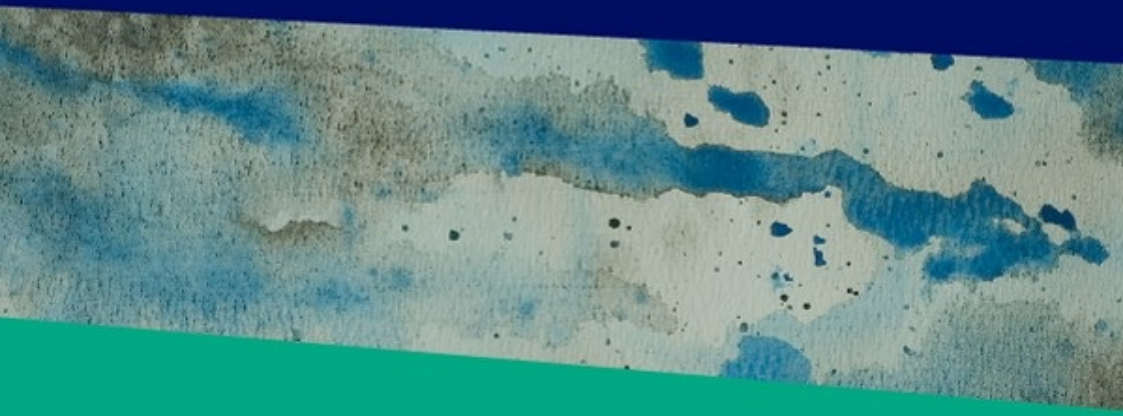
Toward an Interactional Description of Depression



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Essential Papers on Depression

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Developments in the interactional description of schizophrenia have not been paralleled in the area of depression. As yet, concepts such as pseudomutuality, double-bind, schism, and skew have found no counterparts. Kubler and Stotland (1964) have argued, "emotional disturbance, even the most severe, cannot be understood unless the field in which it develops and exists is examined. The manifestations of the difficulty in the disturbed individual have meaning depending on aspects of the field. The significant aspects of the field are usually interpersonal" p. 260). Yet the study of depression has focused on the individual and his behavior out of his interactional context.

To a large degree, the depressed person's monotonously reiterated complaints and self-accusations, and his provocative and often annoying behavior have distracted investigators from considerations of his environment and the role it may play in the maintenance of his behavior. The possibility that the characteristic pattern of depressed behavior might be interwoven and concatenated with a corresponding pattern in the response of others has seldom been explored. This paper will address itself to that possibility.

For the most part, it has been assumed that the depressed person is relatively impervious to the influence of others. Ruesch (1962) stated that to talk to the depressed person makes little sense; to listen, little more. Grinker (1964) conceptualized depressive symptomatology as communication to others, but argued that the depressed person is

not responsive to communication from others: “The depressed person … cannot use information for the purpose of action; he cannot perceive the cues of reality; he makes statements but does not care if he is understood” (p. 578).

In terms of systems theory (von Bertalanffy, 1950; Allport, 1960; Miller, 1971), the usual conceptualization of the depressed person is one of a relatively closed system. Grinker (1964) was explicit in stating that the depressed person repeats his messages and behavior without reception or acceptance of resulting feedback. Beck (1964, 1967) described the cognitive distortions that dominate the information processing of the depressed person so that experiences are rigidly interpreted to maintain existing schema of personal deficiency, self-blame, and negative expectations.

The implicit assumption of these and other writers has been that the support and information available to the depressed person are incongruent with his depression, and the persistence of his symptomatology is evidence of a failure to receive or accept this information. Withdrawal, isolated intrapsychic processes, or as Beck describes (1967), interactions of depressive schema and affective structures, produce a downward depressive spiral. The present paper will adopt an alternative argument that the depressed person is able to engage others in his environment in such a way that support is lost and depressive information elicited. This in turn increases the level of depression and strengthens the pathogenic pattern of depressed behavior and response of others. If a depressive spiral develops, it is mutually causative, deviation-amplifying process (Maruyama, 1963) in the interaction of

the depressed person with his environment. Thus, what is customarily viewed as some internal process is, I believe, at least in part a characteristic of interaction with the environment, and much of what is customarily viewed as cognitive distortion or misperception is characteristic of information flow from the environment. It should be noted that while the depressed person's different interpretation of his predicament is traditionally attributed to his distortion or misperception, general disorders of thought and perception are neither defining criteria nor common among depressed patients (McPartland and Homstra, 1964). An observer who fails to take into account the intricacies of someone's relationship to his environment frequently attributes to him characteristics that he does not possess, or leaves significant aspects of his experience unexplained (Watzlawick et al., 1967). Feedback introduces

phenomena that cannot be adequately explained by reference to the isolated individual alone (Ashby, 1960, 1962). For the study of depression, identification of a pattern of depressive feedback from the environment demands a more complex conceptualization of the disorder than one explaining its phenomena with reference to the isolated depressed person.

Lemert (1962), in his study of the interpersonal dynamics of paranoia, argued that the net effect of the developing interaction pattern between the paranoid person and others is that (1) the flow of information to the person is stopped, (2) a real discrepancy between expressed ideas and affect among those with whom he interacts is created, and (3) the situation or group image becomes as ambiguous for him as he is for others. In this context of attenuated relationships, exclusion, and disrupted communication, the

paranoid person cannot get the feedback on his behavior that is essential in order for him to correct his interpretations of social relationships. Lemert concluded that the paranoid person may indeed be delusional, but that it is also true that in a very real sense he is able to elicit covertly organized action and conspiratorial behavior.

