Jules R. Bemporad

Change Factors in the Treatment of Depression

Curative Factors in Dynamic Psychotherapy

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Change Factors in the Treatment of Depression

Jules R. Bemporad

Most depressed persons seek psychotherapy following some major upheaval in their lives that has forced them to reconsider the ways they derive meaning, esteem, and gratification from their everyday existence. For some, this psychological upheaval resulted from the loss of a significant relationship with another person. Others may have experienced a loss in social or economic status such as loss of a prestigious career position. Still other depressed persons complain not of an actual loss but of a realization that a very important goal which they have set themselves will never be achieved. In this case, the loss appears to be of a fantasied or expected status or accomplishment that cannot be obtained. Finally, some depressed persons have not suffered any loss—real or fantasied—and so their depression may appear without any apparent precipitant. With treatment, however, it becomes clear that the exacerbation or onset of their depression can be traced to a time of psychological crisis and readjustment. In such a case, some seemingly trivial experience—reading a certain book or seeing a certain play or movie or having a conversation with a friend—has caused a reevaluation of the meaning and satisfaction of one's whole existence, leading to the conclusion that one is inexorably caught in a frustrating and nongratifying

lifestyle.

These are the three major types of clinical presentations that are usually found in patients presenting with a primary depressive disorder.[1] Despite manifest difference in the immediate causes of the depression, those who suffer all three types share similar personality characteristics, patterns of child rearing, and irrational systems of beliefs about themselves and others. The superficial differences are really variations on a more basic theme. It is this more fundamental attribute of the personality that is responsible for the production and maintenance of clinical depression. For everyone becomes depressed at one time or another; yet for most of us this painful affect lasts for only a short time and occurs only after an appreciable, realistic loss or frustration. In some persons, however, this initial depressive reaction does not pass and intensifies with time. Furthermore, the precipitants of the depressive episode do not appear commensurate with the extent of the reaction. Most people who feel depressed mobilize considerable psychic effort to combat their dysphoria and find activities or psychological mechanisms to alleviate their mental pain. Depressives, on the other hand, seem to collapse under their melancholic state, to give up and become hopeless and helpless, often expecting others to relieve them of their painful burden. Finally, healthier people become saddened or depressed in response to an *external* deprivation, whereas depressives, in contrast, experience an alteration in their conception of themselves. This is an extremely significant

characteristic of the depressive, as Freud (1917) astutely noted in his differentiation between grief and melancholia. He stated that in grief there is a sense of an environmental loss whereas in melancholia it is the ego—one's own self—that is impoverished.

This inner cause of depression was also eloquently described by Kierkegaard (1849) over a century ago. He wrote that "when the ambitious man whose watchword was 'either Caesar or nothing' does not become Caesar, he is in despair thereat. But this signifies something else, namely, that precisely because he did not become Caesar he cannot endure to be himself' (p. 152). As for those depressions that follow a loss, Kierkegaard describes them as follows; "A young girl is in despair over love and so she despairs over her lover, because he died or because he was unfaithful to her…. No, she is in despair over herself. This self of hers, if it had become 'his' beloved, she would have been rid of in the most blissful way … this self is now a torment for her when it has to be a self without him" (p. 153).

It would seem that there is a predisposition in some people to repeated and severe episodes of depression which exists before the onset of a clinical episode. It is this premorbid personality pattern, this way of living, that psychotherapy must ultimately alter to effect lasting change.

Patterns of Depressive Personality Organization

Perhaps the most conspicuous feature of the depressive's personality is an extreme reliance on limited external sources for maintaining self-esteem. Arieti (1962) has commented on this characteristic, noting that in contrast to the schizophrenic in whom decompensation results from a failure subjectively felt to be of cosmic magnitude involving the patient's involvement with his entire interpersonal world, episodes of depression often follow the loss of a relationship with only one person. Arieti therefore termed the object of this lost relationship "the dominant other," suggesting that the depressive had excessively relied on him or her for nurturance. When one loses this dominant other, one feels deprived of one's source of meaning and self-esteem; such a person cannot independently reinstate avenues of psychological support and lapses into depression.

This extreme reaction to a loss is best appreciated in the context of the depressive's premorbid mode of conceiving of the self and others. Slipp (1976) found that depressives are trained from childhood to shun autonomous means of gratification, i.e., obtaining esteem directly through their own efforts. Rather, their sense of worth was derived from the parent, who constantly judged their merit. The rewards of hard work or public achievement therefore become meaningless in themselves and are used only in the attempt to secure praise from the powerful parent. The parent also punished the child severely by inducing shame and guilt for any attempt to derive extrafamilial gratification. All of the child's successes were perverted

so that they brought no joy in themselves but were accepted as just repayment for the parent's love or one's proper duty to the family. All other means of obtaining worth or a positive sense of self were derided as silly or unproductive or seen as signs of disloyalty.

