Depression

Depression is a very common condition, and, worldwide, one of the foremost causes of suffering and disability. A number of different depressive patterns exist. Depression may range in severity from a temporary state of low morale which anyone is likely to experience in the face of commonplace setbacks, to a tormenting condition of melancholic hopelessness which may result in suicide. As in the case described in the previous chapter, depression is sometimes clearly a response, though perhaps an excessive response, to definable events like bereavement, a broken love affair, failure in an examination, loss of a job or a financial reversal. In major depressive disorder low mood is likely to be accompanied by insomnia, loss of appetite and consequent loss of weight, and other physiological manifestations. Some people feel chronically 'down' and are persistently dysphoric. In bipolar disorder the sufferer swings between episodes of elevated mood and depression, although even when 'high' there are often traces of depression. Mania can be helpfully thought of as a 'manic defence' against misery and depression, especially as the manic patient often causes chaos around them, and facing up to the consequences of that is depressing in itself.

The origins of depression: contextual and developmental

Contextual as well as developmental factors play a big part in determining whether or not a traumatic event produces clinically definable depression or not. Depression seldom comes out of the blue without any precipitant, and people who react to traumatic events with depression are generally contending with a variety of difficulties that render this response more probable. Thus, those who are struggling with an unsatisfactory marriage or with poor housing are more likely to become depressed. So are women who lost their mother before the age of eleven. Other factors which make them more vulnerable are having three or more children under the age of fourteen at home; having no other adult in whom to confide; and having no employment outside the home (Brown and Harris 1979). Working-class women are more likely to become depressed in response to precipitating events than their middle-class counterparts. Those who have to cope with chronic physical ill health are also more vulnerable to depression; and in underdeveloped countries, chronic depression is common as the result of malnutrition, disease, and infestation with parasites. In our own culture, certain infections, for example glandular fever and influenza, are notorious for leaving the sufferer depressed, as are the biochemical changes which follow upon the end of pregnancy, or which occur at the menopause. Pre-menstrual tension and depression are sometimes associated.

It is important that therapists take into account all the circumstances of the patient's life, both past and present, if they are to understand the condition. In addition, they must study the personality of those who are particularly liable to depression; even if they believe that there is a significant genetic contribution to this liability, which in some cases is undoubtedly so. Blatt (2008) makes an important distinction between people who suffer from 'anaclitic' (leaning-on or dependent) depression, and 'introjective' (self-absorbed; isolated) depression.

These represent different strategies of defences against feeling mental pain, species of 'affect phobia' (McCullough et al 2003). In anaclitic depression the pain is partially transferred to, or shared with, the person on whom the sufferer is dependent (in therapy often the therapist). In introjective depression the sufferer tries to isolate himself from others so as to suffer no further losses, and experiences the medicalized symptoms of depression rather than the sadness, helplessness, and misery of loss.

Some of those who are temperamentally inclined toward depression are, except when actually suffering from the condition, robust, aggressive personalities who, most of the time, cope successfully with their underlying tendency by being overactive, and may exemplify subclinical bipolar disorder. Balzac and Winston Churchill were both examples of this type. However, most of the depression sufferers who come the way of the psychotherapist belong to the more passive, dependent anaclitic group.

In the face of adversity, people with this kind of personality tend to feel both helpless and hopeless. Instead of imagining that, by their own efforts, they can improve their condition, they believe themselves to be at the mercy of events. On the surface, they may display not only misery, but hopeless resignation, affirming that whatever adverse circumstance is making them depressed was not only to be expected, but also, in some way, their own fault. Their resignation is more apparent than real; for, like the rest of mankind, they not only suffer, but also resent what has caused their suffering. However, instead of their resentment being mobilized to make an effective response, it is repressed and turned inward, showing itself only in self-blame and self-deprecation.

Such people, therefore, often seem far more ineffective and inadequate than in fact they are; and the psychotherapist's task is not only to reinforce the glimmer of hope which has brought the patient to seek help, but also to disintegrate the passive, aggressive aspect of his personality which, being largely repressed, is unavailable to him.