The present paper will attempt to demonstrate in a similar manner aspects of the interpersonal dynamics of depression. What will be sought is an interaction and information flow pattern congruent with the established phenomena of depression, and at the same time, indications as to why this, rather than alternative patterns, persists in the apparent absence of external constraint. Existing descriptions of the interpersonal behavior of the depressed person will be examined, and an attempt will be made to reconstruct the interactional contexts in which this behavior has

meaning.

It should be made clear that such a perspective does not deny the existence of important intrapersonal factors in depression. Numerous writers have pointed out that the depressed person's feelings of worthlessness and helplessness do not arise *de novo* in his immediate stimulus situation (Chodoff, 1972). McCranie (1971) has argued that there is a "depressive-core" in the personality of the depression-prone person, consisting of a tendency to feel worthless and helpless and an oversensitivity to stimuli that impinge on these feelings. Together, these are aroused from dormancy by specific situations such as loss and threat to self-esteem. However, the emphasis of this paper will be on means by which the environment comes into congruence with these feelings. The depressive's vague, generalized feeling that there is something wrong with him,

and his search for this among his minor defects, imperfections, and personal attributes, may arise from a depressive core to his personality, but at the same time, the confusing response from the environment serves to validate these feelings. Likewise, conflicts about the reception of support and approval from others may be deeply rooted in the depressive's intrapersonal style, but these conflicts can only be aggravated by the mixed messages of approval and rejection received from significant others, and by their withdrawal from him despite reassurances to the contrary.

Furthermore, the present exposition does not deny the importance of possible biochemical or genetic factors in the etiology of depression. Price (1974) has argued that even in disorders in which the importance of such factors has been clearly established, there may be a large number of links in the causal chain between specific etiological

factors and the symptoms displayed by an individual. Social and interpersonal variables may determine to a large degree whether a disorder occurs and the form its symptoms will take. It is assumed that to initiate the process described below, a person need only begin to display depressive behavior.

DEPRESSION AND INTERPERSONAL BEHAVIOR

Since Freud, real and imagined object losses have been given prominence in the explanation of depression, and depressive process has often been seen as miscarried restitutive work. While most early formulations focused on intrapsychic phenomena, there were implications for interpersonal behavior. As early as Abraham (1911,1916), the overdemanding aspects of the depressive's orality were noted. Rado (1928) assigned major etiological importance to an

accentuated need for dependency in the depressed person. Fenichel (1945) described the neurotically depressed person's interpersonal maneuvers—his demonstrations of his misery, his accusations that others have brought about the misery, and even his blackmailing of others for attention—as desperate attempts to force others to restore damaged self-esteem. Yet in seeking this gratification, he is at the same time afraid to receive it because of the revenge that he expects will accompany it. In the psychotically depressed person, the loss is more complete, the objects have fallen away, and the restitutive effort is aimed exclusively at the superego.

Cohen et al. (1954) described the depressed person as seeing others as objects to be manipulated for the purpose of receiving sympathy and reassurance, but also as seeing them as being critical, rejecting, and ungenuine in

their support. Further, in the achievement of reassurance, the depressed person finds concealed disapproval and rejection. According to the Cohen et al. formulation, what the depressed person seeks is a dependent relationship in which all his needs are satisfied, and in his failure to obtain this, he resorts to the depressive techniques of complaining and whining, if this too fails, he may lose hope, and enter into the psychotic state, where the pattern of emptiness and need continues in the absence of specific objects.

Grinker (1964) interpreted the factor patterns obtained in an earlier study of depression (Grinker et al., 1961) as representing relatively constant patterns of communication. “What is requested or seemingly needed by the depressed patient expressed verbally, by gestures or in behavior, varies and characterizes the pattern of the depressed syndrome” (1964, p. 577).

Bonime (1960, 1966) described how the depressed person can dominate his environment with his demands for emotionally comforting responses from others. He considered depression to be a practice, an active way of relating to people in order to achieve pathological satisfactions, and he dismissed any suffering the depressed person may incur as secondary to the satisfaction of manipulative needs.

Aggression played a central role in early psychoanalytic formulations of depression (Abraham, 1911; Freud, 1917), but later writers have increasingly disputed its role. Bibring (1953) went so far as to declare that depression was an ego phenomenon, "essentially independent of the vicissitudes of aggression as well as oral drives" (p. 173).

Fromm-Reichmann(1959) argued that

aggression had been considerably overstressed as a dynamic factor in depression, and that if hostile feelings were found in the depressed person, they were the result of the frustration of his manipulative and exploitative needs. Cohen et al. (1954) attributed the hostility of the depressed person to his "annoying impact on others, rather than to a primary motivation to do injury to them" (p. 121). On the other hand, Bonime found the hurting or defying of others to be essential to depressed behavior.