As a result of this orientation, which stresses that love can be obtained only by abstinence and hard work, depressives often achieve considerable success in later life and, from afar, seem to be highly competent, well-adjusted people. Yet their success means little and they use it only to wrest praise from some dominant other who has transferentially replaced the parent. If this relationship with the dominant other is disrupted, such people suddenly find themselves without sources of pleasure or meaning, and depression ensues.

Episodes of depression sometimes follow job promotions. In such cases, depressives have worked so well under benign or rewarding superiors that they are appropriately promoted. Yet after a few weeks, they find that their work is no longer interesting, that they are uncertain of its worth, that they feel empty and lonely. The depressives have lost their needed relationship with their old superiors and find they cannot function without the old reassurance and feedback. A more obvious example is those depressions that follow the loss of a spouse or loved one. Here again, one finds that the lost other seemed to bestow meaning and worth; he or she actually supplied a needed sense of self that the depressive is incapable of achieving alone.

In addition to the "dominant other" depressives described above, there are also "dominant goal" types who are similar in that they too have precariously limited their avenues of esteem to one external source: that of fulfilling some great ambition. These depressives shun gratification and involvement in everyday life—except for what is related to their goal—for fear that other activities will interfere with their all-encompassing objective. They lead essentially anhedonic lives, taking no pleasure from daily life and avoiding alternative sources of esteem. When this monomaniacal quest for the goal is closely examined, however, it is found that the goal, per se, also has little inherent meaning. What is important is the fantasied transformation of the self that is supposed to occur when the goal is achieved. These depressives attach all sorts of surplus meaning to the end of their quest: they will finally be loved, they will be worthy, they will at last "show the world" how talented they really are. Without this goal, however, they feel unworthy and inferior.

"Dominant goal" depressives were pushed to achieve as children but were not allowed to enjoy the *process* or the inherent aim of their achievements. Their accomplishments were to be used to redeem the family or to prove themselves in the world's marketplace, but not to bring meaning in and of themselves. All other possible areas of esteem and meaning were ridiculed or discouraged through shame and guilt. It is their narcissistic use of an external event (the achievement of a goal), as well as their lack of alternate

sources of meaning, that predisposes such persons to clinical depression. When they come up against situations which force them to realize that their goal cannot be attained, they lose all sense of purpose. They believe themselves to be forever unworthy or defectives view that cannot be tolerated. As Kierkegaard wrote, when the man who has to be "Caesar or nothing" cannot become Caesar, he senses himself to be nothing.

The "dominant other" and "dominant goal" types of depressives suffer from constant apprehension and periods of mild dysphoria for fear of losing their external means of achieving worth, but usually can function without impairment as long as they believe their sources of esteem are intact and realizable. There are some people who are unable to achieve even this pathological mode of obtaining transient satisfaction. These depressives share many characteristics with the previously described types—self-inhibition, anhedonia, and limited means of esteem. They differ in that they derive what little gratification they are capable of by following a rigid code of conduct. They live by a set of strongly adhered-to taboos which allows them little pleasure or involvement. Superficially, they may appear to be highly moral, but in reality their standards are neither rational nor motivated by a conscious sense of ethics. Rather, these people are still blindly following the strict dictates which were inculcated in childhood. Such persons become clinically depressed when faced with certain adverse life circumstances. Some may realize that their mode of life brings them little pleasure, but they find

they cannot alter their ways: they are caught by their own beliefs, and any attempt at change brings terrifying anxiety or shame.[2] Others would gladly behave differently and live a more satisfying life but believe it is too late. They feel they are too old to have the romantic love affair they secretly desired or to choose a more rewarding vocation. From an objective standpoint, these people may appear to have become depressed without a discernible cause; their depression seems to be “endogenous.” However, close scrutiny, usually after an extensive period of psychotherapy, will reveal that some experience, or series of experiences, has caused them to reevaluate their way of life and to have found it wanting.

Although such evaluations usually occur in middle, or even advanced, age, this form of depression is not infrequent among adolescents or young adults who find that living by the childhood standards of their parents is not applicable, or not satisfying, in the extrafamilial world. Anthony (1975) writes that John Stuart Mill underwent just such a depressive episode in early life when he perceived that abiding by his family belief system would doom him to unhappiness. According to Anthony, Mill asked himself if he would be happy if he accomplished all that his father had asked of him. Mill was forced to answer no, and of that moment of self-confrontation, Mill later wrote, "At this, my heart sank in me; the whole foundation on which my life was constructed fell down ... I seemed to have nothing to live for." Anthony comments: "He fell ill when he became aware that the realization of his

father's aims in life would not satisfy him, and he regained his mental health (to the degree that this was possible) when he understood that the death of the father brought with it the growth of identity, autonomy, and responsibility for the son" (p. 448). Not all such people are as fortunate as young Mill. Many cannot detach themselves from the parental ideal, or cannot concretely change their ungratifying existence.