Self-esteem

The most striking characteristic of most depression sufferers is the absence of built-in self-esteem. When a person is actually suffering from depression, it is usual for him to feel, and to refer to himself as, worthless, no good, hopeless, not worth bothering with, a failure, a 'waste of space'. Although the patient's depression may have been initiated by bereavement, a broken love affair etc. his feelings of hopelessness and his self-castigation seem to the observer to be out of proportion to the event which sparked them off. The respiratory tract of an asthmatic is unduly sensitive to certain allergens which cause a degree of bronchial spasm and outpouring of mucus comparable to that induced in a normal person by poison gas. Similarly, the psyche of the depressive is unduly sensitive to events which lower self-esteem, reacting profoundly to reverses which, to the normal person, seem minor or at least endurable. Thus, a quarrel that to some might seem no more than a passing episode, seems to the depressive to be the end of the world. Failure in an examination which, to most students would involve no more than a transient annoyance at having to repeat some work, may spark off feelings of total worthlessness.

People with a tendency to depression often take the view that, in their periods of depression, they have greater insight into the true nature of things than when they are cheerful, and that periods of freedom from depression are no more than mirages which obscure reality. Most therapists take the opposite view, believing that the patient's depressed mood distorts his vision. However, there is a sense in which the patient is right: a great part of his life is determined by efforts to avoid depression; to establish defences against this dread
condition by over-activity, gaining esteem from external sources, or any other manoeuvre which will prevent descent into the abyss. It seems that the state of depression underlies all the fronts which he may present to the world, rather as a house may beneath the surface be in a sad state of decay despite presenting a brightly painted exterior.

Although the depressed person's protestations of his own worthlessness may seem exaggerated, he is right when he affirms that his state of depression is more real, more truly reflective of his essential self, than his state of mind at other times: it is so for him, however it may seem to anyone else.

From what source is self-esteem derived, and why is it that the depressive has so little of it? The psychodynamic account of the origins of self-esteem runs as follows. The human infant is born into the world in a helpless and dependent state, and remains so for a period that, in comparison with his total lifespan, is longer than that of any other creature. It is reasonable to assume that the human infant has, at first, but little notion of his own capabilities or lack of them. As he matures, however, he becomes increasingly aware of his dependency and helplessness relative to adults. If he is brought up in a home in which he is welcomed, played with, cuddled, and delighted in, the likelihood is that he will come to feel himself sufficiently a worthwhile person to counteract his realization of his own inevitable inadequacy when compared with adults. Loved children are generally praised for every new accomplishment; for every word learned, for the beginnings of manual skills, for all kinds of achievements which, only a year or two later, will be taken for granted. And the more that parents are 'irrationally' adoring, the more is a child likely to grow up thinking well of himself, irrespective of his accomplishments. Unconditionally loving parents habitually, and rightly, overvalue everything that their infants do. Because his parents value him so highly, the child comes to have a good opinion of himself. Whereas his self-esteem originally depended upon repeated affirmations of his worth from outside sources, it gradually comes to depend upon something within himself which has become built-in as part of his own personality. The process is not unlike that of the formulation of conscience, in which prohibitions originally promulgated by parents become the person's own conscience or super-ego.

Contact with the mother may be interrupted by her illness or death. Research into the development of subhuman primates has confirmed the hypothesis that some forms of depression may be related to severance of the mother-child tie in infancy (Suomi 2008).

Monkeys kept up in isolation for six months are fearful and insecure when introduced to their peers: they are unable to play, and, later, are unable to mate. Infant monkeys which are separated from their mothers for short periods even when they have already become somewhat independent, not only become depressed at the time, but show after-effects which persist for years, for example, less social play and greater fear of strange objects. Similar processes may operate in humans, although research suggests that the long-term effects of childhood bereavement result from the consequent social disruption rather than the loss itself (Rutter 1981).

Depression precursors are as much to do with the subtleties of parent-child relationships as with major trauma. Parents may not proffer enough irrational adoration; or may tend to keep the child over-dependent, thus depriving him of any sense of his own achievement. A child may be born with a physical disability, or may suffer so much ill health that he continues to feel inadequate compared with his peers. Or the parents may set such high standards that the child comes to feel that he will inevitably fail to live up to them. Depression-prone people do not necessarily feel disregarded but rather that they have been weighed in the balance, and found wanting.

