PSYCHOTHERAPY OF SEVERE DEPRESSION

CASE REPORTS

SILVANO ARIETI, M.D.

Severe and Mild Depression

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Silvano Arieti

In this chapter the case of Doris Fullman[1] is reported in detail. The other cases are described briefly and only in their essential aspects. All these patients have been treated exclusively with psychotherapy from the time they started office treatment. Although described in detail, the case of Doris Fullman is not examined in all its possible aspects. Some inferences have been omitted because they are relatively easy to make, and their omission may give the therapist in training an opportunity to fill the gaps. Other inferences have been omitted because they are so difficult to make and they are uncertain: their omission will stimulate the reader to venture his own interpretation.

Doris Fullman

The last day of March 1967, Mr. Andrew Fullman came to my office, having requested a consultation by phone. He promptly told me that it was not for himself that he came, but on behalf of Doris, his wife. Doris, a fifty-eight year-old Jewish woman, had been in a psychiatric hospital and was not getting better. The hospital staff did not know what to do. All types of treatment, drug therapy, shock therapy, psychotherapy, and milieu therapy had been tried with no appreciable result. His wife was still very depressed

and suicidal ideas persisted.

Mr. Fullman added that this depression was not the first in his wife's life. Although she had been depressed several times, the first time she became seriously depressed was after the birth of the first of their three children. He was told at the time that probably his wife's depression was related to the fact that during her pregnancy she had developed high blood pressure. A second very severe depression developed much more recently, after the mother of the patient died. I inquired about the relations between Doris and her mother, and Mr. Fullman said that the mother had been rather authoritarian, overcritical, and demanding, and she had never approved of Doris. The mother had been a "son of a bitch." Upon my probing, Mr. Fullman told me that his marriage was a happy one, although Doris had felt somewhat deprived sexually. He did not elaborate on this topic. He stressed the point that Doris wanted to go home, but the hospital would only discharge her against medical advice because of her suicidal tendencies, and he did not know what to do.

I told him that I would call the hospital, talk to the doctors in charge, and then we would make some decisions. He said that he would wait for my call. He hoped I would call very soon. It was now his vacation time and he had decided to go on a cruise, although sorry to go alone and without his wife.

I called the hospital and got a most pessimistic report. The patient was suffering from a severe depression and was in a group of patients constantly watched for the possibility of suicide. The fact that the depression had not lifted after such a long time made several members of the staff suspect that an underlying schizophrenic disorder was probably at the basis of her condition, although hallucinations, delusions, and ideas of reference were never elicited. From the beginning of her hospitalization, Mrs. Fullman had received high doses of Tofranil® with no result, but recently her medication had been changed to Thorazine® (200 mg q.i.d.), Stelazine® (2 mg b.i.d.), and Artane® (2 mg b.i.d.). This change was put into effect when doubts arose about the diagnosis. I asked whether the hospital could send the patient to my office for a consultation, accompanied by an attendant. I was told that this could be done.

When I saw Doris for the first time (April 15, 1967), I observed her face, posture, and attitude and exchanged a few words with her. I felt I was already in a position to make some early assessment, to be convalidated later of course, because although these early assessments are useful, they may be drastically wrong. I could immediately exclude schizophrenia, confirm the diagnosis of severe depression, and feel that the patient could relate to me well and probably I could to her.

She told me that she had heard about me and was eager to see me, but

she was very depressed and probably unable to talk. Two days before she had gotten up with the idea that she would never get well. She had definite suicidal ideas: life was not worth living. However, she believed she would never commit suicide. I told her that I felt we could talk to each other, and that I certainly wanted to see her again. I was seeing her that day because her husband had come to consult me and I had made the arrangements for her visit in my office. She told me that her husband's vacation time had come up and he had already gone on a cruise. Somewhat surprised, I asked, "How do you feel about your husband going on a cruise without you?" She replied, "Angry, because the Aurora, the ship my husband is on, is a ship I like very much. I am not angry at him, but at my illness, which prevents me from going with him." She had difficulty in talking and was quite slow in her speech. In an attempt to sustain the dialogue I became more friendly, and in a somewhat joking tone I told her she was the only woman I knew who allowed her husband to go alone on a cruise. She replied that she recognized he was entitled to a vacation. She had been in the hospital for almost three years and he did not have anybody to go with. She said that she was not at all angry at her husband. If she was angry at somebody, it was at her mother, who had recently died at the age of seventy-nine. Her mother was a person whom she could never please in spite of trying very hard.

