PSYCHODYNAMICS OF SEVERE DEPRESSION

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Severe and Mild Depression

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In the previous chapter we have seen that an unsolved state of sorrow tends to develop into a state of depression. Because they are most suitable to didactical examination, we predominantly have taken into consideration states of sorrow that unfold rather quickly as the result of specific, mostly sudden events. In practice we find that many states of sadness leading to severe depression have a long course, either chronic or subchronic, liminal or subliminal. We also find that in many cases in which a specific occurrence was the obvious and major precipitating factor, a subliminal state of sadness resulting from previous contingencies preexisted. Thus it is important to study the longitudinal psychodynamic history of each patient. A psychodynamic history is not just a sequence of events from birth to the present time, but an unfolding of psychological forces which derive from the interplay between external and internal events.

As mentioned in chapter 1, every human being is in a fundamental state of receptivity; that is, ready and capable of being influenced by the environment. But human beings are not to be defined only in terms of this

state of receptivity. Every human being even in early childhood has another basic function which is integrative activity (Arieti, 1977). Just as the transactions with the world not only inform but transform the individual, the individual transforms these transactions with his integrative activity and in turn he is informed and transformed by these transformations. No influence is received like a direct and immutable message. Multiple processes involving interpersonal and intrapsychic dimensions go back and forth.

The object of this chapter is to describe the way the environment influences the future severely depressed patient and the way he integrates these influences. It will become apparent that these ways are quite different from those of the normal person or the typical schizophrenic patient.

Childhood

As a rule, the childhood of a person who as an adult suffers from a form of severe depression has not been so traumatic as the childhoods of people who become schizophrenic or even seriously neurotic.

The parents of the patient generally give a picture of cohesiveness and stability. Only in a minority of cases is there serious talk of divorce. The family gives the appearance of having stable foundations and adhering to the conventions of society. The family conflicts, schisms, and special constellations described for families of schizophrenics are not seen as

frequently in the families of patients suffering from affective disorders. When they exist, they are less pronounced than in the families of schizophrenics.

The future severely depressed patient generally is born in a home which is willing to accept him and to care for him. The word accept has a special meaning in this context; the mother is duty-bound and willing to administer to the baby as much care as he requires, and she is willing to provide everything for him that he needs. This willingness of the mother is in turn accepted by the child, who is willing to accept everything he is offered; that is, early in life the child is very receptive to the influence (or giving) of the significant adult (parent). There are no manifestations of resistance toward accepting this influence, such as autistic manifestations or attempts to prevent or retard socialization that one finds in schizophrenia (Arieti, 1974). If we use Martin Buber's terminology (1937), we may say that the "Thou" or the other is immediately accepted and introjected. The "Thou" is at first the mother, but this receptivity to the mother enhances a receptivity for both parents and all other important surrounding adults, and promotes a willingness to accept them with their symbols and values. It also promotes a certain readiness to accept their food (either the milk of the mother or regular food) and thus predisposes some people (but by no means all) to overeating, obesity, and the seeking of compensation from food when other satisfactions are not available.

This receptivity to others and willingness to introject the favors of others at this early age promotes special personality traits in the future patient. He tends to become an extrovert and also a conformist, willing to accept what he is given by his surroundings not only in material things, but also in terms of habits and values, and to rely less than the average person on his autonomous resources. This readiness to accept—this psychological receptivity—will predispose him also to pathological or exaggerated introjection; that is, he tends to depend excessively on others for certain aspects of life which will be considered later.

In the second year of life (or earlier, according to some authors) a new attitude on the part of the mother drastically changes the environment in which the child is growing. At times the sudden change is experienced as a severe trauma. The mother continues to take care of the child but considerably less so than before, and now she makes many demands on him. The child receives care and affection provided that he accepts the expectations his parents have for him and he tries to live up to them.

This brusque change in the parents' attitude is generally the result of many factors. Predominantly, their attitude toward life in general tends to evoke in the child an early sense of duty and responsibility: what is to be obtained must be deserved. The parents are generally dissatisfied with their own lives and at times harbor resentment toward the children who represent

increased work and responsibility. However, this hostility is seldom manifested openly; it generally is manifested by the fact that the parents overly increase their expectations.

Thus the child finds his environment changed from one which predisposed him to great receptivity, to one of great expectation. These dissimilar environments actually are determined by a common factor; the strong sense of duty that compelled the mother to do so much for her baby is now transmitted at an early age to the child himself. Frequently in families of depressed patients there are many children. When the future patient is in his second year of life, a sibling often is already born and the mother lavishes her care on the newborn with the same duty-bound generosity that she previously had for the patient. This of course makes the change in the environment more marked for the patient.

This displacement by a younger sibling seems to be important in the dynamics of many cases of manic-depressive psychosis and other forms of severe depression, although no statistical proof of it can be given. Statistical studies so far have concerned themselves more with the order of birth (that is, whether the patient is the first-born child, second-born, etc.).[1]

In many cases the brusque change had to occur because of unexpected events: the child had to be abandoned by the mother because of illness,

economic setback, forced emigration, or political persecution. The child then was left in the custody of an aunt, grandmother, cousin, stranger, or orphan asylum and was subjected to a violent and unmitigated experience of loss.

For some patients the abrupt change that we have described has already taken place at the time of weaning. Future affective patients are generally breast-fed in their infancy and then suddenly deprived of mother's milk. No bottles, rubber nipples, or pacifiers are used. There is a sharp transition from the breast to the glass. In a minority of patients this loss of the breast plays an important role.

In many other patients the abrupt change occurs later, generally in the preschool years but at times even in grammar-school years. (See the case of Mrs. Fullman in chapter 10.) In other cases specific events take place which make the child feel threatened in his main love relationship. The change may be in the composition of the family, in the attitude of the parents, or on account of some unusual event. When the patient gives to the therapist an account of this change as he remembers it much later, the threat seems in some cases at least to have been experienced in an exaggerated manner. However, in many other cases there seems to have been a justification for an intensely unpleasant feeling. In still other cases the child does not remember the experience of having been threatened, but he remembers acting as if he had been threatened, and indeed at times he remembers facts which should

have threatened him. The word threat and not loss is used here, although the child in many instances has sustained a loss (of mother, maternal maid, love, etc.). If the child experiences the disturbing event as a loss, he tends to become immediately depressed. But the person who becomes depressed only in adult life, somehow in childhood was able to compensate partially for this traumatic experience, or to experience it as a threat for which he had to find coping devices.

Freud (1917) suggested that the withdrawal of love, approval, and support on the part of the parent or parent surrogate during an important stage of development predisposes a person to depression in life. Abraham (1916) felt that depression occurring later in life was predisposed by a withdrawal of love in very early childhood and fixation at the oral stage. No matter how devastating these events have been in some cases, patients who become depressed only in adult life have had throughout their childhood a capacity to muster defenses which somewhat diminished the sense of loss. The loss was transformed into a threat with which the child had to learn to deal. Some stability and feeling of hope was maintained.

