. Schur, ed. *Drives, affects, behavior.* Vol. 2. New York: International Universities Press.

Zilboorg, G. 1928. Malignant psychoses related to childbirth. *American Journal of Obstetrics and Gynecology* 15:145-158.

____. 1929. The dynamics of schizophrenic reactions related to pregnancy and childbirth. *American Journal of Psychiatry* 8:733-767.

____. 1931. Depressive reactions related to parenthood. *American Journal of Psychiatry* 87:927-962.

____. 1941. A *history of medical psychology.* New York: Norton.

____. 1944. Manic-depressive psychoses. In S. Lorand, cd. *Psychoanalysis today.* New York: International Universities Press.