When I explored the relation with her mother a little more, the patient told me that her mother used to make constant requests and tell Doris how to

behave, even when Doris was in her fifties. The patient felt she had to go along with her mother in order not to incur her disapproval. To be approved of by her mother was absolutely essential, especially when the patient was very young. Since her marriage, her dependency on her mother had sharply decreased. However, after the mother died she felt very guilty for having put her into a home for the aged instead of caring for her. She felt that her guilt had probably contributed to the depression. She also said that she was eager to leave the hospital and go home, and yet she told Dr. B., her doctor in the hospital, strange things; for instance, that she hated her home and wanted to set it on fire.

At the end of the session I told her that I felt we were communicating well, and that I would make arrangements with the hospital to have her regularly accompanied to my office by an attendant for the session. When I knew her better I would tell her when I thought she could leave the hospital. She was attentive, yet incredulous. I felt I had reached her. And indeed, at the end of that very first session I felt I already knew a great deal about her. She seemed to be a very submissive person and unable to assert herself. When Doris left, the idea of her husband going on a cruise alone came back to my mind as something which was nagging at me. And yet I dismissed the idea, and thought that I had been unwise to make a little joke about it. The patient was probably right in saying that after all, she had been in the hospital almost three years and Mr. Fullman was entitled to go on a vacation. But then I said

to myself that Mrs. Fullman had been able to influence me: she had been persuasive enough to make even me accept her general orientation of submission. After all, it was true that he was entitled to a vacation, but did he have to go on a cruise especially on the Aurora, which Doris liked so much? Wasn't he rather insensitive? It is because I think it is important to retrace the marginal thoughts which come to the therapist's mind even during the very first session that I include these details. It was already obvious that the patient had made an impact on me, and I hoped I had on her.

So far I have stressed only the exchange of ideas. It was evident to me, however, that her slow movements and her austere and rather stiff face—although capable of a little emotion and of a tiny smile when I was trying to cheer her—as well as the look of melancholy that she seemed to wear, constituted an intense picture of depression which elicited in me an eagerness to penetrate into her secret anguish and to help her. Her submissiveness and placating ways were already giving me precious clues. The idea came to me that her case seemed to fit some of my theories. The mother had been the patient's dominant other, and further analysis would have to confirm or deny the hypothesis. "Beware," I said to myself, "not to force the case into your favorite preconceived schemata."

Between the first and the second session, I continued to get reports from the hospital that the patient was very depressed, inactive, and suicidal.

When she again came to see me, accompanied by an attendant, the second session was as revealing as the first. Doris started by saying that she was very depressed. She had the feeling that she would never get well, and she was very discouraged. After all, before going to the hospital, she had been in treatment with Dr. N., a psychotherapist, for fourteen years and had not gotten well. And the first serious depression had occurred at the age of thirty-two, after the birth of her first child. I asked her to tell me something about her childhood. She told me that she had two brothers and she used to compete with them for her mother's affection, without ever being sure of getting it.

Then she told me that when she was eight years old an incident had occurred, but perhaps she would lose precious time in recounting the episode to me. I encouraged her to tell me what happened, and she told me that one day she and her brother Richard were playing together. They started to fight. In a fit of anger she threw a pen at him and the pen hit Richard in the eye. Richard was rushed to the hospital, but he lost the eye. Doris told me that she always felt guilty about what she had done then. I asked her whether she was scolded or punished by her parents, and she told me no. The parents were very nice, and realized that what she had done to her brother was unintentional. Not only was she not punished, but the whole incident was never mentioned to prevent her from feeling guilty. After all, she was only a child, and she was playing when the accident occurred. I thought that the

patient felt more guilty than she admitted, and that this matter should not be so easily dismissed without even touching on the possible implications; but it was obvious that she was not ready to discuss that episode further, and I did not insist. I told her that what she had said to me was important and that eventually we would discuss the event in greater depth. I told her that I wanted to see her regularly once a week as long as she was in the hospital, and probably three times a week when she was discharged. She came regularly once a week, accompanied by an attendant.

The third session was also important. She told me that she was afraid she would not get well because she did not want to get well. She felt hopelessly depressed with no desire to live. She said she had no feeling for anybody, not even her husband and children. As a matter of fact, she had felt depressed when Walter, her son, was born twenty-six years previously. She believed that every woman would be happy to have a son, but she was depressed when she gave birth to him. She was so depressed that she felt she could not take care of him. At the same time she felt guilty for not being able to be a good mother. She had always felt guilty toward Walter for the way she reacted to his birth. When her twin daughters Elsie and Roberta were born, she tried to make up for the poor mothering she had displayed toward Walter. But again, what she had done for Elsie and Roberta was only because she felt she had to do it, and not out of love.