Renewed interest in the relationship between hostility and depression—particularly in the psychoanalytic view that depressed persons turn hostility that had originally been directed at others (hostility-outward), against themselves (hostility-inward)—has generated a number of empirical studies. Wessman et al. (1960) suggested that relatively normal persons became hostile outward

when depressed, whereas persons tending to become severely depressed were more likely to internalize or suppress this hostility. The data of Zuckerman et al. (1967) supported this view, indicating that only in the relatively normal was hostility correlated with depression on mood questionnaires or as rated by interviewers. Friedman (1964) found depressives to have more "readily expressed resentment" as shown by their endorsement of adjectives such as "bitter," "frustrated," and "sulky," yet found no greater overt hostility. In a later study, Friedman (1970) showed that feelings of depression and worthlessness were consonant with hostile and resentful feelings, even though depressed persons were not more likely to directly express these feelings to persons in the environment. Schless et al. (1974) found equal numbers of depressed patients turning hostility inward and outward,

with both types of hostility increasing as depression became more severe. However, because these patients also saw other people's anger as more readily expressed and more potent, they feared retaliation, and therefore expressed hostility only in the form of resentment. In summary, recent studies have been interpreted so as to call into question classical psychoanalytic formulations of the relationship of depression, hostility-inward and hostility-outward. On the other hand, the view that hostility may serve a defensive function against depression has been supported. That depression is preceded by increases in hostility that is directed out but cannot be expressed directly to appropriate objects in the environment, is taken as a failure of this defensive function (Friedman, 1970; McCranie, 1971; Schless et al., 1974).

Most writers who comment on the complaints

and self-accusations of the depressed person have rejected the idea that they should be taken literally. Lichtenberg (1957) found that attempts to answer them directly with assurance, granting of dependency, and even punishment all increased depression and feelings of personal defect. Freud (1917) suggested that the self-accusations are actually aimed at someone else, a lost love object, and further notes, "…it must strike us that after all the melancholic does not behave in quite the same way as a person who is crushed by remorse and self-reproach in a normal fashion. Feelings of shame in front of other people, which would more than anything characterize this latter condition, are lacking in the melancholic, or at least they are not prominent in him. One might emphasize the presence in him of an almost opposite trait of insistent communicativeness which finds satisfaction in self-exposure" (p. 247).

In an attempt to modify depressive behavior in a family situation (Liberman and Raskin, 1971), the baseline data indicated that other family members rejected opportunities to interact with the depressed person, and that all initiations of interaction between him and his family in the baseline period were undertaken by him.

Paykel and Weissman (1973) reported extensive social dysfunction in women during depressive episodes. Interpersonal friction, inhibited communication, and submissive dependency occurred in both the initial episodes and in subsequent relapses. Onset of social difficulties was related to symptoms, but these difficulties continued months after the symptoms remitted, a fact that Paykel and Weissman argue must be taken into account in any treatment plan.

As mentioned earlier, the provocative and

often annoying behavior of the depressive has distracted investigators from consideration of the role of the response of others. An exception, Jacobson (1954) noted that "however exaggerated the patients' hurt, disappointment, and hostile derogation of their partners may be, their complaints are usually more justified than may appear on the surface" (p. 129). According to her, the depressed person often makes his whole environment feel guilty and depressed, and this provokes defensive aggression and even cruelty precisely when he is most vulnerable. Depressives also have a tendency to develop an "oral interplay" with those around them, so that mutual demands and expectations are built up to inevitable disappointment and depression for everyone concerned.

Cohen et al. (1954) found therapists generally uncomfortable working with depressed patients.

They identified a tendency of therapists to react to depressive manipulations with unrealistic reassurance and "seductive promises too great to be fulfilled," followed by hostility and rejection. The present author became aware of a dramatic example of this when a student therapist showed up at a Florida suicide prevention center with a recent client. The therapist had attempted to meet her client's complaints of worthlessness and rejection with explicit reassurances that she more than understood her and cared for her, she *loved* her! After weeks of such reassurance and increasingly frequent sessions, the client finally confronted the therapist with the suggestion that if the therapist really cared for her as she said, they should spend the night together. The therapist panicked and terminated the case, suggesting that the client begin applying her newly acquired insights to her daily life. The client

continued to appear for previously scheduled appointments and made vague suicidal gestures, at which time her therapist brought her to the suicide prevention center. When it was suggested that the therapist should honestly confront her client with what had happened in the relationship, the therapist angrily refused to speak to her, stating that she truly loved her client and would do nothing to hurt her.

Lewinsohn and his associates (Lewinsohn and Shaw, 1969; Lewinsohn, 1969; Lewinsohn et al., 1970; Libet and Lewinsohn, 1973) have undertaken an ambitious clinical research program focusing on a social interaction of the depressed person from a behavioral point of view. In attempting to develop hypotheses about the reinforcement contingencies available to the depressed person, they have attempted a precise specification of the social behavior of the

depressed person. Libet and Lewinsohn found depressed persons in group therapy to be lower than controls on a number of measures of social skill: activity level, interpersonal range, rate of positive reactions emitted and action latency. Their data are subject to alternative interpretations, however, particularly since they also found that rate of positive reactions emitted was highly correlated with rate of positive reactions elicited. While depressed persons may well be deficient in social skills, some of the observed differences in group interaction situations may be due to the fact that fewer people are willing to interact with depressed persons (which results in a narrower interpersonal range and less opportunity for activity), and in this interaction emitted fewer positive responses (thereby also reducing the positive responses elicited from the depressed). The most useful

behavioral conceptualization of social interaction involving depressed persons would specify the lack of social skills of all participants, as evidenced by their inability to alter the contingencies offered or received. Behavioral interventions in the depressed person's marital and family relationships would therefore involve training all participants in these social skills, and go beyond simply altering the contingencies available to the depressed person. Behavioral observations and self-reports of a couple in the Lewinsohn study (Lewisohn and Shaw, 1969) seem to support such a view.