Psychotherapy

Initial Stage: Course and Confrontation

The first phase of psychotherapy aims at achieving two major objectives: setting a proper course for the remainder of the therapy and helping the patient to become aware of the pathological mode of living which predisposed him to depression. In most cases, these objectives are immediately threatened by the patient's acute emotional discomfort and persistent requests for magical relief from his dysphoric state. The patient will not consider looking inward but wants only to reiterate his miserable plight. Levine (1965) writes about the patient's "broken-record response"—repetitive complaints which therapists must actively interrupt by introducing new topics. Spiegel (1965) describes how the patient can wear out the therapist by limiting verbalizations to the recounting of symptoms and negative preoccupations. At the same time, the acutely depressed patient will

us every means to induce the therapist to offer reassurance and nurturance. The patient will appear so grateful for a message of hope for the future or a word of encouragement that the therapist may believe that such ministrations will cure the patient's depression. However great the temptation may be to comfort a fellow human being, the therapist who offers reassurance or adopts an excessively sympathetic role is setting up a therapeutic relationship that is doomed to failure. Although adopting an initial nurturing role may achieve temporary symptomatic improvement, it will detour the proper course of therapy. The patient will subtly demand more and more until the therapist finds himself in the unrealistic position of shouldering the burden of the patient's everyday life. The therapist feels trapped into giving more and more support without being able to explore the reasons for the patient's behavior. If the therapist then attempts to reinstate a more constructive therapeutic relationship in which the patient assumes responsibility for cure, the patient may become resentful or intensify depressive complaints.

Jacobson (1971) has commented on the pitfalls of allowing an unrealistic preoccupation with and idealization of the therapist to develop. She writes of her therapy with one such patient: "There followed a long, typical period during which the patient lived only in the aura of the analyst and withdrew from other personal relationships to a dangerous extent. The transference was characterized by very dependent, masochistic attitudes

toward the analyst, but also by growing demands that I display self-sacrificing devotion in return" (p. 289). Kolb (1956) had also noted that the beginning of treatment with depressives "bears upon the therapist heavily because of the clinging dependency of the patient. The depressed patient demands that he be gratified. He attempts to extract or force the gratification from the therapist by his pleas for help, by exposure of his misery, and by suggesting that the therapist is responsible for leaving him in his unfortunate condition" (p. 589).

In light of these observations, the therapist must communicate a willingness to give full attention and expertise to help patients help themselves without being manipulated into giving reassurances or sympathetic comfort. Nor should the therapist become the focus of the patient's life. From the outset, patients should understand that feeling better is their own responsibility and not an obligation of the therapist. On the other hand, it would be equally counterproductive for the therapist to remain silent and assume a strict analytic posture. That would allow the patient to go on endlessly complaining or, perhaps, to create a grossly distorted transference relationship in which the therapist is seen as a magical, omnipotent helper, an image which will later cause a negative therapeutic reaction when the therapist does not live up to these idealized expectations. Rather, the therapist should be active in the sessions and introduce new themes so as to break the monotonous reiteration of complaints. Also, since most depressives have been raised in an atmosphere of deceit and hypocrisy, it is most

important for the therapist to be forthright and honest about his or her own limitations and expectations.

Finally, the therapist should accord patients an expectation of mature behavior and treat them with dignity and respect. Interpretations should represent a shared and equal discovery of relevant information rather than the transmission of insight from a sage to a novice. Patients have to learn to look within themselves by themselves rather than waiting to be told what their difficulties are. Accordingly, transference material is best aired immediately, especially as it embodies patients' attempts to idealize the therapist and to resist acceptance of therapeutic responsibility.

The other major objective of the initial stage of therapy concerns confrontation, meaning that patients are to be helped to become consciously aware of how they had previously structured their belief systems about themselves and others so as to predispose them to depression. This aim is achieved through the interpretation of dream material, timely comments about patients' reconstructions of present and past daily activities, and the analysis of fantasies, hopes, and fears. The therapeutic situation itself may force patients to confront some of their distortions when they unsuccessfully try to turn the therapist into a needed transference figure. This last process is perhaps the crucial one, for it will allow patients consciously to realize their distortions as they are concretely living them out with a person who, in

contrast to others, will neither acquiesce to them nor reject them out of hand, but will submit the distortions to analysis.