The next time she came, she said again that she was very depressed. There was nothing in her which pushed her toward getting well. The idea had come to her that I had called her husband who had returned from the cruise, and I had told him to put her away for good, maybe in a state hospital. She had a feeling of hopelessness. She said that her family life was also like an emotional vacuum. Nothing could push her back into her home. She had no love for her husband and children. She had never accepted them, and they never accepted her. Even her sex life with her husband was no good. Apparently he found her undesirable; since they were married, Andrew never approached her or showed any desire to make love unless she made overtures.

At this point I started to talk to her, and I explained that from what she had told me so far I could conclude that she was a person who had never followed her own wishes. As a matter of fact, she would not even listen to her wishes; she did not even know what they were. She lived for others with resentment, and therefore with the feeling that she did not love the others. She lived only for doing what she felt the others expected from her. Thus she had the feeling that the others did not love her, because they expected so much from her. From now on she must listen to her inner self, to her secret desires, and I would help her to do so. Although I spoke with conviction, my interpretations appeared to me somewhat pat; perhaps psychiatrically correct, but lacking some additional important dimensions specific to the

case. The patient added, “But if I listen to my wishes, I feel guilty. I always felt guilty, guilty, guilty! I was five and told my mother a boy had pulled up my skirt and kissed my knees. My mother looked at me with contempt and said, ‘I know what kind of woman you will grow up to be.’ But,” the patient added, “I did not feel guilty when the boy kissed my knees. I would have forgotten all about it. I knew nothing at all about sex. I felt guilty later about everything, and about what my mother had previously told me about this boy, and about everything which smacked of sex.”

“You said you started to feel guilty later. When?” I asked. The patient said, “I don’t know.” I said, “I have the feeling you know.” The patient, paused, pensive, and then said, “I know you know. Everybody knows; but nobody has ever admitted the truth.” She started to cry and said in a rather loud voice, “My brother! My brother’s eye! I made him lose an eye! I had not told you before how it happened. We were playing, but soon he started to torment me. I told him, I’ll throw this pen in your eye. And I did it. The pen did hit his eye. It was intentional, doctor. I remember that after the accident I thought: Why didn’t they punish me? They didn’t; nobody even scolded me. But I expected they would. I still do. Even today I say to myself: Why don’t they punish me? When I look at others, I expect them to punish me.”

“And you feel you must atone, and be submissive and obey. You are still carrying a heavy burden for what you did when, as a little child, you were

playing with your brother. You told him that you were going to hit him in the eye, and it happened that you did. That's why it is so easy for you to accept this role of the guilty one. When this accident occurred, you even thought of what you possibly had done wrong before, and you remembered the episode of the boy who kissed your knees and what your mother said."

The following session, Doris told me that for the first time in years she felt better. She smiled at me. I had really helped her, she said. Now she felt hopeful again. What I had said had made sense to her. I reminded her that she had done most of the talking during the previous session, but I had helped her to see the significance of what she told me.

In the rest of that session and in others which followed at that time (Spring, 1967) she disclosed several things to me which were preying on her mind. Her husband was a very successful businessman, but she was not a successful woman, mother, or wife. In reality the brother of her husband had started the business in which her husband was still involved, but her brother-in-law died and her husband, who was his partner, took his place. After the death of her brother-in-law she felt sorry for her husband, who was depressed, and therefore, to console and please him, she became pregnant at the age of thirty-two; that is, five years after she got married. She actually felt more depressed than her husband about the death of his brother.

In the following sessions she became alternatively more depressed and less depressed. She dreamt that her husband was marrying a very young woman and divorcing her. In the sessions which took place over the span of a month, she gave me a detailed account of how she had become the depository of guilt feelings: guilt when the brother-in-law died, because she had not taken care of him; guilt about the way she felt about her son when he was born; guilt when Dorothy, the sister of her husband, died and left her money to the patient's husband. Doris enjoyed Dorothy's money, but she had wished Dorothy's death because she was very bossy and had acted as a mother-in-law. Even when Doris married her husband, she was not sure that she loved him. It happened that her husband had been in love with another woman to whom he had been engaged. This woman suddenly broke the engagement and married her boss. Mr. Fullman had been very depressed. Doris felt that perhaps she had to compensate for what another woman had done to him. I told her, "You had to atone for what another woman had done. Your mission was to make your husband happy, not so much to make yourself happy." The following session she said that she could not face what I had told her about her marriage, but yes, it was true that she had to atone; she felt guilty about many things. I told her that she was depicting her situation accurately. She had assumed not only an attitude of submission but one of responsibility and guilt for the whole family.