How does the child try to adjust to the new threatening situation? The child who later is likely to develop an affective disorder tends to adopt special mechanisms. A common one (although as we shall see later, it is decreasing in frequency) is to find security by accepting parental expectations no matter

how onerous they are. The child does not reject the parents emotionally, or avoid them as the schizoid often does, but he consciously accepts them. He must live up to their expectations no matter how heavy the burden. It is only by complying, obeying, and working hard that he will recapture the love or state of bliss which he used to have as a baby; or at the very least he will maintain that moderate love which he is receiving now. Love is still available, but not as a steady flow. The flow is intermittent and conditioned, and therefore it does not confer security. The child feels that he will be punished if he does not do what he is supposed to, and mother may withdraw her love totally. At the same time that the anxiety of losing the mother's love occurs, the child is given hope that he will be able to retain this love or recapture it if and when it is lost. The child thus feels he has a choice, or the freedom, to retain the parental love. No matter what he chooses, however, he has a hard price to pay: submission or rejection. He also feels that mother is not bad in spite of her appearance; on the contrary, she is good. She is good even in punishing him, because by punishing him she wants to redeem him, make him worthy again of her love. Thus the mechanism is different from what occurs in many preschizophrenics; although the future affective patient has an image of himself as being bad, he does not feel that he is beyond the possibility of redemption as the preschizophrenic often does. The anxiety about being unable to fulfill parental expectations changes into guilt feelings. If affection or forgiveness is not forthcoming, the child feels that it is his own fault; he has

not lived up to what was expected of him, and he feels guilty. When he feels guilty he again expects punishment. He wants to be punished because punishment is the lesser of the evils; he would rather be punished than lose his mother's love. If he is not punished, he often works harder in order to punish himself.

A little later, but at a very early age, many of these children assume responsibilities such as the support of the family. If they engage in a career, it is often in order to bring honor and prestige to the family. In a certain number of cases, the family belongs to a marginal group of society because of religious or ethnic minority status or other reasons, and the child feels that it is his duty to rescue the family with his own achievement. In all these cases we can recognize a pattern of compliance, submission, and self-imposed hard discipline.

In some patients incestuous wishes toward parents and, as frequently, toward siblings of the opposite sex further elicit strong guilt feelings for which the patient feels he must atone by making even more rigid the pattern of relating that we have described.

Other findings make the picture more complicated and difficult to understand. For instance, the parents of some patients appear to be not strict, but overindulgent. This is possible because in this second stage of childhood

the parents do not need to enforce any rules with their actions. The rules, the principles, have already been incorporated by the child. As a matter of fact, some of the parents now regret that the children take rules with such seriousness.

Before proceeding to describe other possibilities in the early family life of the depressed adult, we must make some theoretical considerations which take as a paradigm the situation of compliance and submission that we have described. (We shall analyze variants later.) This interpersonal relation based on compliance and placation has predisposed the child to select and adopt specific ways of facing the world, others, and himself. We do not refer exclusively or predominantly to enduring patterns of behavior, but to ways of thinking and choosing that are related to the integrative activity of the child. At times this integrative activity remains only a predisposition to live according to some schemata. At other times the integrative activity leads to the organization of patterns as rigid as imprintings which last the whole life, especially if they are reinforced by repetition of the same events. These patterns of living do not consist only of movements, or of specific external behaviors. They are cognitive-affective structures which have been built as a result of learning, in the act of facing the early interpersonal situation. To be specific, they are built on the appraisal of external events, the ability to choose some actions instead of others, and the capacity to anticipate the effect that these actions will have on the interpersonal environment.

A theory based on the prevalence of certain cognitive constructs is at variance with psychological and psychiatric conceptions that exclusively see patterns of living as reactions to environmental situations. The concept of reaction which is derived from a behavioristic frame of reference implies almost total passivity in regard to the influence of the environment, and deterministic ineluctability. According to the interpretation offered in this book, the patient sizes up a particular environment and relates to it in the best possible way or, rather, interrelates in the roles of both subject and object. The cognitive construct which receives our major consideration in this book has to do with a person who is very important to the individual in question. I have called this person the *significant other.* The significant other, generally the mother, is the adult from whom the child expects nourishment, acceptance, recognition, love, and respect.

In the interpersonal relation that we have described, the child develops an attitude of excessive compliance in dealing with the significant other. Each individual relates to more than one person and also to groups; for instance, to the family in its totality. Nevertheless, I have referred to the significant other in the singular because at this stage of development the dyadic relation is by far the prevailing one. The interpersonal pattern of behavior that the child displays in relation to the mother and which he later generalizes to his dealings with other people can be seen to derive from the interpersonal branch of the basic construct that we are considering. However, the original

construct has another branch, the intrapersonal, which is expanding rapidly. It has to do mainly with the child's self-image; how the child sees himself in consequence of the way he believes other people think of him, and the way he evaluates himself as a consequence of the way he deals with people.

Each important construct can be seen as having a psychological bifurcation, with one intrapersonal branch and the other interpersonal. Both branches are intrapsychic—even the interpersonal one. They are internal structures that lead to certain external behavior and inner elaboration of this behavior. In the construct based on the relation of excessive receptivity and compliance that we have described, we can recognize a structure, a choice, a purpose—the realization of loss or threat and the attempt to cope with it.

We will now describe other situations and inner constructs and show how they predispose the patient to consequent patterns that make it difficult for him to do sorrow work, and thus make him likely to become depressed sometime in his adult life. In many instances we find that as a child the patient believed that he could reacquire love, approval, and consideration not just by complying, obeying, and working hard, but by converging all or almost all of his efforts toward a goal—for instance, toward becoming an outstanding man, a leader, an actor, or a great lover. In late childhood and early adolescence these aims were fantasized in terms of becoming a great scientist, writer, industrialist, winner of the Nobel prize, and so forth. In other cases the aim

was to find a great love or a mission. Although early in life this pattern was developed in order to please or placate the significant other, it soon became an aim in itself. The significant other lost significance and was replaced gradually by a significant goal. The patient came to live for that goal exclusively. His whole self-esteem and reason for living were based on reaching the goal.

To have goals and life aspirations is a common occurrence in normal children and adolescents. As a matter of fact, it is a desirable trait for the young individual to conceive of some directions for his life and even to have fantasies and daydreams about them. However, in the person who later becomes seriously depressed, the significant goal occupies the major part of the psyche and leaves no room for other goals, or for flexibility toward other possibilities. Unless the trend is later corrected, these children become not only achievement-oriented to the exclusion of other aspects of life, but oriented toward achieving only in a given way.

Unless they shift their orientation—and fortunately many of them do — already at a young age they appear self-centered and selfish, at times even oblivious of the needs and feelings of others, including those close to them. Whereas the individual who is concerned with pleasing the significant other maintains an important interpersonal relation, even one of dubious value, the person who lives for the significant goal tends to be aloof and self-involved.

A third important pattern with which the child tries to cope with the sudden change in environmental circumstances is the attempt to make himself more babyish, more in need of the significant other. He develops a pattern of dependency. If the child makes himself aggressively dependent, the mother or other important adults are forced to reestablish an atmosphere of babyhood or young childhood, that is, of early bliss. The child and later the adult will develop a very demanding and at the same time clinging, dependent type of personality.