Eventually, the picture of a basically anhedonic person will emerge, one who, often despite considerable public achievement, has never been able to enjoy any activities or accomplishments. All the talents of the depressive have been harnessed to the need for recognition from selected others endowed with imagined power; or have been centered on some distant goal; or have been stifled for fear of appearing self-indulgent, foolish, or sinful. Human contacts have similarly suffered from the patient's self-inhibitions; others are feared as potential judges or condemned as silly or childish. Interpersonal relationships have usually been characterized by subterfuge, manipulativeness, and control rather than by a free and open exchange of feelings and ideas. The basic theme is clear and repetitive: to dare to be spontaneous or joyful will result in punishment, whether by loss, abandonment, shame, or criticism. The atmosphere is heavily pervaded by sin, accountability, and self-denial, sometimes complicated by a feeling of helplessness and aloneness and a longing for external structure and direction.

As patients are confronted with these basic personality patterns, the hope is that they will begin to understand that their depressive episodes were the result of a pathological lifestyle. As Bonime (1960) has commented, depression should be seen as a *practice* rather than as an episodic illness with

healthy intervals. Patients should recognize that if they wish to stop their suffering, they must radically alter their way of constructing their experience and activities. Within the therapeutic relationship patients must identify and confront the underlying causes of their dysphoria before they can begin the difficult process of altering those fundamental systems of beliefs, modes of relating, and manner of experiencing their world that culminated in their depression.

Second Stage of Therapy: Resistance and Change

The patient's realization that his irrational beliefs and distortions of everyday life are ultimately self-defeating or counterproductive does not automatically ensure that his inner self or previous activities will change. Neurotic behavior is never easily relinquished, for these older, well-ingrained patterns have for years offered security, predictability, and even some gratification, albeit transient and inappropriate. To remake one's personality is frightening and involves risk, so it is not surprising that patients will resist change even when they know that it is in their best interests. This process of "working through" is the real battleground of therapy, with frequent advances, retreats, and stalemates. This conflict occurs in the psychoanalytic treatment of almost all pathological conditions but perhaps especially in the therapy of depression, since this disorder so permeates the person's entire being.

The resistances that are seen in depressed patients take the following forms. Some despair over giving up their dominant other or their dominant goal, for they believe that if they eliminate this powerful system of gratification and esteem life will have no meaning whatever. Others fear terrible retribution for deriving genuine, autonomous pleasure from their activities, as evidenced in fantasies of being abandoned, humiliated, or shamed, or fantasies in which others get hurt. For all, enjoyable activities are burdened by guilt and anxiety. For example, a depressed young woman was asked to go on an expense-paid trip as a reward for excellence at her job. She was constantly afraid that her family would die or that some other catastrophe would occur in her absence. This belief was clearly irrational for she often traveled on business without apprehension. Since the latter trips were not for pleasure, she did not feel that they would result in harm to others. It was not her absence, but the fact that she was daring to enjoy herself, that was the root of her anxiety. This magical connection between pleasure and disaster will be found again and again in the dreams and fantasies of depressives. One depressed young man, whose case has been reported in detail elsewhere (Arieti and Bemporad, 1978), started to date as a result of his progress in therapy. However, when he was out enjoying himself with a woman or with friends, he was overcome by the conviction that his father was dying. So strong was this belief that he had to excuse himself and call his parents to see if his father was really all right.

Those patients who complain that their lives are meaningless unless they receive external praise or work toward some grandiose accomplishment may nevertheless find that they can begin to enjoy doing things that they used to forbid themselves. They may begin to read novels, go to movies, spend time with friends, or start hobbies, activities which had once been condemned as unproductive and shameful. These new activities should be encouraged because they represent a change, however small, in the perception of one's self and how one should behave. Often this new conceptualization of the self is first tested in the safety of dreams, sometimes to the alarm of the dreamer.

Such a dream heralded the readiness for change in a depressed young woman after she had realized that it was her whole lifestyle that left her vulnerable to repeated episodes of depression. This woman had been raised by grandparents who were strongly religious and puritanical, and who felt that they were superior to their neighbors (and to people in general). As a child she was not allowed to play with other children after school but had to return home, do her homework, and then receive instructions from her grandmother about the ways of the world. Essentially, these "lessons" stressed that people were evil and dangerous, that temptation lurked everywhere, and that hard work was the only salvation from sinfulness. The patient remembered her childhood with ambivalence: her grandparents' house was big and gloomy, the atmosphere was sterile, she was always afraid of doing something "wrong" that would make her grandparents ashamed of

her, yet there was love and acceptance if she obeyed their dictates. Later, there was also a sense of prideful superiority in not being silly or lazy like other children.