The following session, she said she felt much better. She had not needed

pills to fall asleep at night. Then she looked at me and said firmly, “Did you know, doctor, if I had wanted to hit my brother in the eye with that pen, I could have tried a thousand times and not succeeded. It was an accident that I hit that spot.” She looked at me and smiled. Then she added, “This was told to me before, and I did not believe it. But now I do. I was not good at all at aiming, but I happened to hit the spot.” I rose and said, “Mrs. Fullman, you have made a major breakthrough. You are on the way to getting rid of the burden of guilt, the main origin of your depression. I predict that in the beginning of June you will be able to leave the hospital.”

And indeed, at the beginning of June Mrs. Fullman left the hospital after almost three years of confinement.

In the following months there was a gradual but steady improvement, and a quick readjustment to life. The patient reported much more information about her marriage. On the wedding night her husband did not show any intentions of having sexual relations with her. When she asked Andrew why he was not interested in making love, he replied, “We are going to be married for the rest of our lives. Why rush?” She was convinced that Andrew was right and she felt that there was something wrong with her for expecting so much. Since her childhood, her mother had been able to convince her that she was much too interested in sex and that sex was dirty. We have already seen that her guilt feelings about her brother’s accident and her assumption of the

guilty role made her rekindle previous episodes in her life for which she could have felt guilty, especially the episode of the boy who kissed her knees.

Throughout almost thirty years of marriage, her husband had very seldom made sexual overtures. She had to take the initiative, and then he would go along. Therefore she felt undesirable and unattractive. However, in pictures taken early in her married life which she brought in to show me, she appeared quite attractive. As the treatment proceeded, she became able to express complaints about her husband. According to her, he was bereft of romantic feelings and never indulged in affectionate gestures. He would never use endearing terms like “sweetheart” or “honey.” He would not hold her hand in the movies, would not buy her a bouquet of flowers, would not hug her before going to sleep. She knew that the members of her husband’s family were rather cold and not given to expressions of warmth. They never kissed and embraced, but who knows? Perhaps Andrew was so cold because he did not love her.

Andrew belonged to a well-to-do family, whereas she came from a poor family of immigrants who lived in the slums. Her parents came from Russia when she was eleven. She still remembered an uncle who remained in Russia; he loved her very much and did not make demands on her like her mother. The memory of this uncle had remained with her as something to revere.

When she got married, she thought she would liberate herself from her mother's yoke. Instead she assumed new yokes. First, she felt that all the members of her husband's family and especially Dorothy, the wealthy sister-in-law, considered her inferior because of the social class from which she came. She always had to placate, to accommodate, to follow, and to attune her tastes and her ways to those of the Fullmans. Second, she felt that her husband also was superior to her and everything had to be done for his sake. After all, he was an important businessman and had an unusual social position. He had to be well dressed, respected, and catered to. According to the patient her husband had a very pleasant personality and everybody admired him and paid respect to him, but not to her. She was a doormat: a doormat which, if not stepped on, acted as if she would say to the passerby, "you have forgotten to step on me."

At this point we are in a position to attempt a profile of Doris before going into a few other interesting aspects of the case. Much more clearly than in the majority of cases of depression, a single episode in childhood played a crucial role, with its aftermath affecting the patient for the rest of her life. The accident which caused the loss of her brother's eye crystallized in Doris an attitude of guilt, expiation, and submission. Most probably it would have been better to punish Doris immediately after the occurrence of the accident, not severely, but in a firm and clear disciplinary manner. Lack of punishment left her with a suspended feeling of guilt and unworthiness for which she entered

an interminable pattern of expiation. Nobody spoke about her guilt, but a sense of guilt was in the air, and she felt that it was expected of her to be very good, obsequious, and obedient. Without admitting this feeling to herself, she felt she had the obligation to expiate for the terrible thing she had done. Doris's mother was a very demanding, rigid, perfectionistic woman, never satisfied about the state of the world or about the way things were done, especially by Doris. Because of her mother's personality, Doris most probably would have manifested these depressive traits even if the accident had not occurred. However, Doris made an unconscious connection between the accident and the way her mother treated her, and later between the accident and the way the world was treating her.