Since the 1950s this last pattern of living has become much more common at least in the United States. The increased frequency may be related to different fashions of raising children. The child senses permissiveness in the family environment and believes that by making claims and being demanding, he will reestablish the previous position of blissful dependency.

We must clarify the fact that in spite of these predominant patterns being established in childhood, secondary patterns coexist in all patients who later develop an affective disorder. The child develops a strong resentment toward the significant other who in the first type of mechanism imposes so much, or who in the third type does not give enough. Such resentment manifests itself in attacks of rage, anger, rebellion, or even violence. When such anger becomes manifest, it is often enough to dispel an oncoming feeling of sadness. For this reason, some therapists believe that any depression hides

an underlying anger. This is true only to a limited extent: the anger is consequent to a situation which already existed and was unacceptable to the child. Anger alone is not a solution to the conflict-laden situation, although it may be a temporary defense against depression.

Feelings of anger in many cases are promptly checked and repressed, not only in childhood but throughout the life of the patient. Sadistic thoughts and impulses are at times very pronounced but seldom acted out. Consequent guilt feelings are brought about by these impulses, as well as feelings of unworthiness. The patient soon learns that rebellion does not pay: on the contrary, it increases the atonement he must undergo later. The stronger his sadistic impulses, the stronger the masochistic tendencies become. He soon desires peace at any cost, so that any compromise is worthy of peace. The mechanism which permits him to maintain a certain equilibrium is the repression of this resentment. However, the resentment is retained unconsciously, and it appears in dreams and occasional outbursts which do reach consciousness. In children and adolescents who have adopted the second pattern, there are also episodes of anger and rebellion. They do not want to sacrifice everything for the sake of the significant goal. They go on sprees of indolence, effervescence, or erratic behavior. These sprees, however, remain eposodic and do not become prominent features.

There is an additional dynamic mechanism which is found in some cases

of manic-depressive psychosis. The child senses that the acceptance or introjection of parents is too much of a burden and, without realizing it, shifts the direction of his incorporations to other adults in the environment (much older siblings, uncles, aunts, grandparents, friends, etc.) whom he internalizes instead of parents. Not only does the common tendency of children to introject adults become exaggerated, but peripheral adults become parentlike figures. The child unconsciously resorts to this mechanism in order to decrease the burden of the parental introjection, but in many cases this defense does not prove useful. As Fromm-Reichmann (1949) remarked, there will be no single significant adult to whom the patient can relate in a meaningful way. The relationship with these other grownups is again determined by a utilitarian purpose, duty, or role. The introjection of such adults eventually fails to provide what the child needs and may end by confusing him (how can he satisfy all the adults?) and increasing his burden and feeling of guilt.

Predepressive Personality

The personality of the patient who develops an affective disorder is partially determined by one of the three main inner constructs and related patterns of living described in the previous section, and also by what has been accrued or brought about with these patterns. Even after a pattern has become prevalent, the individual is capable of dealing with the environment

in a relatively large variety of ways. However, a certain rigidity of personality can be detected, and his future actions are more easily predicted. Finally the prevailing pattern becomes almost exclusively used.

First I will describe the personality of patients who have tried to adapt to their initial traumatic environment by adopting a pattern of placation. The first question which comes to mind is whether this type of personality corresponds to types already described in the psychiatric literature— for instance, to the compliant or moving-toward-people personality described by Karen Homey (1945, 1950).

This type of personality certainly has some characteristics in common with Horney's compliant personality, and perhaps it is a special variety of it. However, it has some characteristics of its own. Horney's compliant person manifests this attitude toward life in general and in many interpersonal exchanges, but the future severely depressed patient is more restrictive or discriminating. His placating attitude is manifested not toward life in general, but exclusively or at least in much more accentuated forms toward a person, the parents, or an institution. He generally converges the majority of his dealings on a person or institution. However, if we take into consideration a large number of these people, we find in them strong feelings of patriotism, religiosity, and loyalty to a political party or to their family. These people often wish to have a military or an ecclesiastic career. These institutions and

organizations are unconsciously or subconsciously experienced as parents to be placated.

Group loyalty and *esprit de corps* play an important part in the psychological constellation of this personality type. Under the pretense of belonging to a group, a close-knit family, or an organization, the individual hides his loneliness.

In many cases we find a self-conscious individual, always motivated by duty, with the type of personality Riesman et al. (1950) called inner-directed. Often this devotion to duty assumes the form of devotion to order. Abraham (1924) described the rigid need for order, cleanliness, and stubbornness of the predepressed person. He mentions also his perseverence and solidity.

Shimoda (1961), a Japanese author who has studied depression deeply, refers to the tendency of the predepressed to certain thoughts and feelings. These persons appear to Shimoda to have integrity and to inspire a feeling of reliance.

Tellenbach (1974), a German author who has studied melancholia from different angles, also describes how the predepressed person craves order, cleanliness, and regularity. He expects a great deal from himself and tries to do even more. Tellenbach reports accurate clinical descriptions of patients who throughout their lives were ruled by this need to search for order and

regularity, and to work as much as possible. Tellenbach does not try to explain, however, how this tendency originated.

According to my own experience, this type of predepressed person occasionally succeeds in overcoming some of his difficulties. He may even be able to channel them in original ways and become creative in special fields; but if he does not overcome his difficulties and spends all his energies to placate others, he does not unfold his creative possibilities and remains an imitator. However, what he tries to do, he does well. He has deep convictions and his life is motivated by principles. He must be a dedicated person. He is generally efficient and people who do not know him well have the impression that he is a well-adjusted, untroubled individual.

On the contrary, he is not a happy man.[2] He selects a mate not because he loves her, but because she "needs" him. He will never divorce the mate because she is in terrible need of him. At the same time he blames himself for being so egotistical as to think that he is indispensable. The necessity to please others and to act in accordance with their expectations, or in accordance with the principles that he has accepted, makes him unable to get really in touch with himself. He does not listen to his own wishes; he does not know what it means to be himself. He works incessantly and yet has feelings of futility and emptiness. At times he conceals his unhappiness by considering what he has accomplished, just as he conceals his loneliness by thinking of the

group to which he belongs. But when he allows himself to experience these feelings of unhappiness, futility, and unfulfillment, he misinterprets them again. He tends to believe that he is to be blamed for them. If he is unhappy or finds no purpose in life, it must be his fault, or he must not be worthy of anything else. A vicious circle is established which repeats itself and increases in intensity, often throughout the life of the patient, unless fortunate circumstances or psychotherapy intervene. Thus the inner construct that was described in the previous section becomes more entrenched and more and more acquires the originally conceptualized feelings of duty and guilt.

The patient often has partial insight into his own mechanisms but he does not know how to solve them. For instance, he is willing to accept the role in the family and in society which has been assigned to him, and yet later he scolds himself for playing this role, for not being spontaneous. But if he tries to refuse the role, he has guilt feelings. His conclusion is that no matter how he tries to solve his problems, he will feel he has made the wrong choice. A patient told me that she “felt like a little girl who pretends to be grown-up but is not. I am acting.” But she must live in that way; that was her duty. It was her fault that she “acted” and did not accept social behavior as being spontaneous or real-life.