It was not until this woman attended college that she began to suspect that her view of life was limited and inappropriate. Away from home, she began to question the family's values as she saw fellow students having fun or enjoying purely creative endeavors. Despite these doubts, she could not bring herself to alter her strict code of conduct and continued to spend almost all of her time studying, at times secretly envying the casual freedom of her peers. She graduated with honors and also won other prizes, but her achievements were perverted by her grandfather, who literally took her diploma, saying that *he* had really earned it since he had paid the bills and she had merely done what was to be expected of anyone who was being supported by someone else. She went along with this line of thinking, even feeling proud that she had pleased him.

After college, this woman got a good job in her field and continued to work hard at her career. But her life consisted of nothing except her work. After a hard day, she would return to her apartment and go over the events of the day, deciding whether she had done a good job, much as she had replayed the day for her grandmother as a child. And like her grandmother, she usually found something she had done "wrong" and berated herself. This was her

Monday-through-Friday schedule. On Saturday she ran errands, and on Sundays she spent the day planning the next week's work. In addition, every Sunday she called her grandparents, who somehow managed to "ruin" her day by complaining about their ill health or her lack of gratitude. These calls always left her feeling guilty and worthless.

She became increasingly depressed as she sensed that her life was devoid of gratification. She was desperately lonely, but her fear of what others might do to her prevented any real social involvement. She did have some acquaintances who were dependent on her and used her as a "mother figure" or wise counsel; she thus avoided exposing her own needs, remaining in a superior, if isolated, position. Her work, which was supposed to be her salvation, was becoming a nightmare, as she always expected failure and humiliation. She knew she got little satisfaction from life but felt incapable of changing on her own.

After some months of therapy, during which she was confronted with the basis for her ungratifying lifestyle and pervasive fear of pleasure, she reported the following dream: She was in her grandparents' dark, gloomy house, adjusting a shade so that it would let in more light. Suddenly she was transported to another, unfamiliar house where she was lying on a bed wearing a frilly dress with her hair long and pulled back (as she had worn it as a teenager). She was so startled at seeing herself in this way in the dream

that she awakened abruptly with a sense of anxiety.

Obviously, the whole range of associations to this dream cannot be fully reported here. What is important is the sequence of images leading from "childhood self' to "shedding light" (which would make the house less gloomy) to a new (or perhaps old, but repressed) sense of self. In therapy too she was "shedding light" on her earlier self-image and its perpetuation into the present, accompanied by gloom and despair. Therapy revealed the possibility to be someone completely different, a self that may have been secretly desired. The woman on the bed represented sexuality, femininity, dependency, and vanity: all of the terrible "should nots" of childhood. These attributes so frightened the patient that she abruptly awoke. The fact that she was able to see herself in this new light in the dream, however, enabled her to apply the dream content to waking life, and to integrate this estranged self (albeit in a less extreme and pejorative form). Finally, depressives often dream of or recall themselves as adolescents during the initiation of change. During adolescence there may be a normal developmental tendency to rebel against family strictures and define a new identity for oneself. In most depressives, this adolescent rebellion was short-lived and the person quickly fell back into the older pattern of obedience. This transient sense of freedom has not been forgotten, however, and is reactivated in symbolic representations when the patient once again tries to shape an independent self.

Another type of dream which indicates change in the depressed person is one in which a parent dies. In contrast to the Freudian interpretation of such dreams (Freud, 1900), which centers on Oedipal rivalry, for the depressive this type of dream appears to indicate a sense of freedom from the powerful parent. The dominant parent (rather than the same-sexed parent of the Oedipal triad) is disposed of in the dream. Thus, for both male and female patients, it is usually the father who dies in the dream. The following example may be seen as typical of these "death" dreams. [3] A depressed woman in her late thirties dreamed that two women were in a beautiful room. One woman was thin, downcast, and unattractive; the other was beautiful and voluptuous, with intricate tattoos on her body. The voluptuous woman said, “Use my body and I’m happy,” and then went into a luxurious bathroom, exuding a great sensual aura. Suddenly, this beautiful woman did something “disgusting,” which could not be specified. Then the scene changed to a hospital room where the patient learned from a teenage boyfriend that her father was dying. She felt “sad and horrible” as well as guilty and abandoned; but she could not prevent the death. The boyfriend consoled her and finally told her, “I’ve always loved you,” whereupon the patient awoke in a state of apprehension.