Studies of suicide attempts and their effects on interpersonal relationships also provide data relevant to this discussion. While suicide attempts do not have an invariable relationship to depression, there is a definite association. McPartland and Homstra (1964) examined the

effects of suicide attempts on subsequent level of depression. They conceptualized depressive symptomatology as “a set of messages demanding action by others to alter or restore the social space” (p. 254), and examined the relationships between suicide attempts and the ambiguity of the depressive message and the diffuseness of its intended audience. They were able to reliably place depressed patients at definite points along a dimension of interactive stalemate on the basis of the range of intended audience and the stridency of message in depressive communications. Patients who were farthest along this continuum, whose communication was most diffuse, nonspecific, strident, and unanswerable, were most likely to have long hospital stays and diagnoses of psychosis. Suicide attempts tended to reduce the level of depression, apparently by shifting the interactive burden onto others. Other

studies (Rubenstein et al., 1958; Moss and Hamilton, 1956; Kubler and Stotland, 1964) have indicated that suicidal patients who improve following their attempts on their lives consistently have effected changes in their social fields, and those who fail to improve generally have failed to change their situation fundamentally.

THE DEPRESSED PERSON IN HIS ENVIRONMENT

Depression is viewed here as a response to the disruption of the social space in which the person obtains support and validation for his experience. This view, and a view of depressive symptomatology in terms of message value and intended audience, is similar to that of McPartland and Homstra (1964), but the present analysis will place a greater emphasis on the contribution of the social environment to depressive drift. The interpersonal process described will be a general

one, and it is assumed that the course of a specific depressive episode will be highly dependent on the structure of the person's social space. One of the implications of the approach taken here is that an understanding of the social context is vital to an understanding of depression, although traditionally it has been largely ignored.

Social stresses leading to depression include loss of significant relationships, collapse of anticipated relationships, demotions (and in some cases, promotions), retirement, missed chances, or any of a variety of other changes in a person's social structure. Depressive symptomatology is seen as a set of messages demanding reassurance of the person's place in the interactions he is still able to maintain, and further, action by others to alter or restore his loss.

Initial communications—verbal expressions of

helplessness and hopelessness, withdrawal from interaction, slowing, irritability and agitation—tend to engage others immediately and to shift the interactive burden to others. The receivers of these messages usually attempt to answer the depressed person's requests directly. However, as previously noted by Grinker (1964) and Lichtenberg (1957), their literal responses present him with a dilemma. Much of the depressive's communication is aimed at ascertaining the nature of relationship or context in which the interaction is taking place; Grinker (1964) has compared this to the various "how" and "why" questions that young children direct to their parents, and has suggested that both children and depressives will be left feeling rejected, ignored, or brushed aside if provided with a literal response.

If communication took place at only one level, depression would probably be a less ubiquitous

problem. However, the problem is that human beings not only communicate, but communicate about this communication, qualifying or labeling what they say by (a) the context or relationship in which the communication takes place, (b) other verbal messages, (c) vocal and linguistic patterns, and (d) bodily movement (Haley, 1963). A person may offer support and reassurances with a rejecting tone or he may offer criticism in a supportive and reassuring tone.

> When messages qualify each other incongruently, then incongruent statements are made about the relationship. If people always qualified what they said in a congruent way, relationships would be defined clearly and simply even though many levels of communication were functioning. However, when a statement is made which by its existence indicates one type of relationship and is qualified by a statement denying this, then difficulties in interpersonal relations become inevitable [Haley, 1963, pp. 7-8].

It is enough that vocal and linguistic patterns and body movement are ambiguous and subject to alternative interpretations. However, a further problem for the depressed person is that the context, the nature of the relationship between the depressed person and the persons communicating to him, may require time and further messages to be clearly defined.

The depressed person's problem is to decide whether others are assuring him that he is worthy and acceptable because they do in fact maintain this attitude toward him, or rather only because he has attempted to elicit such responses. Unwilling or unable to endure the time necessary to answer this question, the depressive uses his symptoms to seek repeated feedback in his testing of the nature of his acceptance and the security of his relationships.

While providing continual feedback, these efforts are at the same time profoundly and negatively affecting these relationships. The persistence and repetition of the symptoms is both incomprehensible and aversive to members of the social environment. However, the accompanying indication of distress and suffering is powerful in its ability to arouse guilt in others and to inhibit and direct expression of annoyance and hostility from them, as observed in both the family difficulties of depressed persons (Jacobson, 1954) and the problems therapists report in their efforts to relate to depressed patients (Cohen et al., 1954).

Irritated, yet inhibited and increasingly guilt-ridden, members of the social environment continue to give verbal assurance of support and acceptance. However, a growing discrepancy between the verbal content and the affective

quality of these responses provides validation for the depressive's suspicions that he is not really being accepted and that further interaction cannot be assured. To maintain his increasingly uncertain security, the depressive displays more symptoms.