The patient also tends to put his superiors or teachers in a parental, authoritarian role. Quite often he feels angry at them as they seem to expect

too much, or because they themselves have been found to be at fault. The patient does not know how to act: Should he continue to accept the authority of these people and the burden that acceptance implies, or should he remove them from the pedestal? But if he removes them, there will be a void. His authorities are part of him, his values, and the symbolic world upon which he sustains himself, and to do without them is impossible. Furthermore, he would feel very guilty. The patient often realizes (as Cohen and his co-workers illustrated, 1954) that he tends to underestimate himself. It is his duty to undersell himself. On the other hand, he tends to blame himself for underestimating himself and giving himself no chance to develop his own talents and potential abilities. The patient is becoming more rigid: what used to be a defense, or a practical way to get along sufficiently well with people in everyday living, becomes a character armor. At times the rigidity of thinking and acting slips into obsessive-compulsive symptoms. Some patients are often diagnosed, with with some justification, as obsessive-compulsive.

In spite of the characteristics so far described, in many cases the patient succeeds in giving the impression that he is able to live independently or be really involved in his work. In many cases, however, he eventually becomes anchored to a person whom he needs to please, follow, and receive approval from. At this point we recognize that the equilibrium he has been able to maintain is precarious and sustained mainly or exclusively in relation to the person whom he must please. This person is no longer the significant other;

at this point he is what I have called the *dominant other* (Arieti, 1962). The relation between the patient and the dominant other is not just one of submission on the part of the patient and domination on the part of the other. With this attitude are feelings of affection, attachment, love, friendship, respect, and dependency, so that the relationship is a very complicated one. The dominant other is experienced by the patient not only as a person who demands a great deal, but also as a person who gives a great deal. And as a matter of fact, he either does give a great deal or is put by the patient into a giving role. The patient can no longer accept himself unless the dominant other accepts him, and he is unable to praise himself unless the dominant other praises him or is interpreted by the patient as praising him. As Bemporad wrote (1970), the patient is incapable of autonomous gratification. The fundamental characteristics in the relationship are the inequality in the two roles and the fact that the patient is so anchored to the dominant other that he cannot establish a deep or complete relation to any other person. Although this state of affairs was tolerable when the significant other was the mother and the patient was the child, it is no longer so and becomes maladaptive. The same construct that was applied to the childhood situation is used, and in some respects it has become more inflexible than it was then.

The dominant other provides the patient with the evidence, either real or illusory—or at least the hope—that acceptance, love, respect, and recognition of his human worth and meaning of his life are acknowledged by

at least one other person. The dominant other is represented most often by the spouse. In the predominantly patriarchal structure of our society the dominant other is often the male and the submissive partner is the female. We shall return to this aspect of the problem in greater detail later.

Far less often in the role of the dominant other are, in order of frequency, the mother, a person to whom the patient was romantically attached, an adult child, a sister, the father. The dominant other also frequently is represented, through anthropopathy, by the firm where the patient works or a social institution to which he belongs such as the church, a political party, the army, a club, and so forth. All these dominant others are symbolic of the depriving mother, or to be more accurate, of the once-giving and later depriving mother. If the real mother is still living and is the dominant other, she acts in two ways; her role is actual in the present and also symbolic of her old role. If the dominant other dies, he becomes even more powerful through the meanings attached to his death.

The second type of predepressed person, who is characterized by the pursuit of a significant goal, gradually becomes haunted by a dominant goal. The dominant goal is omnipresent, always lurking about; it determines most actions of the patient and excludes many others. The goal as a rule is grandiose, like winning the Nobel prize or becoming the chief of the firm, and the actions of the patient can be interpreted as being motivated by the

attempt to attain what his grandiose self-image demands. However, I do not believe that the dominant goal is exactly the same as the grandiose image described by Karen Homey (1945). Again, perhaps it is a variety of her concept, the variety which occurs in people prone to develop a severe depression.

The dominant goal is conscious, although the patient is not aware of the magnitude of its role and all its ramifications. The dominant goal seems more plausible and more realistic than Horney's idealized image: some people do reach their dominant goal. The patient certainly works hard and does his best to reach it. Although he is a daydreamer, his investment in achievement is used not only in daydreaming, but in acting as efficiently as he can. He does not postpone. The attainment of the dominant goal seems to be motivated by a thirst for glory. In most cases, however, it is more than that; it is a search for love. Unconsciously the patient feels that he will be worthy of love from others or from himself only if he succeeds in achieving the dominant goal. Often at a conscious level too, the search for the dominant goal coincides with the search for a perfect love.

Not so subtle as in the other types of predepressed personality is a relationship of dependency in which the mechanism of obviously leaning on mother and maternal substitutes has been adopted after the initial trauma in childhood. Contrary to the types previously described, this third type includes

people who even at a superficial examination appear maladjusted. These patients have never forgotten the bliss of their first year of life and still expect or demand a continuation of it. They demand and expect gratification from others, and feel deprived and sad when they do not get what they expect. They are demanding but not aggressive in the usual sense of the word, because they do not try to get what they want through their own efforts: they expect it from others. They have not developed that complex of duty and hard work typical of the complying, introjecting patient.

These patients alternate between feeling guilty and having the desire to make other people feel guilty. They generally find one person on whom to depend, and they make this other person feel guilty if he does not do what they want. The sustaining person (generally the spouse) is empowered with the capacity to make the patient happy or unhappy and is supposed to be responsible for the patient's despair and helplessness. He also plays a dominant role in the life of the patient, but only because the patient expects a great deal from him, not because he makes demands on the patient. Relatively often in this group we find women who depend entirely on their husbands, who are generally much older. In these cases the dominant other is not only the person who is supposed to accept, love, respect the patient, but also the person who protects and gives material things. At times the request is immense: the patient almost seems to request, metaphorically, milk or blood.

In some cases there is an apparent variation in the picture when the patient tries desperately to submerge himself in work and activities, hoping that eventually he will find something to do which will make him worthy of recognition from other people. Whereas the first two types of predepressed persons looked inward for a solution to their conflicts, the third type looks externally for the solution.

A fourth type is observed in some patients who develop manic-depressive psychosis. It is manifested either as the prevailing type of personality or as a temporary characterological structure which from time to time replaces one of the three pictures previously described. This fourth type, the forerunner of the manic, is lively, active, hearty, and friendly. On closer scrutiny the person's apparent health and liveliness are found to be superficial. In a certain way the patient actually escapes into actions or reality, but he remains shallow and dissatisfied. If he happens to be engaged in work in which action is required rather than concentration, he may do well and maintain a satisfactory level of adjustment; otherwise he may sooner or later get into trouble. He claims that he has many friends and the interpersonal relations seem warm and sincere, but they are superficial and lack real kinship. One patient said, "I joke, I laugh, I pretend; I appear radiant and alive, but deep down I am lonely and empty." This type of person is only in certain respects the opposite of the duty-bound individual. He tries to escape from his inner-directedness, but he does not correspond to what

Riesman called the “other directed” person. Imitating Riesman’s terminology, we could call this hypomaniclike person outer-directed but not other-directed. He does not escape into others; he escapes from his inner self, because the inner self has incorporated the burdening others. He escapes into the world of superficial reality where meditations, reflections, or deep emotions are unnecessary. His main attitude can be interpreted as a great denial of everything which, if admitted, could lead to depression.