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The absence of an inner sense of worth has a number of consequences. First, such a person may become more than usually dependent upon the good opinion of his fellows. Depressed people are highly attuned to what others think of them, since repeated assurance of their good opinion is as necessary to his psychic health as are repeated feeds of milk to the physical well-being of infants. They are 'hungry' for approval (which some psychoanalysts take as evidence that depression is related to an 'oral' regression), and need recurrent proofs of their acceptability in the shape of repeated reassurance from others, recurrent successes, or other bolstering devices to prevent them relapsing into despair. Being so dependent upon the good opinion of others and so vulnerable to criticism means that the depression-sufferers are less than normally assertive with other people, and overanxious to please them. Some become expert at identifying with others, and are exceedingly sensitive to what the other person is feeling. Because they are so anxious to avoid blame, and to obtain approval, they develop antennae which tell them what might upset, and what might please those with whom they are associated.

This kind of adaptation to others carries with it obvious disadvantages. The habit of deferring goes hand-in-hand with a kind of passivity and can be looked upon as a prolongation of one aspect of childhood. Children defer to their parents because they need to in order to keep their parents' approval; and also because, for many years during which they are growing up, the parents do in fact 'know better' because of their longer experience. Depression sufferers often defer to persons who, in reality, are their equals or even inferiors; and this habitual mode of behaviour has the effect of reinforcing their sense of their own worthlessness.

Moreover, habitual to be so orientated to what others are feeling, often has the effect of making people uncertain of their own feelings; of dissociating them from their inner selves. Since they are always guided by the opinions of others, they end up by having no identifiable opinions of their own. Always adapting to the emotional state of others, they become progressively less conscious of what they themselves are feeling. Because of this habitual suppression of the independent, executive aspect of their personalities, such people feel themselves to be more helpless than the average person, and turn to others to tell them what to do in any situation in life requiring decision. An underlying conviction that whatever choice they themselves make is likely to be wrong, and a desire to avoid blame if things in fact turn out badly, supports this tendency; with the consequence that they not only feel themselves helpless, but often are in reality. Someone with good self-esteem assumes that whatever they decide it will probably turn out well. Someone with low self-esteem believes that their happiness turns on making the right decision, leading to agonies of indecision, believing that their whole future rides on the decision, rather than focusing simply on the pros and cons of the specific choice to be made.

Recent non-psychoanalytic work has emphasized the role of helplessness in depression. Helplessness and hopelessness march hand in hand. The depression-prone feel themselves to be powerless to affect the course of events, and therefore 'give up' and adopt a passive role. In the histories of depressed patients, it sometimes emerges that the individual did far less well at school or university than his intellectual gifts would warrant. This is generally because, at some point in his development, he became convinced that his own efforts would be useless. Later in life, when experience has taught them that some measure of success does in fact follow from their own efforts, they may substitute ceaseless striving for passivity. This is why achievement of a goal is often followed by depression. The writer who completes a book, the businessman who brings off a deal, the person who is given promotion, may all find that depression rather than euphoria follows their success. If one has been striving very
Therapeutic strategies

In sum, people suffering from depression are wrestling with all or some of the following issues: loss and avoidance of the pain associated with grieving; lack of unconditional acceptance and consequent feeling that they must please others; deficient inner sense of worth or self-esteem; passivity; perfectionistic generalization from temporary or minor faults to global condemnation; suppressed anger.

If this outline is accepted, it is possible to delineate what the therapist is aiming at and to suggest how positive results may be achieved. First, the fact that the therapist is willing to continue to see a depressed patient over a period of time in itself reinforces hope and counteracts despair. Second, the therapist's acceptance and understanding of the patient tends to counteract the latter's negative view of himself, and may over time become internalized as a good internal object. The patient, because he comes to feel that there is at least one person in the world who genuinely appreciates him, may alter his attitude towards others, assuming that they are more likely to be friendly than critical. This can stimulate benign circles of reinforcement and activity, as opposed to the vicious ones of depressive passivity and isolation. Third, the therapist may be able to mitigate the depressive negative view of his own accomplishments and effectiveness (often referred to as 'punitive superego') by drawing attention to the many occasions on which he has behaved intelligently and competently. Fourth, the therapist will try to validate and mobilize the assertive side of the patient's personality, partly so that he is less frightened of his angry feelings, and also in order that he may be able to 'attack' life more successfully.