At this point the first of a number of interactive stalemates may be reached. Members of the depressed person's environment who can find a suitable rationalization for their behavior may leave the field or at least reduce their interactions with him. Considerable effort may be involved in efforts to indicate that this is not in fact rejection, but given the context, these efforts do little more than reduce credibility and increase the depressive's insecurity. With those members of the social environment who remain, a self-maintaining pattern of mutual manipulation is established. Persons in the environment find that they can reduce the aversive behavior of the

depressed person and alleviate the guilt that this depressed behavior has a uncanny ability to elicit, if they manipulate him with reassurance, support, and denial of the process that is taking place. The depressed person, on the other hand, finds that by displaying symptoms he can manipulate his environment so that it will provide sympathy and reassurance, but he is aware by now that this response from others is not genuine and that they have become critical and rejecting. While this situation is attractive for neither the depressed person nor members of his social environment, it provides a stabilization of what has been a deteriorating situation.

One alternative facing the depressed person is for him to accept the precipitating disruption of his social space and the resulting loss of support and validation. However, now that he has begun showing symptoms, he has invested portions of

his remaining relationships in his recovery effort. That is, he has tested these relationships, made demands, and has been frustrated in ways that seriously call into question his conception of these relationships. If he abandons these efforts, he may have to relinquish the support and validation derived from these relationships while accepting the precipitating loss. At this point he may be too dependent on the remaining relationships to give them up. Furthermore, as a result of the mixed messages he has been receiving from others, he now has an increasingly confused and deteriorated self-concept, which must be clarified. With new desperation more symptoms may be displayed.

Various possible efforts by the depressed person to discover what is wrong with him (i.e., why he is being rejected and manipulated) and to reestablish a more normal interactive pattern are

in this context indistinguishable from the manipulations he has used to control the responses of others. Therefore they are met with the usual countermanipulation. Requesting information as to how people *really* view him is indistinguishable from symptomatic efforts. If the depressed person attempts to discuss the interpersonal process that is taking place, he touches on a sensitive issue, and is likely only to elicit denial by the others or an angry defensive response. On the other hand, efforts by others to assure the depressed person that he is really accepted and that they are not rejecting him are in this context also indistinguishable from previous manipulations that they have employed, and therefore serve to strengthen the developing system. Thus, interpersonal maneuvers directed at changing the emerging pattern become system-maintaining, and any genuine feedback to the

depressed person is also indistinguishable from manipulations. Persons leaving the social field increase both the depressed person's feelings of rejection and his impetus to continue his behavior pattern. Persons just entering the social field can be quickly recruited into the existing roles, since their efforts to deal with the depressed person—even if genuine—are likely to be quite similar to those now being employed manipulatively. They therefore become subject to the compelling countermanipulations of the depressed person, come to respond manipulatively themselves, and are inducted into the system.

Descriptions of the depressed person at this point in his career focus on the distortions and misperceptions that serve to maintain his depression. What is generally ignored is that these "distortions" and "misperceptions" are congruent with the social system in which the depressed

person now finds himself. The specific content of the depressive's complaints and accusations may not be accurate, but his comments are a recognition of the attenuated relationships, disrupted communication, and lack of genuineness that he faces. These conditions serve to prevent him from receiving the feedback necessary to correct any misperceptions or distortions. He has played a major role in the creation of this social system, but the emergence of the system has also required the cooperation of others, and once established, it tends to be largely beyond the control of its participants.

Depending on characteristics of both the depressed person and his environment, a number of punishing variations on the above pattern may develop. Members of the social environment who have been repeatedly provoked and made to feel guilty may retaliate by withholding the responses

for which the depressed person depends on them. The depressed person may become aware of the inhibiting influence his symptoms have on the direct expression of negative feelings, and may use these symptoms aggressively, while limiting the forms that counteraggression can take. He may also discover and exploit the interdependence of others and himself. While he is being made acutely aware of his dependence on others and the frustrations it entails, he may also become aware of the extent to which others are dependent on him, in that their own maintenance of mood and their ability to engage in varieties of activities require in some way his cooperation. Either because of outright hostility, or as a self-defeating effort to convince others of their need to renegotiate their relationship with him, the depressed person may become more symptomatic in his withholding of these minimal cooperative

behaviors. While hostility may not necessarily be a major etiological factor in depression, the frustrations, provocations, and manipulations occurring in interactions between depressed persons and others would seem to encourage it.

As efforts to end the interactive stalemate fail, there may be a shift in the depressive's self-presentation to one indicating greater distress and implying that the environment has more responsibility for bringing about the necessary changes. McPartland and Homstra (1964) found that they could unambiguously differentiate themes of hopelessness and helplessness from more disturbed themes of low energy and physical complaints in communications of depressed patients. The latter themes were associated with longer hospitalization when hospitalized depressed patients were sampled. McPartland and Homstra give the examples of "I can't sleep and I

can't stand it any longer", "I am too tired to move"; "My head and my stomach feel funny all the time." Unable to restore his life space, the depressive now implicitly demands "a suspension of the rules; a moratorium on the web of obligations under which the person lives, such as admission to the sick role" (McPartland and Homstra, 1964, p. 256). With immediate relationships deteriorating, the depressive addresses his plea to a more general audience, but in more confusing and unanswerable terms. Literal responses to his communications may involve medical intervention for his specific complaints, but this generally fails to alleviate the problem. Any efforts to move the interactional theme back to the depressive's sense of hopelessness and helplessness threaten to reopen the earlier unfruitful and even punishing patterns of relations, and tend to be resisted. Unable to answer, or in many cases, even to

comprehend the depressive's pleas, members of the social environment may withdraw further from him, increasing his desperation, and quickening the depressive drift.