Such an individual may at times seem so free as to be considered psychopathic. Actually, it is his deep concern with conventional morality that often leads to this pseudopsychopathic escape. Some of the pseudo-psychopathic hypomanics have demonstrated asocial behavior since childhood when, for example, in order to escape from inner and external restrictions, they ran away from home or school.

These affective, prepsychotic personality types are seldom seen in pure culture. When the patient changes or alternates from one of the first three types of personality to the fourth, he presents the so-called cyclothymic personality.

The Development of the Severe Attack

The types of personality described in the previous section lead not to a stable equilibrium, but to an almost constant state of dissatisfaction and

sadness (or, in some cases, hypomanic denial of sadness). If we closely examine the period of time that precedes the depression—and this period may vary from a few days or months to decades—we see a crescendo of maladjustment which is contained only by the defenses that have been described. In this unstable background, obvious and realistic factors often bring about a full-fledged attack of severe depression. These specific precipitating factors are distinct events in the life of the patient, and are not necessary in any absolute sense. However, since they occur in the most typical cases and clarify the psychodynamics of severe depression in general, I shall discuss their occurrence and import. Later we will examine the cases in which precipitating factors cannot be individuated.

The main precipitating situations may be classified into three categories: (1) the patient's realization that his relationship with the dominant other has failed; (2) the death of the dominant other; and (3) the patient's realization of having failed in his attempt to reach a dominant goal, and his subsequent negative reevaluation of the self-image.

These situations are considered separately for didactic reasons, but they have a single and common basis: the loss of something very valuable. This "something," even if represented by a concrete situation, transcends the reality of the concrete situation. At times the loss has not yet occurred, but the knowledge that it is impending seems so certain to the patient that he

experiences depression instead of anxiety. The precipitating event causes a great deal of anguish or psychological pain, which is felt very intensely for these reasons:

1. The patient's cognitive appraisal of the event leads him to realize that it will cause a disorganization of his life structure and self-image.

2. His main cognitive construct and pattern of living will no longer enable him to cope with the situation. This realization reevokes what can be pictured as a distant but resounding echo of the pain sustained early in life, when the patient felt he had lost the love of his mother or the mother substitute. The present loss has the same value as the loss of the mother's love.

3. The patient realizes that all the methods which he used to prevent the catastrophe have failed.

4. He also believes that the methods he used were the only ones he could use or knew how to use. Thus he finds himself in a situation of helplessness. He cannot put into practice the methods used by the normal person recovering from normal sadness. For the patient, using alternative courses is an impossibility. Thus he cannot do sorrow work.

5. Instead, his sadness becomes depression, which continues to increase in intensity.

The development of these psychological events will be described in greater detail in the following sections.

Depression Following Deterioration Of The Main Interpersonal Relation

The situation in which the patient realizes the failure of his main interpersonal relation (the relation with the dominant other) is in my opinion the most typical of those which lead to severe depression. Thus it will be described in detail, the other situations, which will be examined later in this chapter, will be described only or predominantly in those aspects which differ from the situation we are now examining. Depression following deterioration of the main interpersonal relation occurs much more often in women, so I shall refer to the patient in the feminine gender. It is to be understood that the same situation takes place in a considerable number of male patients.

Events that have drastically affected the life of the patient may have occurred recently. The husband may have asked for a divorce, or may have been discovered as having an extramarital affair. Often, however, a few disparate happenings, certain decisions which have been made, or a review of one's life have induced the patient to reexamine her marital situation. At times the effect of the precipitating event was unforeseeable: reading a book, or seeing a play or a movie which revealed itself full of psychological significance for the patient. The marital partner— whom the patient

considered a protector, a pillar on whom she depended entirely, a distributor of love, sex, affect, approval, food, and money—is now seen as an authoritarian person who imposes his rule at times in a subtle, hardly recognizable fashion, at other times in an obvious way. The patient's life, believed to be devoted to affection, family care, doing hard work, or the nourishment and reaffirmation of love, is now seen as a nongenuine life. The patient has denied many aspects of living because she wanted peace and approval at any cost. She has been excessively compliant, submissive, and accommodating. By always doing what the husband wanted and by denying her wishes, she has not been true to herself; as a matter of fact, she has betrayed herself. In some cases the patient may exaggerate and see the authoritarian husband as a tyrant, somebody who deserves not love but hate, somebody who wants to enslave her and change her real nature. In most cases she does not realize that she also has played a role in establishing this type of interpersonal relation. She has done so with her submissiveness and ingratiating attitude, by accepting the patriarchal model of society, or by making the dominant other believe that she was perfectly contented or even happy with this state of living. She has indeed submitted herself, bent her head, and allowed herself to be transformed against her real wishes. There is nothing wrong, of course, in adopting the husband's ways of living if the wife really wishes to do so or because she genuinely believes they are better or more adequate than her own. But if she accepts them only to placate the

spouse, and if she deceives herself into thinking that she likes these changes in her way of living when she really does not, she injures herself.

The new evaluation of her husband—the kind of dominating person he really is—is not easily accepted. A normal person would accept the new appraisal, no matter how painful it was, and try to do her best with what remained of her life (separation, divorce, other affections.) But the patient cannot. She cannot bring herself to conclude that she has wasted her life. She still needs the same dominant other to praise her, approve of her, and make her feel worthwhile. How could he continue to play that role if she expressed hate, rebellion, or in some cases even self-assertion?

Thus the patient finds herself in a situation in which she cannot change her cognitive structures. She has reached a critical point at which a realignment of psychodynamic forces and a new pattern of interpersonal relationships are due, but she is not able to implement them; and this is her predicament. Often she denies her negative appraisal of the dominant other and of her life—that is, she represses her ideas—but the feeling of sadness remains conscious and is intensely experienced. Inasmuch as she cannot organize alternative structures, such as new plans for her life and new ways of evaluating herself as a person, she feels helpless. She cannot do what normal people resort to in order to solve their sorrow.

The anguish is experienced and retained, and as a rule becomes more and more pronounced. The sorrow is replaced by an overpowering wave of depression which submerges every idea. A few very painful thoughts remain. Eventually almost all ideas become unconscious and the patient is only aware of an overpowering feeling of depression. The slowing down of thought processes is also responsible for the decrease in mobility that the patient shows at this point. Movements and actions, in order to be implemented, must be preceded by ideomotor activity which is now greatly decreased. The slowing down of thought processes is, however, a self-defeating mechanism. At this point, constellations of thought continue to activate the depression even if they are unconscious. If we ask the patient why she is depressed, often she does not know.