The psychotherapist who undertakes the treatment of people suffering from mood disorders may find it helpful to bear in mind the following considerations. First, nearly all episodes of depression resolve themselves one way or another. Close examination of such recoveries usually discloses psychological factors of a more or less subtle kind which have prompted recovery, just as it is usually possible to uncover the precipitants of the attack. Loss triggers depression; 'new start' events help people overcome it. These factors seem to be of three kinds.

First, the patient, especially if he manages to remain at work, may find that his self-esteem is partially restored by discovering that he is not entirely useless. It is inadvisable to reinforce a depressed person's desire to 'give up' and retire to bed or to hospital unless he is exhibiting clear-cut psychotic symptoms, dangerously suicidal, or is so depressed that he cannot function.

Second, a depressed person may recover because he has been able to re-establish a loving relationship with people who are emotionally important to him. People who are vulnerable to depression may be thrown into a state of profound despair by the kind of transient quarrel which we all may have with people who love us and whom we love. The depressive has no certainty that he is worthy of love or that love will last. Its temporary disappearance is, to him, a confirmation of his pessimistic convictions. However, if a tactful spouse or other loved person manages to convince him that he is still loved, or if, more importantly, he manages to admit that he too was wrong, his depression will often lift, at least for the time being. Such a 'flight into health' however is likely to be short-lived, and may be misinterpreted by therapists, who may erroneously flatter themselves that it is the consequence of their ministrations. It also may mean that the patient breaks off treatment prematurely. Ultimately it is the patient's decision whether or not to continue in therapy but it is worth pointing out that the aim is for relapses to be less frequent or less severe; and that learning how to deal with such episodes more effectively takes time and patience.

Because of this dependency, passivity, and anxiety to please, people with depression quickly form a positive transference. Or rather, they will rapidly appear to do so, for such patients seem to be more compliant and grateful than actually they are. Psychotherapists are easily deceived into thinking that such a patient has accepted an interpretation when, in fact, he may disagree or have reservations which he does not yet dare to express. It is particularly important for the therapist to be alert to this possibility, and to interpret excessive politeness, deference and over-eager compliance with the therapist's remarks. It is vital that the patient should learn that it is possible to be quite different from other persons and yet retain friendly relations with them — 'to agree to differ.' A certain amount of healthy aggression is required to maintain differentiation of oneself as a separate entity.

The third and most difficult task is to help the patient get in touch with his hostility. And yet it is by means of the disinhibition and expression of this that recovery often comes. Since the depressive adaptation almost certainly began in childhood, it will be particularly difficult to uncover and to help the patient to accept his hostility to his parents, whom he is likely to have idealized. A child who is a poor mixer and who cannot stand up for himself is prone to idealization since he may feel that his parents are the only persons in the world who care for him, and that his very existence depends upon maintaining an image of them as 'perfect.' The persistence of such a belief in adult life impairs the patient's capacity to achieve independence and make new relationships.

One opportunity for disinterring hostility is when the therapist goes on holiday, or unavoidably has to cancel an appointment. The more dependent the patient, the more he will resent being abandoned. His depression is likely to increase while the therapist is absent, and he will probably complain of this while carefully refraining from criticizing the therapist in any way for leaving him. But his complaints are likely to be phrased in such a way that...
criticism of the therapist is implicit, for instance by employing a querulous tone of voice. Or else the patient may fall silent, saying that he has nothing to say, or that therapy is useless. This is a form of sulking, and if the patient can be brought to see this, he will be one step on the way to discovering that hostility can be expressed without his relationship with the therapist being compromised or even terminated.

Suicide

The risk that a depressed patient may commit suicide should never be ignored. Most people working in the field of mental health have known or worked with someone who goes on to kill themselves, and it is normal to feel guilty and depressed when this happens (Michel and Jobes 2010). As after any bereavement, one searches one’s mind for occasions where one may have said the wrong thing or failed the dead person in any way. On the other hand, it is very rare, although sadly not unknown, for patients to take his or her life while actually in regular treatment. Nevertheless it is important to have a sense, or explicitly to ask, how far ahead in terms of minutes, hours or days the patient can visualize themselves continuing to live, despite feeling suicidal. The next session needs to be within that interval, and that may mean a period of very frequent sessions, or possibly referral for admission or to a crisis team. Suicide in the context of therapy is more likely if the patient has had to discontinue treatment because of moving elsewhere; if the therapist unexpectedly cancels a session, however good the reason; or where the therapist has seen the patient only once or twice and has not had time to establish a relationship.