With a second interactive stalemate now reached, the depressed person may attempt to resolve it by increasing his level of symptomatology and shifting the theme of his self-presentation to one of the worthlessness and evil. "I am a failure; it's all my fault; I am sinful and worthless." Unable either to restore his social space or to reduce his obligations sufficiently for him to continue to cope, the depressive now communicates his bafflement and resignation. The intended audience is now more diffuse, relationships are even more attenuated, and the new message is more obscure and perplexing. The social environment and the depressive soon arrive at another stalemate. Otherwise helpless to

alleviate the situation, remaining members of the environment may further withdraw or, alternatively, have the depressive withdrawn through hospitalization. In the absence on any relatedness to others, the depressive may drift into delusions and frankly psychotic behavior.

DISCUSSION

Once an individual has suffered a disruption of his social space, his ability to avoid depressive drift, or to abort the process once it has begun, depends on the structure of his social space and on his interpersonal skills. With regard to the latter, it is generally ignored that the person facing this situation is dealing with a changing environment, and that the skills needed to deal with it are likely to be different from those required by a more stable, normal environment. Consequently, persons who previously have had adequate skills

to deal with their life situation may lack the skills to cope with a disrupted social space. With regard to the structure of this social space, resistance to depression seems to depend on the availability of alternative sources of support and validation, particularly of the type that cannot be threatened by depressive symptomatology, (2) the availability of direct nonpunitive feedback should the person's behavior become annoying or incomprehensible; and (3) the ability of the social space to generate new sources of support and meaning that are unambiguously independent of the presence or absence of symptoms. Earlier speculative writings (Abraham, 1911) and later behavioral studies (Lewinsohn, 1969) have suggested that depressed persons tend to be quite limited in their range of interactions, and that this may be a major source of their vulnerability.

Stable relationships may generally provide a

buffer against depression, but when they are stable yet low in support and validation, they may encourage a chronic depressive cycle. If, for instance, in a marriage of this type, the depressed person recognizes that his spouse is tolerating more than is reasonable from him without protest, he may begin to assume that she is staying with him out of some obligations, rather than because she accepts him and wants a relationship (Haley, 1963). The depressed person may then test whether he is really accepted by driving the other person to the point of separation with his symptoms. Yet if the spouse passes the test by continuing to tolerate the annoying behavior, the depressed person may not necessarily be reassured about his acceptance. Rather he may only be convinced that his spouse remains because she is unable to leave. On the other hand, if she makes an effort to leave the situation, she may be

indicating that their relationship has been voluntary and that he had been accepted. With reconciliation the spouse may again seem too tolerant and a new series of doubts, testing, and strife may be enacted. While such a cycle may produce chronic difficulties, it may also be an alternative to a downward depressive spiral. Essentially the depressed person finds himself in the awkward situation of wanting to avoid rejection, yet at the same time fearing acceptance.

The constraints operating on the person who has suffered a disruption in his social space are his need for support and validation, and the investment of his remaining relationships in his efforts to receive such support. The symptoms of the depressed person offer a powerful constraint on the ability of members of the social environment to offer adjustive feedback, and while eliciting verbal messages of sympathy, support,

and reassurance, these symptoms disrupt the relationships and cultivate hostility and rejection.

Those who resist induction into the system without rejecting the depressed person do so because they are able to resist the pressure to convey discrepant messages. A successful therapist in Cohen et al. study stated, “I keep in mind that I am talking to the patients not so much verbally as preverbally. I use the verbal communication as a means of carrying inflection and an accompaniment of facial expression and postural components” (1954, p. 129).

Several writers have suggested that the emerging communication context can be disrupted by strong affective expressions such as anger, excitement, and amusement (Lazarus, 1968), which are incompatible with the pattern of mutual manipulation that maintains the context. As early

as 1820 a London physician reported the cure of a depressive episode using anger induction. He informed the patient that in Scotland there was another physician famous for his cures of the disorder, and that the patient should leave immediately in order to procure relief. The patient undertook the journey but discovered that the famed doctor did not exist. Returning home to confront his doctor about this abuse of confidence, he found “a desire to upbraid [the doctor] had engaged his entire thoughts on his way home, to the complete exclusion of his original complaint” (Williams, 1820). A modern version of this technique of constructing situations in which aggressive responses are appropriate and rewarded is being put into effect in a number of Veterans Administration hospitals (Taulbee and Wright, 1971a, 1971b). A depressed patient, even one who is severely disturbed, is assigned to