This dream portrays the usual dichotomy between the "good" ascetic image and the "bad" hedonistic self as well as the aforementioned return to adolescence (in the figure of the teenage boyfriend). The dream also conveys that, if pleasure is to be obtained, the father (and the self that was created in

relation to him) must cease to exist. In this dream, the woman regains love from an extrafamilial figure, the boyfriend, showing that the father's loss does not mean eternal abandonment but, perhaps, a chance to find intimacy outside the family circle. In real life, the patient's father had actually died years before, but she remained tied to him by following his dictates and by searching for alternate "dominant others" to structure her life as he had in childhood. It is significant that the boyfriend did not fulfill this role; her relationship with him was remembered as a brief interlude of true mutuality that had to be given up out of a sense of duty and shame.

Some of these death dreams portray the futility of continuing to serve the dominant other; in others, there is open rebellion; in still others, there is simply a sense of resignation—a recognition that the older order has passed and the former authority has been dethroned.

A similar realization may occur in waking life if the dominant other is still alive or if his or her role has been transferred to a new authority figure. An example of the former case occurred during the therapy of a middle-aged executive. He had a "dominant other" type of personality organization and had functioned well in the context of a favored status relationship with his boss. However, he had been transferred to another department where his new boss was aloof and gave his colleagues little feedback. This new superior simply expected everyone to do their jobs and was not concerned with

personal niceties. The patient found himself becoming more and more depressed when he failed to elicit the needed reassurance from his new superior. He vacillated between seeing no meaning in his work and getting furious at the company's usually trivial errors, which he now magnified. In therapy, he was able to connect his current plight to his childhood experience of devoting himself to pleasing his father. The latter rarely gave praise and was harshly critical of all the children, but the patient remembered feeling euphoric and important when the father did acknowledge some achievement.

The patient's father was still living and in a nursing home, where the patient visited him regularly. On one occasion, he went to see his father full of high expectations, as he had concluded a very successful business transaction. As he began to describe his accomplishments to his father, however, the latter completely ignored his son's remarks and viciously berated him for wearing a pink shirt, which he considered unprofessional. Such a response from the father was not unusual, but this time, as a result of the work that had been accomplished in therapy, the patient could objectively analyze his initial sense of disappointment and deep feeling of failure for not pleasing the older man. Although this experience led to a transient state of depression, it also revealed to the patient his whole dependent lifestyle—his use of others to supply him with a feeling of worth. This experience added a dimension of immediate reality to the insights that had been achieved in therapy and gave the patient the motivation to change radically his childhood system of

perceiving himself in relation to paternal transference figures. This clinical vignette illustrates one of the major objectives of the working-through process: one must perceive usual situations in a new way and then use such insights for the purpose of change.

Actually, most of the process of change is not so dramatic, but occurs in a gradual interplay between the gaining of insights in therapy and the application of this knowledge to everyday life, which in turn leads to new material that serves as a source of fresh insights. The treatment of a young lawyer will illustrate this lengthier and more common type of working through.

This young man's symptoms were chronic episodic depression, migraine headaches, insomnia, and fatigue. His history was typical of most depressives: his father was a tyrannical person who dominated the household but whose love could be temporarily obtained by very hard work; his mother was a childish and ineffectual woman who lived in her husband's shadow; the father stressed achievement and induced shame and guilt for failure or "laziness." The patient's two siblings were also professional men and high achievers.

This young man aspired to be either the United States Attorney General or a Supreme Court Justice. There is nothing inherently wrong with setting

one's sights high, but for the patient nothing except his ambition seemed to matter. He worked about seventy hours a week, performing his job in an exemplary manner but deriving little gratification from it. He was extremely critical of himself and others: he had periods of despair when he thought of himself as not smart enough to ascend the ladder of his profession or when he believed he might have alienated someone who could block his rise to success. He was constantly angry at others for not noticing him enough or for not repaying what he believed were obligations to him because he worked so hard. At home, he reprimanded his wife for not appreciating him or pouted in order to elicit care and concern. He genuinely loved his young children but unrealistically expected that they too should show gratitude for his long hours of labor. In essence, he expected everyone both to share in his aspirations (as did his father) and to render privileges and praise for his work (as did his father). He had no idea that other people had their own interests and careers and were not constantly focusing their attention on him. Finally, he had no hobbies or pursuits aside from his legal career. Any diversion from his work had to be repaid by extra studying or writing. He believed that others were keeping a mental tally sheet of his activities and, in the manner of his father, looked on his time away from work with displeasure.