At times a few thoughts remain as conscious, cognitive islands in the ocean of the depressive feeling. The patient may feel very guilty. The guilt is caused by emerging thoughts that offer a new evaluation of the dominant other. The patient feels guilty for seeing him in so bad a light when she used to see him as a saint to be revered and respected. In her depressed condition, she is generally not able to trace the guilt feeling; she just feels guilty and may give absurd explanations for her guilt. She has done “terrible things,” and so forth. In many instances hate for the husband is not repressed to such a degree that the patient cannot feel guilty about it. On the other hand, if she were able to deal with this hate at a fully conscious level, she would be able to

change the situation less inadequately. As a matter of fact, she could even realize in certain cases that her hate was too strong a feeling, and not congruous with the circumstances. But she cannot face what she believes would undermine the foundation of her life and prove the futility of all her past efforts. Thus she represses her hate and she continues to follow a pattern of silent submission. Even when she was not so sick, she did not reveal or admit to her friends the hostile feelings for her husband.

The guilt feeling to which we have referred often assumes such a predominant role as to confer to the symptomatology the picture of self-blaming depression, the manifest aspect of which was described in chapter 3. Special characteristics of the environment either facilitate or make less probable the occurrence of guilt feelings, as will be described in chapter 16. The self-blaming picture is much less frequent now than it was until the middle 1940s. Nevertheless, even at present this picture is observed quite frequently.

The guilt feelings continue in these patients a trend started in childhood, that no matter how much the patient docs to remedy the situation, it is not enough. Later she feel that it is her fault that the relationship with the dominant other has not worked out. Finally, she feels guilty, as has been described, for feeling in such a negative way toward her husband. When the patient reaches the state of severe despair and blames herself, suicidal ideas

occur with progressive frequency.

The number of suicidal patients is greater in men. Thus I shall refer again to the patient in the male gender.

The patient who blames himself seems to send a message: “I do not deserve any pity, any help. I deserve to die. I should do to myself what you should do to me, but you are too good to do it.”

As the suicidal ideas recur, the patient may make a suicidal attempt which in a considerable percentage of cases is successful.

At this point we must try to understand the significance of the suicidal attempt. Several hypotheses have been advanced.

I. The patient wants to punish himself.

II. He wants relief from suffering or an end to a worthless life.

III. He wants to kill symbolically the dominant other.

IV. The suicide has no meaning. It is just an indication of the worsening of the biochemical alteration which brought about the depression.

In accordance with the general character of this book, we shall consider only 1, 2, and 3. The first two possibilities are self-contradictory or self-

exclusive until seen from the standpoint of the emotional state of the patient. The feeling that it is better to die than to suffer so much is certainly experienced. The patient would not carry out the suicidal ideas, however, if they were not reinforced or sustained by the other idea that he deserves to die and he must inflict the supreme punishment on himself. In some cases it is possible to retrace in the patient who has attempted suicide the notion that he was making a desperate effort to redeem himself by punishing himself. Probably in a subconscious, nonverbalized way the patient feels, "Punish yourself and you will be accepted again. You are acceptable but not accepted. Forgiveness is eventually available. The intermittent love will be given again." Of course, if the patient is dead he cannot receive love, but this is a realistic consideration which he cannot conceive of at the present time. Or perhaps he believes that he will be forgiven and loved in the memory of the survivors. Thus two or more logically self-contradictory motivations coexist and reinforce one another.

The orthodox Freudian interpretation holds that suicide represents the attempt to kill the detested person who has been incorporated—in the terminology used here, the dominant other.

As I mentioned in a previous section, the individual who is prone to this type of psychotic depression has totally accepted the Thou since his early infancy. At times he lets the Thou suffocate or smother the I. In this light, the

suicidal attempt is the culmination of the process; it is the Thou who finally kills the I, not the I who kills the Thou. If the I killed the Thou, there would be a complete and sudden reversal of the previous and constant trend of self-denial. Rado (1951) ingeniously tried to solve the problem by assuming that the superego (the Thou) is divided into two parts, one which the patient wants to love and another which he wants to kill. However, I am convinced that, at least in my clinical experience, the patient really wanted to kill himself. But by killing himself he would achieve a complete acceptance or introjection of a distorted image of the Thou.

There are several other factors that support this point of view. First, many cases of suicide seem to occur not when the state of melancholia is at its peak but at an early stage of remission, when the worst is over. This characteristic may of course be interpreted in various ways. The first explanation is simple and mechanical: when the patient is very depressed, he is in or almost in a stupor; he cannot act, he is extremely slow or immobile, he cannot move or think coordinately, and therefore he cannot carry out his intentions. When he becomes less retarded and more capable of coordinating his thoughts, he goes ahead with his destructive intention. The alternative possibility is that the patient who has gone through terrible experiences at the acme of his depression is afraid that these experiences may recur and, rather than face them again, he prefers to die. (This of course corresponds to the first possibility mentioned.)

Another interpretation is possible: the patient who has a great deal of guilt feels that even the most severe depth of depression has not been enough; it has not succeeded in relieving him entirely of his guilt, and only by killing himself will he entirely redeem himself.

This last interpretation is supported by other factors. Significantly, there is almost complete relief after the suicide attempt. The Freudian interpretation would lead one to expect an increase in guilt feeling (for having attempted but not actually succeeded in killing the superego) and a consequent increase in depression. As Weiss (1957, 1974) and others have emphasized, in the attempt itself—that is, in gambling with death—the patient feels that he has been punished adequately. He has done what the Thou wanted and now he can live peacefully. Often there is no need for the suicide attempt; after having gone through the acme of his depression, the patient feels suddenly relieved, and a marked improvement occurs.

According to Kolb (1959), "The suicidal maneuver is often determined by family-indicated permission for acting out." In his clinical experience, the psychodynamic explanation of acting out which has been given for other antisocial acts is also valid for suicide: in families where suicide has occurred, the likelihood of suicide for the manic-depressive patient is much higher than otherwise. Where suicide has not occurred, one usually finds threats of suicide or intimidating actions suggesting suicide on the part of the parents.

Through many years of practice I have found, however, an increasing number of patients who did not feel guilty and yet had decided to put an end to their "worthless" lives. In several cases there was a confusion about whether the patient considered life, at least his own, or himself to be worthless. The only certainty was the horrible mental pain which had to be terminated at any cost.

The relief experienced by the patient after an acute attack of depression is remarkable. The patient feels guilt-free and accepted, and wants to settle down in his own life. Even reality seems pleasant, and he does not want to be alone; he wants to be close to the mate. This attempt, however, will not work out unless successful therapy intervenes. The patient who improves after the nadir of depression, whether or not this nadir led to a suicidal attempt, eventually will feel depressed again. The relatively free interval may last a few hours, days, weeks, months, or longer.

The improvement or depression-free interval is susceptible to several hypothetical interpretations. One is that the patient feels he has expiated his guilt. However, another one seems to me more plausible and consonant with what several patients in psychotherapy have told me. An idea presents itself which somehow succeeds in cutting the main line of depressogenic cognition and flashing a lesser, more hopeful, but secondary cognitive structure. This lesser structure may have always existed or, more seldom, have been

provided by an unexpected external event. The secondary cognitive structure in some cases may be organized and increased to the point of offering considerable relief. In many cases, however, the predominant depressogenic structure tends to acquire the upper hand and the patient becomes depressed again.

In some untreated cases the depression may become chronic and severe; in others it remains chronic but less severe; and finally, it may alternate between being severe and mild. At the present stage of knowledge we cannot be absolutely sure why some untreated cases of severe depression become intermittent, improve, or even recover. For some unpredictable reasons they eventually become capable of escaping from the rigid cognitive construct and finding alternative patterns.