monotonous, nongratifying, and repetitive tasks such as sanding wood with fine-grain sandpaper, counting tiny seashells, or bouncing a ball on a small square on the floor. Although the patient is not ridiculed or belittled, his task performance is continually criticized as not perfect. This continues —usually three or four days are needed—until the patient "blows up," refuses to follow orders, or becomes verbally (seldom physically) aggressive. At that time he is removed from the task, given hearty social approval, and assigned a more pleasant task. This antidepression program takes place in the context of a larger Attitude Therapy Program designed to maximize the consistency of expectations and emotional expression communicated to the patient. During the dull-task phase of treatment, an attitude of kind firmness (Taulbee and Folsom, 1966) is prescribed to the entire staff. They are instructed not to give in to

the patient's pleadings to be left alone to suffer, not to try to cheer him up, and not to offer sympathy or encouragement. After the patient has "blown up," a matter-of-fact attitude is prescribed to the staff members. They are instructed to communicate clearly to him their explicit expectations and to make social reinforcement contingent on his meeting these expectations. Studies of the effectiveness of this program indicate that it is more effective than a variety of alternative programs in terms of measures of depression, anxiety, interpersonal orientation, and length of hospital stay (Taulbee and Wright, 1971b).

Although many writers have indicated that a depressive reaction lifts when a patient regains his ability to express anger toward others (Friedman, 1970), some research indicates that the mobilization of anger is not necessary for

symptomatic improvement (Weissman, et al., 1971; Klerman and Gershon, 1970). Interpersonally, hostility may be one of a number of means of disrupting or blocking the operation of a depressive interpersonal system. Involvement in this system is difficult to avoid once it has begun. The symptoms of depression have an ability to perpetuate themselves through the involvement of others in a system of manipulation and countermanipulation that soon gets beyond the control of its participants.

The author is presently engaged in research that examines the response of others to depression and the quality of the communications context that emerges. Preliminary results from a study involving an interpersonal behavior questionnaire suggest that a person is less likely to respond in an overtly hostile manner to the behavior of another person when the second

person is depressed. This inhibition persists even when it is indicated that the second person is responding hostilely. The inhibition of appropriate hostile behavior may be a characteristic of interactions involving the depressed person, and not just of the depressed person. Another study involves twenty-minute phone conversations between naive subjects and target individuals from three groups: depressed outpatients, nondepressed outpatients, and normals. Preliminary results suggests that subjects respond with unrealistic reassurance and useless advice to the depressed outpatients. They are more likely to be depressed, anxious, and hostile themselves after conversations with depressed patients, and are more likely to reject opportunities for future interaction. For the most part, changes in the a subjects' mood remain concealed during the conversation, and the depressed patients are given

little direct indication of their impact on others. If the subjects do respond with any hostility, it emerges only in occasional statements, such as "You certainly seem to have had a lot a problems, but problems are what allow us to grow, and so you'll have lots of opportunity to grow in the future." Further research is needed to examine the nature of the depressive's social field so that the specific relationships that resist or perpetuate the depressive interpersonal system can be identified and described.

CONCLUSION

Depression has been conceptualized here as a self-perpetuating interpersonal system. Depressive symptomatology is congruent with the developing interpersonal situation of the depressed person, and the symptoms have a mutually maintaining relationship with the

response of the social environment. Essentially, the depressed person and others within his social space collude to create a system in which feedback cannot be received, and various efforts to change become system-maintaining.

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REFERENCES

Abraham, K. "Notes on the Psychoanalytic Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions" [1911], "The First Pregenital Stage of Libido" [1916], in *Selected Papers on Psychoanalysis;* Basic Books, 1953.

Allport, G. "The Open System in Personality Theory," *J. Abnormal and Social Psychol.* (1960)61:301-311.

Ashby, W. R. *Design for a Brain* (2d Ed.); Science Paperbacks, 1960.

Ashby, W. R. "Principles of the Self-Organizing Systems," in H. von Foerster and G. W. Zupf (Eds.), *Principles of Self-Organization;* Pergamon, 1962.

Beck, A. T. "Thinking and Depression: II. Theory and Therapy," *Arch. Gen. Psychiatry* (1964) 10:561-571.

Beck, A. T. *Depression;* Hoeber, 1967.

Bibring, E. "The Mechanism of Depression," in P. Greenacre (Ed.), *Affective Disorders;* Int. Univ. Press. 1953.

Bonime, W. "Depression as a Practice: Dynamics and Psychotherapeutic Considerations," *Compr. Psychiatry* (1960) 1:194-201.

Bonime, W. "The Psychodynamics of Neurotic Depression," in S. Arieti (Ed.), *American Handbook of Psychiatry,* Vol. 3; Basic Books, 1966.

Chodoff, P. "The Depressive Personality," *Arch. Gen. Psychiatry* (1972) 27:666-673.

Cohen, M. B., et al. " An Intensive Study of Twelve Cases of Manic-Depressive Psychosis," Psychiatry (1954) 17:103-137.

Fenichel, O. *The Psychoanalytic Theory of Neurosis;* Norton, 1945.

Friedman, A. S. "Minimal Effects of Severe Depression on Cognitive Functioning. *"J. Abnormal and Social Psychol.* (1964) 69:237-243.

Friedman, A. S. "Hostility Factors and Clinical Improvement in Depressed Patients," *Arch. Gen. Psychiatry* (1970) 23:524-537.

Freud, S. "Mourning and Melancholia [1917]," *Standard Edition of the Complete Psychological Works,* Vol. 14; Hogarth, 1951.