Initially, this patient was confronted with his monomaniacal quest for a lofty goal, which was really his father's goal. He gradually realized that in his pursuit of his ambition he enjoyed fantasies of its achievement but not the

process of getting there. His work was drudgery for him because he saw it as only a means to an end and not as an end in itself. Work was also a source of apprehension, as he feared that trivial mistakes would doom his career plans. Finally, he erroneously perceived work as a way to barter for love and force positive reactions from others. This line of inquiry led to an exposure of his distorted view of human relationships: that one extorted obligations from others through hard work, and that everyone judged everyone else.

He began to make some changes in his job by resolving to be less directly involved in the work of his subordinates (possibly much to their relief) and, to his surprise, found that they functioned just as well without his paternalistic meddling. He found that they still respected him and liked him without his having to "take care" of them. He also realized that others in his firm were only peripherally aware of his labors and that, although he was justifiably regarded highly, he could not be angry with others if they did not conspicuously praise his every transaction. Others were simply not his father, nor would they assume that role. He had to learn to reward himself for a job well done.

The implementation of these insights led to a release of tension and an amelioration of his headaches and insomnia. He began to understand how he unwittingly recreated his childhood situation in all of his relationships, therapy included, and connected his periods of depression to occasions when

others did not react to him in a predictable, reassuring manner. At the same time, he protested that he was losing control of his life, that he would never achieve his destiny. The therapist interpreted that he was learning a new way of relating to others and a new way of seeing himself, which understandably made him feel vulnerable and anxious since he was giving up the security of his well-worn (if inappropriate) system of obtaining meaning and esteem.

With some trepidation, he began to work less, and was surprised, as well as relieved, to find that his superiors did not really notice if he did not stay late or work weekends as long as his output was satisfactory. On one occasion, he had to pick up his four-year-old son from nursery school, and the young boy, accustomed to seeing his mother, began to cry and protest that he wanted his mommy. The patient felt that the child was ungrateful, since he had had to rearrange his schedule so as to pick him up. After recounting this vignette in therapy, he came to realize how he inappropriately expected gratitude from everybody, even a tired four-year-old, whenever he went out of his way for them. His whole method of setting up situations so that he felt victimized and righteously indignant was explored and applied to his marriage as well as his career. He realized that he used work to blackmail others into fulfilling his needs and related this insight to how his father exploited him as a child by using work to excuse himself from many parental responsibilities.

Eventually, he said that for the first time in memory he felt he had a choice about what he wanted to do with his life. He had always done what was "expected" and never what he really desired, so much so that he had no idea what he actually wanted from his life. He rethought his grandiose career plans and confessed that even being a Supreme Court Justice would give him little pleasure if he continued to structure his existence along the lines of doing for others (namely, his father and his substitutes) and not for himself. Concurrently, he was able to empathize genuinely with others rather than seeing them only as sources of praise or criticism. He enjoyed working and being with others more since he stopped viewing these activities as means to enhance or impede his great quest. At this point, he was free of symptoms, and—free of the many childhood "shoulds"—was on the way to deriving esteem and pleasure directly from a multiplicity of gratifying new activities that would, it was hoped, protect him from depression in the future.

Final Stage: Consolidation

The problems encountered during this phase of therapy may have more to do with external obstacles than internal ones. As patients alter their behavior as a result of therapy, they may find that others in their immediate environment will resent such changes. This conflict is to be expected in most instances of psychotherapeutic change, but perhaps is more deeply experienced by depressives since so much of their illness has been embedded

in pathological modes of relating to others. Significant others will unconsciously try to undo what they perceive as irritating and threatening changes that have so transformed what had been, to them, a comfortable relationship. This unconscious resistance may be found in the parents or colleagues of the depressive, but it is most commonly seen in the spouses of older, married depressives. These marital partners truly want the patient to get better and detest the frequent episodes of clinical depression that the patient has had to endure. Yet they do not want to give up the premorbid style of relating which actually predisposed the patient to these depressed episodes. The spouses must become aware of the unfavorable result of their former marital equilibrium to help create a healthier interpersonal system. During this stage of treatment, the therapist may wish to refer the spouse for individual therapy or may wish to see both partners for conjoint therapy. If the latter course is selected, obviously the therapist must be careful not to become the advocate of the patient but must allow the sessions to be used for expression by both partners. This interlocking reinforcement of depression in married couples is so frequent that Forrest (1969) suggests combining marital therapy with individual sessions from the start for optimal results.

Another task of the final stage of therapy is a coming to terms with the ghosts of the past. Too often there is a rapid transition from an idealization of past authorities to a bitter resentment of these same people. The patient should understand that the pathogenic actions of parents (or other childhood

influences) were a result of their own pathology and that these childhood idols were just ordinary people with the usual limitations as well as positive attributes. It is most important that the patient appreciate his own willful participation in recreating his childhood situation in adult life, regardless of how he was treated as a child.