Some patients, especially those who could be classified as suffering from manic-depressive psychosis, are able to change the depression into a manic, hypomanic, or mini-manic attack.

In the manic attack the Thou is not eliminated or projected to the external world; it is only disregarded. The patient must continue to force himself into a distracted and frenzied mood which shuts out not only introspection, but any well-organized thinking. In the manic state there is no elimination of the Freudian superego, as perhaps there is in some

psychopaths. The superego is very much present, and the manic frenzy is a method of dealing with it.

But neither the depression nor the manic attack actually bring about a solution to the deeply rooted conflicts. Even after having paid the penalty of the severe attack, many patients (but not all) will have a more or less free interval and then tend to be affected again by the same difficulty, which will be channeled into the same pattern—with the cycle likely to repeat itself. Moreover we must realize that this type of depression, as well as all the others that shall be discussed in this book, becomes the fundamental and habitual mode of living. As we shall discuss later, the patient selects depressive thoughts (Beck's depressive triad) to sustain the familiar mood. Little disappointments, losses, or accidental happenings that lead the patient to self-accusation, guilt, or severe depression are actually symbolic of an earlier and greater disappointment, or of lifelong disappointment. Kraepelin (1921), to show the relative unimportance of psychogenic factors, reported a woman who had three attacks of depression: the first after the death of her husband, the second after the death of her dog, and the third after the death of her dove. From what has been discussed so far, it is apparent that each of these deaths was not necessarily traumatic per se. One may guess that the death of the dove reactivated the sorrow the patient had experienced at the previous deaths, and it was also symbolic of a much greater loss, perhaps of the meaning or purpose in her life.

So far I have interpreted psychodynamically attacks of severe depression caused by the realization of the failure of an important interpersonal relation, as in the case of a patient who follows a pattern of submission and placation in her relation with a dominant other. The patient who instead follows a pattern of dependency and eventually develops a symptomatology of the claiming type, at a certain point in her life realizes that she no longer can depend on this interpersonal relationship. Without being aware of it, to a considerable extent she still is claiming the lost paradise or the bliss of the early life when she was completely dependent on the duty-bound mother or mother substitute. As the patient makes herself dependent on the dominant other and becomes more demanding, she feels more deprived. Any unfulfilled demand is experienced as a wound, a serious deprivation, an insult, or an irreparable loss, and it brings about an unpleasant feeling of sadness which cannot be solved and is followed by depression.

The new way of experiencing the relationship with the dominant other is based on the fact that the affect or love which reassured her and in whose name she expected a great deal is now recognized as uncertain, insincere, unreliable, about to finish, or finished already. She too does not love the husband anymore, and therefore she feels she cannot expect much from him. The sad reality, however, is that she depends on him psychologically, economically, and socially, and she cannot do without him. Like the previous

type of patient that I described, she finds herself in a trap from which she cannot escape. She becomes more and more depressed and suicidal. In these cases the suicide attempt seems to convey the message, "Do not abandon me. You have the power to prevent my death. You will feel guilty if you don't give me what I need and let me die." However, there is a feeling of hopelessness, the feeling that the dominant other will not listen to this appeal and will let her down. For a certain number of patients in this category the dominant other is not the spouse, but one or both parents. Many patients have always remained dependent on their parents. Although they would like to be free of them to go on their own, be self-supporting, and get married, they cannot. They are caught again in a vicious cycle from which they cannot escape (dependency and resentment or hate for the persons on whom they depend). Perhaps more than any other patients, they represent those described by Abraham who, as a consequence of early love deprivation, remain fixated at oral erotism and maintain a general dependency on people.

Depression Following Death, Loss, Or Disappearance Of The Dominant Other

In these cases depression occurs when the dominant other is no longer available. The most common cause is death. Cases involving divorce will not be considered here because the separation was caused by a failure of the interpersonal relation, and these cases are therefore included in the previously described category. However, some cases in which one spouse

suddenly abandons the other, gives ultimatums, or unexpectedly declares his intention to dissolve the marriage may represent a mixture of the two categories.

Less common precipitating factors of severe depression are loss of friendship, companionship, affection, or approval because a person close to the patient moved away or got married and had to exclude the patient or relegate him to a minor role.

Contrary to the typical cases in the first category, the patient at a conscious level does not feel abandoned by the dominant other on account of failure in the relationship; rather, it is because of circumstances beyond his control such as death or moving to a distant location for reasons of work. Whether the patient considers these causes legitimate is debatable: in most cases there is no doubt that at least unconsciously the patient considers the dominant other responsible for leaving, even if he left because he died. He should not have allowed himself to die. There is also no doubt that some patients feel, even at a conscious level, responsible for the disappearance or death of the dominant other. If they had treated him better, he would not have died. Instead the bad behavior of the patient has made the dominant other unhappy and sick or more likely to die. Thus the patient has “killed” him or her.

In other cases the patient feels guilty because in moments of reemerging resentment he recognizes that he wished the death of the lost person. The wish has now become reality: to the wish is attributed the primitive power of engendering reality. The patient accuses himself of having entertained the murderous desire.

All these interpretations connected with guilt are derivatives of Freud's concept that guilt and self-depreciation are diverted anger which was directed originally toward the love object (our dominant other). As I have already mentioned, however, guilt does not seem to play such an important role as it did once. Perhaps it will reacquire importance in the future.

Bemporad (1970) has advanced another explanation. The patient, who was totally dependent on the dominant other for self-esteem, acceptance, approval, and appreciation, realizes that he cannot depend on him any more. And yet he is incapable of "autonomous gratification," of supplying what he needs to himself. He becomes sad and then depressed because of being deprived of this gratification. In other words, the depression is the result of deprivation (emotional and cognitive). Bemporad's interpretation is valid in some cases of severe depression, as well, but with support from other factors that complicate the picture. First, I must stress that for the reasons illustrated earlier in this chapter, the patient is incapable of finding cognitive-affective alternatives to what was provided by the former dominant other. Second, the

patient does not want to believe that the dominant other could be substituted. He rejects the possibility because to admit it would be tantamount to conceding that the dominant other was not indispensable in the first place. This conclusion, if accepted, would require a reassessment of the patient's whole life and might induce a state of panic that the patient cannot even contemplate. Thus he is still motivated to think that the dominant other was indispensable and irreplaceable. Whenever reality indicates the opposite—that life can be worthwhile even without the dominant other —such possibility is assessed in a distorted way, appears threatening, and may bring about further depression.

Depression Following Realization Of Failing To Reach The Dominant Goal

This type of depression occurs among men more frequently than depressions which follow other patterns, but in terms of absolute incidence this depression too is more frequent among women. The goal most frequently experienced by women as not achieved or not-to-be-achieved is romantic love. Being unloved for them means being unlovable. Thus what is disturbing is not only the lack of the joy of love, but the injury to the self-image. However, the cultural and social changes which are rapidly taking place in the status of women have already diminished the frequency of unachieved love as the precipitating factor of severe depression. To be exact, love does remain an important precipitating factor when it is lost, as described in the previous

category. It is less frequently the precipitating factor of severe depression in the role of a dominant goal which has not been achieved.