Fromm-Reichmann, F. *Psychoanalysis and Psychotherapy:*

Selected Papers; Univ. of Chicago Press, 1959.

Grinker, R. R. "Reception of Communications by Patients in Depressive States," *Arch. Gen. Psychiatry* (1964) 10:576-580.

Grinker, R. R., et al. *The Phenomena of Depression;* Hoeber, 1961.

Haley, J. *Strategies of Psychotherapy;* Grune & Stratton, 1963.

Jacobson, E. "Transference Problems in the Psychoanalytic Treatment of Severely Depressed Patients." *J. Amer. Psychoanal. Assn.* (1954) 2:595-606.

Klerman, G. L., and Gershon, E. S. "Imipramine Effects upon Hostility in Depression," *J. Nerv. and Mental Dis.* (1970) 150:127-132.

Kubler, A. L., and Stotland, E. *The End of Hope: A Social-Clinical Study of Suicide;* Free Press, 1964.

Lazarus, A. A. "Learning Theory and the Treatment of Depression," *Behav. Res. and Ther.* (1968)6:83-89.

Lemert, E. M. "Paranoia and the Dynamics of Exclusion," *Sociometry* (1962) 25:2-20.

Lewinsohn, P. M. "Depression: A Clinical-Research Approach," unpublished manuscript, 1969.

Lewinsohn, P. M., and Shaw, D. A. "Feedback About Interpersonal Behavior

Change: A Case Study in the Treatment of Depression," *Psychother. and Psychosom.* (1969) 17:82-88.

Lewinsohn, P. M., et al. “A Behavioral Approach to the Group Treatment of Depressed Persons: Methodological Contributions,” *J. Clin. Psychol.* (1970) 26:525-532.

Liberman, R. P., and Raskin, D. E. “Depression: A Behavioral Formulation,” *Arch. Gen. Psychiatry* (1971) 24:515-523.

Libet, J. M., and Lewinsohn, P. M. “Concept of Social Skill with Special Reference to the Behavior of Depressed Persons,” *J. Consult, and Clin. Psychol.* (1973)40:304-312.

Lichtenberg, P. “Definition and Analysis of Depression,” *AM A Arch. Neurol, and Psychiatry* (1957) 77:519-527.

Maruyama, M. “The Second Cybernetics: Deviation-Amplifying Mutual Causative Processes,” *Amer. Sci.* (1963) 51:164-179.

McCranie, E. J. “Depression, Anxiety and Hostility, *''Psychiatric Quart.* (1971) 45:117–133.

McPartland, T. S., and Hornstra, R. K. “The Depressive Datum,” *Compr. Psychiatry* (1964)5:253-261.

Miller, J. “The Nature of Living Systems,” *Behav. Sci.* (1971) 16:277-301.

Moss, L., and Hamilton, D. M. “The Psychotherapy of the Suicidal Patient,*” Amer. J. Psychiatry* (1956) 112:814-820.

Paykel, E. S., and Weisman, M. M. “Social Adjustment and Depression,” *Arch. Gen Psychiatry* (1973) 28:659-663.

Price, R. H. “Etiology, the Social Environment, and the Prevention of Psychological Dysfunction,” in P. Insel and R. H. Moos (Eds.), *Health and the Social Environment;*

Heath, 1974.

Rado, S. "The Problem of Melancholia," *Int. J. Psycho-Anal.* (1928) 9:420-438.

Rubenstein, R., et al. " On Attempted Suicide," *AMA Arch. Neurol, and Psychiatry* (1958) 79:103-112.

Ruesch, J. *Therapeutic Communication;* Norton, 1962.

Schless, A. P., et al. "Depression and Hostility," *J. Nerv. and Mental Dis.* (1974) 159:91-100.

Taulbee, L. R., and Folsom, J. C. "Reality Orientation for Geriatric Patients," *Hosp. and Community Psychiatry* (1966) 17:133-135.

Taulbee, E. S., and Wright, H. W. "Attitude Therapy: A Behavior Modification Program in a Psychiatric Hospital," in H. C. Rickard (Ed.), *Behavioral Intervention in Human Problems;* Macmillan, 1971. (a)

Taulbee, E. S., and Wright, H. W. "A Psychosocial-Behavioral Model for Therapeutic Intervention," in C. D. Spielberger, *Current Topics in Clinical and Community Psychology,* Vol. 3; Academic Press, 1971. (b)

von Bertalanffy, L. "The Theory of Open Systems in Physics and Biology," *Science* (1950) 111:23-29.

Watzlawick, P., et al. *Pragmatics of Human Pragmatic Communication;* Norton, 1967,

Weissman, M. M., et al. "Clinical Evaluation of Hostility in Depression," *Amer. J. Psychiatry* (1971) 128:261-266.

Wessman, A. E., et al. “Characteristics and Concomitants of Mood Fluctuation in College Women, “ *J. Abnormal and Social Psychol.* (1960) 60:117-126.

Williams, J. C. *Cure of Inveterate Dejection;* London, 1820.

Zuckerman, M., et al. “A Multitrait, Multimethod Measurement Approach to the Traits (or States) of Anxiety, Depression, and Hostility,” *J. Projective Techniques* (1967)31:39-48