There is a difficult balance to be struck in assessing suicide risk in patients who are in therapy. If psychotherapy is to achieve one of its main objects, that the patient shall become more independent and autonomous, the risk of suicide has sometimes to be taken. Here, the therapist must listen to and trust their intuitions. Worry about suicide should always be discussed openly with the patient, and where necessary lead to specific actions on the part of the therapist. At an initial consultation, if the therapist feels that suicide is an imminent possibility, they may decide that they cannot take on the case, and take steps to ensure that the patient is admitted to hospital, or treated by some other means than psychotherapy. But if the patient is coming regularly, and a psychotherapeutic relationship has been established, it can be difficult if the therapist suddenly changes from a person who is encouraging independence and freedom of choice into a risk-driven mental health monitor. But patients who threaten suicide must be taken seriously.

The meaning and implications of those feelings need to be thought about. Some may be desperate for the therapist to give them more time. Some are seeking revenge upon those they feel have not loved them; and it is important to seek out and make conscious the hostile motive in suicide, which is almost always present. Others may be seeking oblivion, which often seems to represent a final wish for complete merging with an idealized mother of the kind portrayed by Swinburne (1992) where even the rainiest river, winds somewhere safe to sea. It is often appropriate gently to point out that, if the patient really wants to take his own life, ultimately no one can stop him: and it is the task of therapy for patient and therapist to try to understand the reasons why death might seem so attractive, life hold so little joy.

In general, suicidal people need at least two mental health professionals: a therapist, whose job is to help the person understand why life no longer seems worth living, and another, in the role of case manager, whose job it is to take the steps needed to keep the patient alive, including, occasionally, admission to hospital. Another relevant point is that the distinction between deliberate self-harm and suicidality is best thought of as one of degree, not kind. Even in the most determined suicide attempt there is somewhere a longing to be saved and to find hope. Conversely deliberate self-harm objectively greatly raises the risk of dying, and although often dismissed as ‘attention-seeking’, it is a good principle to consider that embedded in what looks like ‘manipulation’, there is part of the person that is truly seeking oblivion as the only conceivable way of escaping from mental pain.

The ‘depressive position’ and the ‘manic defence’

Melanie Klein and her followers make a useful distinction between what they call the ‘depressive position’ and the ‘paranoid-schizoid position’. While finding such psychopathological language distasteful, we endorse the basic idea that a degree of depressive position’ acceptance that the world is made up of a mixture of light and shade, that love and hate can and usually do co-exist, and that a degree of sadness about this is appropriate and healthy. The ‘paranoid-schizoid position’ is a developmentally earlier state in which the world is divided into good and bad, and one blames others or circumstances for one’s unhappiness, rather than taking full responsibility for one’s own faults and failings and contributing to vicious circles one finds oneself in.

Another useful Kleinian concept is that of the ‘manic defence’ (Wadell 1998), in which one escapes from underlying sadness in a number of ways: overwork, spending sprees, hypersexuality; or by finding legitimate enemies upon whom to vent aggression.

An example of such a person is Winston Churchill (Storr 1989).

Churchill became depressed when he was immobilized, as during his brief imprisonment by the Boers, and when confronted by failures, such as the campaign which he initiated in the Dardanelles during the First World War. His neglectful background gave ample reason why he should be vulnerable to what he called his ‘Black Dog’. But, during most of his life he was adept at staying off depression. While he was awake he was seldom idle, and when he stopped working he immediately went to bed. He had, for much of his life, the sustaining influence of holding a great office. When he was out of office, he turned to creative activities such as painting and wall building (the latter of which might be seen symbolically as wanting to ‘wall off’ his misery). He was at his best during the Second World War in which he had in Hitler an entirely appropriate object for his aggression.

Another example of a famous depression sufferer was the philosopher John Stuart Mill (1873), whose upbringing clearly predisposed him to this condition.