In men the dominant goal which most frequently precipitates a severe depression, because it is experienced as not achieved or not to be achieved, has to do with work and career. Here too, the most traumatic part of this realization is in what it does to the self-image. Certainly the patient is very interested in his career and work, but the depressive elements are his cognitive ramifications—mostly unconscious or only dimly conscious—that associate work and career with what he and others think of him, and with his being a worthwhile person and deserving love. Now he has come to the realization that he is not going to be a great lawyer, doctor, politician, actor, writer, lover, industrialist, inventor, musician, and so forth. He cannot go into another field or give up his ambition because his whole life has been centered on the achievement of this particular goal. Nothing else counts: after this dramatic realization, life seems worthless to him; as a matter of fact, it seems painful and hard to endure.

If he wanted to be a great conductor—a Toscanini—now he has to face the fact that he is not a Toscanini; he is himself, John Doe. But he has no respect for John Doe, and he believes John Doe is nothing. There is some justification in the patient's assessment of himself in this negative way because he spent so much of his thoughts and daydreams in being a

Toscanini, and his psychological life without this overpowering fantasy seems empty. Thus we must realize that the depression is not only a mourning of a fantasy; it is the mourning of a large part of one's life spent at the service of a fantasy. This explains why the depression can reach such depth and be so persistent.

This sequence of thought processes and accompanying negative feelings is made possible by the limitations of the patient, by his inability to find solutions. At times the patient may visualize alternatives, but they seem to him either unsurmountable or not worthwhile. The inability to shift to different ways of living is not due to congenital defect or to lack of intelligence, but is only the result of a life history characterized by rigid adherence to those life patterns that were described earlier in this chapter. This inability of which the patient is often unconscious can be overcome totally or to a large extent by proper psychotherapy.

In some cases the psychodynamic picture is more complicated. The patient feels that he has not been true to himself, or he has not run after the goal in the right way. For instance, he wanted to be a great conductor like Toscanini, but instead he pursued business, money, women, and so on. Now he finds himself trapped: his sadness has become a severe depression from which he does not know how to rescue himself.

Special Cases And Conclusions

Cases that do not fit exactly into the previously mentioned categories but which partake of some of their characteristics are very frequent. I shall mention the most common combinations. The depression may occur after the patient has been dismissed from an institution, organization, or company to which he devoted the prime of his life. This disappointment is often experienced as due to the loss of employment. As a matter of fact, Malzberg (1940) found that during the economic depression of 1929 to 1937 the effect of loss of employment or financial loss was statistically evident in manic-depressive patients. In 1933, for instance, 26.2 percent of first admission patients in New York state hospitals who were diagnosed as manic-depressive presented loss of employment or financial loss as the precipitating factor, whereas in the same year only 9.6 percent of first admission patients with the diagnosis of dementia praecox (schizophrenia) presented financial loss as a precipitating factor.

In some cases, not dismissal but failure to obtain a promotion is the precipitating factor. In these cases the trauma is sustained partially as a loss of a nonpersonal dominant other, and partially as failure to reach or retain the dominant goal. The source of gratification is lost as well as a gratifying self-image that the patient could maintain only through his association with that particular organization.

Depression, often leading to suicide, occurs quite frequently in unmarried men after retirement. They feel suddenly deprived of their only aspect of gratification. In women, depressions occur frequently, but not as frequently as they used to, during or about the time of the menopause, as we shall see in greater detail in chapter 12.

Depressions occur relatively frequently in twins, especially female identical twins. Although my statistics are very limited, I can say that I have found nothing specific in these cases except the psychological picture derived from being a twin. Generally one of the twins assumes the role of the dominant other and the other takes on the submissive or dependent role. The dominant other plays the role of leader, teacher, and mentor; the submissive twin plays the role of the follower, pupil, and child. In these cases the parents have played a secondary role because of their advanced age, detachment, illness, or geographical distance; and they have always remained pale figures, thus permitting one twin to acquire a parental or dominant role. When the dominant twin withdraws his support, or gets married, or separates from the submissive twin, the latter undergoes a severe trauma, experiences a feeling of helplessness, and often becomes depressed.

Less typical but more frequent, especially among females, are cases in which two siblings, not twins but close in age, live in the same dyad of dominant-dominated. In these cases the parents also have played a parental

role which has been less effective than usual and which has been assumed in quite an inappropriate manner by the dominant sibling. The submissive sibling tends to become depressed whenever there is a disruption in his relation with the dominant sibling or whenever he has to revise the image of the sibling which he has incorporated.

In some patients an attack apparently is precipitated not by a loss, but by what may even seem a pleasant event. For instance, women in their forties or fifties who may have undergone previous subliminal attacks of depression can develop a severe attack shortly after the marriage of an only son or daughter. Here the event is experienced by the patient not as something pleasant but as a loss. The child whom the mother needed so much, and who was her only purpose and satisfaction in life, is now abandoning her.

In other cases an attack occurs after a promotion, which is interpreted by the patient as a new imposition that he is unable to cope with. The patient is tired of new duties and, furthermore, the new position with its added responsibility removes the security the patient had established with painstaking effort. In other cases the individual who is faced with promotion dreads the expected envy and rage of previous associates to whom he is closely bound. The expectation of such emotions in others separates him from them and thus leads to feelings of loneliness and depression. In all these cases there is difficulty in abandoning the old patterns of living which conferred

security to the patient, and inability to find alternatives suitable to the new conditions.

If we now try to abstract from all the human conditions that we have described in this chapter what leads to a severe depression, we can say that it is the experience of a loss of what seems to the patient the most valuable or meaningful aspect of his life. Even more crucial is the feeling of being unable to retrieve or substitute what has been lost.

At times the severe sorrow of the depressed person acts also as a representation of what was lost, because as long as the sorrow remains, the loss is not complete. In these cases the sorrow is like the faint image of a lost hope, the shadow of the absent, the echo of a voice heard repeatedly—perhaps with ambiguous resonance, but also with some affection, respect, and love.

At other times, implicit in the experience of loss, is the feeling that life has become unworthy or meaningless. At still other times the patient realizes that the meaning he has given to his life is inappropriate or unworthy, but if he renounces that meaning his life sustains the greatest possible loss: it becomes meaningless. His pain bespeaks his refusal to see life in that way.

Notes

[1] Some statistical works, however, seem to indicate that the first-born child is more liable to manic-depressive psychosis. Of course the first-born child also is more liable to be displaced. Berman (1933) in a study of 100 manic-depressives found that 48 were first-born, 15 second, 10 each third and fourth, and 17 fifth or later. Pollock and co-workers (1939) found that 39.7 percent were first-born and 29.7 percent were second-born. Malzberg (1937) and Katz (1934) could not find any relationship between birth order and manic-depressive psychosis.

[2] As is customary in English, I refer to the general patient as *he* and consider him in his male role. However, as I shall mention later in this chapter, women with this type of personality are more numerous than men. In some special situations which are described later, in which women outnumber men by far—at least in the ratio of two to one—I shall refer to the patient by using the feminine gender.

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