The overriding goal of this stage, however, is the consolidation of the changes that have been achieved. Certain superficial characteristics that are indicative of deeper change may help the therapist gauge the patient's improvement. Almost all of these manifestations revolve around the patient's new independence and ability to derive meaning and pleasure directly from everyday activities. For example, creativity bespeaks the confidence to try new things. Spontaneity also reflects an ability to act with assurance—without constantly having to appraise how others will view one's behavior. The ability to take one's failures (and the failures of others) philosophically and with a sense of humor indicates an end to the hypermoral coloring of all events as "good" or "bad." Being able to take failure in stride indicates that the patient does not feel himself evil or worthless if he does not achieve his every objective and, in turn, that his self-esteem is realistically independent of life's vicissitudes. A most important indicator of change is that the patient no longer works only to obtain praise or to master some remote goal, but instead gains satisfaction from everyday life.

Another manifestation of change is a growing interest in others, not for what they can supply to one's self-esteem but because they are important and interesting in themselves. In losing their mainpulativeness, patients may experience true empathy for the first time, seeing others as similar to but separate from themselves. Therapy is then seen as a endeavor which involves sharing and learning, rather than as a constant struggle to obtain needed feedback from a transferentially distorted other. Therapy should remain *the* place where patients can express themselves without fear or shame until they are able to form other such relationships in their everyday life.

Summary

In closing, it may be worthwhile to offer some guidelines for the psychotherapy of depressives.

During the initial phase of treatment, therapists should be careful not to let themselves be set up as a new dominant other or an excessively idealized figure. These transferential distortions will obviously detour the therapy. Nor should they offer undue reassurance despite their natural inclination to help a fellow human being in distress. Finally, therapists must be wary of being worn out by the repetitive complaints of the depressive and should interrupt the patient's litany of misery by introducing new topics that will direct the patient to fresh material that is more likely to lead to insight. Therapists have

to be active, forthright, and most important, honest about their own fallibility as well as the limitations of therapy. Patients must understand that they will have to assume responsibility for their own improvement, guided by the professional confrontations and interpretations of their therapists.

Patients must learn to look inward for the reasons for their depression rather than expecting magical relief from external sources. Patients should realize that the painful episodes of depression are a direct result of a pathological lifestyle that must be altered. Once this connection is appreciated, therapists can begin to confront depressive patients with their distorted systems of beliefs, interpersonal relations, and self-inhibitions.

Guidelines for the second phase of therapy involve the handling of resistances and the enhancement of change. The therapist should not be threatened by patients' protestations that giving up pathological modes of obtaining esteem will result in a total lack of meaning from life. Nor should the therapist accept patients' convictions that disaster will ultimately follow any attempt to derive an independent sense of meaning or pleasure. Novel (or previously repressed) beliefs and activities are to be encouraged, as are new ways of viewing the self. Often a healthier state of self is initially formulated only in the safety of a dream. Such self-conceptions can be used to demonstrate to patients their own inner resources for change, if patients will allow themselves to apply the wisdom of their dreams to their waking lives.

More frequently, a reported vignette from everyday life can be used to illustrate that patients have a choice in continuing to adhere to a depression-prone mode of being—that they can begin to make changes that will ultimately lead to a healthier and happier existence. In summary, patients should eventually consider the renunciation of their former mode of being not as a loss but as a liberation. This profound change is gradual and time-consuming and often tests the patience of the therapist. Optimally, there will be a self-reinforcing process: therapeutic insights will lead to changes in behavior outside the office that, in turn, will create new experiences which, when reported to the therapist, will form the basis for newer insights, thus repeating the cycle.

The ultimate aim of therapy is to liberate depressive patients from their rigid belief systems and to allow them to be receptive to the genuine novelty of life. In essence, their everyday lives can be curative if they can learn to experience themselves and others without the crippling distortions that have for so long robbed their lives of true meaning and authenticity.

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Notes

1 Manic-depressive psychosis or bipolar illness is excluded from this group. Although this disorder has many psychodynamic and historical features in common with unipolar depression, the course of the illness appears to be influenced by unidentified physiological factors.

2 Obviously, these depressed persons are to be differentiated from those who are realistically trapped

by external circumstances, such as a chronic or fatal illness or severe socioeconomic deprivation. The latter do not deprive themselves by choice, nor do they suffer from distortions which perpetuate their dysphoria. Finally, while certainly unhappy, they exhibit neither the loss of self-esteem nor the narcissistic need so characteristic of pathological depression.

3 This vignette has been reported previously (Bemporad, 1976).