Mill was remarkable in his intellectual precocity. His father, James Mill, himself undertook his education, with the consequence that Mill started to learn Greek at 3-years-old; he recalls: ‘my father, in all his teaching, demanded of me not only the utmost that I could do, but much that I could by no possibility have done.’ Mill was kept from mixing with other children so that he had no idea, until he was over the age of 14, that his achievements were in any way remarkable. Measuring himself against his father, he had always found himself to be wanting. Moreover his physical skills were minimal, and he remained ‘inexpert in anything requiring manual dexterity’. Far ahead in intellectual matters, ‘the deficiencies in my education were principally in the things which boys learn from being turned out to shift for themselves, and from being brought together in large numbers’. Moreover, as Mill observed: ‘The children of energetic parents frequently grow up unenergetic, because they lean on their parents, and the parents are energetic for them’.
Mill suffered from a major depressive breakdown when he was 20-years-old. The first ray of light broke in upon his gloom when he was reading some memoirs in which the author relates his father's death:

'‘the distressed position of the family, and the sudden inspiration by which he, then a mere boy, felt and made them feel that he would be everything to them – would supply the place of all that they had lost' (Mill 1873).

Mill records that he wept at this affecting account; and clearly believes that it was because the book made him able to feel emotion again that he started to improve in spirits. A comparable turning point occurs in Coleridge's *Ancient Mariner* when the protagonist finally feels empathy for fellow creatures (in his case, sea-snakes), and is at that moment relieved of the burden of his depressive guilt (symbolized by the albatross). Mill's 'bibliotherapy' marked the end of his 'afflict phobia' and he could begin to experience the emotions of sadness, grief and anger which, ironically, his depression had blocked. Another interpretation would be that this passage made him aware that sons can sometimes aspire to replace, or even surpass, their fathers; and this realization helped him to feel less inadequate. Some patients recount similar experiences when listening to music, or watching films that resonate with their own situation.

Mill's upbringing clearly demonstrates that a child may receive the most devoted attention from his parents but fail to acquire a proper sense of his own value. And both Churchills' life and Mill's demonstrate that great achievements may in part come about because an individual, who in early life believed himself to be inadequate, is driven to make special efforts to prove the contrary.

**Anxiety**

Inevitably, going to see a therapist is anxiety provoking. Will the therapist understand me? Is it safe to lay bare my hang-ups, conflicts and shameful secrets? Can I rely on her not to gossip or laugh about me? Will she be there for me when I want her, or will she be on holiday at the crucial moment of need?

All these are normal, healthy and expected feelings. We need anxiety to stay safe, and to tell us whom to trust, when to hold back. Just as sadness and grief are normal responses to the loss of a loved one, so fear is an adaptive and protective response to external threat, helping us avoid danger. But if fear is a good thing, anxiety-disordered patients suffer from too much of a good thing. They are overwhelmed with anxiety rather than unable to benefit from it. In this chapter we shall look first at anxiety disorders in general, and then focus on one in particular, obsessionality.

**Freud on anxiety**

As in depression, where the source of the loss is veiled (although almost invariably present if one looks in the right place), in anxiety the source of the threat is often obscure. Thus anxiety and depression have in common either the absence of an obvious stimulus, or a seemingly disproportionate response to a trivial one. To account for this, Freud put forward two radically different theories of anxiety. In his first attempt (Freud 1905) he argued that since in anxiety disorders there is no evident external source of fear, the source must lie within: people are made anxious by their inner feelings – in his model predominantly sexual or aggressive. These id-impulses are repressed, and the result is anxiety. But Freud later saw that anxiety can result not just from the presence of threat, but also from the absence of someone with whom to mitigate and modulate that threat:

'‘Missing someone who is loved and longed for is the key to an understanding of anxiety' (Freud 1928).

Here the cause of anxiety is to be found as much in the absence of a protective relationship as the presence of a threat. Bowlby (1973) argues that we appraise external threat not just for its intrinsic danger, but its danger *in relation to the presence or absence of appropriate protection*. In the absence of a secure base, a child alone is wise to treat strangers with suspicion; if accompanied, the child can rely on the mother to evaluate the stranger and, with the help of her visual cuing, afford to be more exploratory and forthcoming.

**Attachment theory**

A basic postulate of attachment theory is that anxiety is a normal, expected and adaptive response to physical or emotional separation from a secure base. Anxiety becomes pathological when relatively trivial separations trigger intense anxiety responses. From an attachment perspective this can be understood in terms of early developmental experience which instantiate expectations of abandonment and/or difficulties in assuaging anxiety when in the presence of a base whose capacity for security provision is sub-optimal.