Her life became a way to prove that she was able to atone for what she had done and an effort to be accepted by a nonaccepting mother. This feeling was often changed into equivalent cognitive constructs. For instance, at times in her young life she felt she was born for the single purpose of pleasing her mother because her mother needed her. Very early in the patient's life the mother became the dominant other. When she got married, she thought she would liberate herself from this dominant other, but soon the husband was put in the position of being a dominant other. He could never do anything wrong. Again and again Doris tried to please him and his family. She never dared to make her wishes prevail. This state of affairs occurred in spite of the fact that with her industrious and alert personality and ability to grasp new

situations quickly, unless depressed, she helped her husband very much in his career, by making business decisions and proceeding successfully toward a higher socio-economic status.

It is interesting to point out how even certain weaknesses or neurotic traits of her husband were transformed by her into her own faults or shortcomings. Like all persons prone to depression, she had the tendency to introject, which is the opposite of projecting. For instance, although she felt frustrated sexually, she thought that she was too libidinous and therefore vulgar and cheap. Her husband's reluctance to make love on the wedding night was interpreted by her as cogent proof of her lack of charm and sex appeal. It never occurred to her that a husband who acts in that way on the wedding night might have sexual problems of his own. That Mr. Fullman had sexual problems was confirmed to me later when I learned that he could never become aroused unless Doris took the initiative. And yet Doris interpreted his lack of interest in sex as proof that there was something wrong with her rather than with him. Of course there was something wrong with her too, for accepting the situation.

When her first child was born, she had a postpartum depression— the first severe depression in her life. She felt guilty for not being a good mother, and her depression increased. The birth of her child made her realize that she had to accept a life which consisted of pleasing others. She had become

pregnant to console her husband, who was depressed at that time about the death of his brother. Having a child meant to Doris accepting irrevocably the life of a submissive housewife who had to take care of an unwanted child. Nobody was there to explain psychodynamically her postpartum psychosis, or to tell her to accept the fact that she did not accept the child; that the day would come when she would accept him and love him. Nobody was there to relieve her guilt for what she could not prevent. (Sec chapter 11.)

Mrs. Fullman leaned on me as a dominant third, and I told her that for a while she had to accept that type of relation. She understood more and more the role she herself had played in denying herself, in putting herself in the role of the sinner who had to atone. I explained that her husband, although somewhat inconsiderate, was not so domineering or demanding as she had assumed. She herself had put him in the dominant position to replace her mother. It was true that her husband inflicted suffering on her with his sexual detachment, but instead of suggesting treatment to him, she was ready to assume that there was something wrong with her in the sexual area too. I helped Doris to listen to her wishes and to dare to assert herself and depend less on the approval of others. Of course she needed my approval now, but I succeeded in changing my role from dominant third to significant third (as described in chapter 9). Mrs. Fullman underwent the typical changes which occur in persons who emerge from a deep depression. She became too self-assertive at times, and even angry. Occasionally she would express opinions

rather strongly and hurt the feelings of people who were shocked at the change in her personality. They felt that she had been more considerate when she was depressed. In some cases it was difficult to determine whether her anger was justified, due to misconstructions, or due to an inability to reevaluate the new family climate now that an important member had changed so drastically. An important episode will illustrate this point.

When Doris came back from the hospital, everybody tried to cheer her up and her daughter Roberta, in a joking mood, once made a passing reference to a woman named Eloise who had pursued father while he was cruising on the Aurora. This woman had lent him a handkerchief to dry his perspiration, and with that excuse she called up once and asked to speak to him. Doris became very upset and jealous, expressing her indignation to the children and to her husband who insisted that she made too much of it. This woman was described by Andrew as an unattractive spinster who had noticed a man alone on the boat and had tried to attach herself to him. He perhaps had liked to receive some attention, but nothing had happened. A few days later when she was dusting her husband's desk, Doris saw some pictures taken on the Aurora, and in several snapshots Andrew was always next to the same woman in the group of passengers. She asked whether the woman was Eloise, and he said yes. He reiterated that her jealousy was absurd. Nothing had really happened. Doris reluctantly accepted his version of the facts. Knowing how conservative her husband was, she was sure that no sexual

encounters had occurred on the ship, but all the attention that Eloise apparently had bestowed on Andrew, and Andrew on Eloise, infuriated her. She no longer felt depressed, but very angry.

A sort of bombshell exploded a few days later. The phone rang. Doris did not know that her husband had picked up the extension in another room, and she picked up the phone. She heard the jubilant voice of a woman saying, "Hello, Andrew, do you remember the Aurora?" That was all. Doris dropped the phone and went into the other room where Andrew, embarrassed, tried to terminate the conversation as soon as possible. The Fullman's phone was unlisted. Why had Andrew given the number to Eloise? Andrew said that in a moment of weakness or thoughtlessness while he was on the cruise, he had done so. He reaffirmed again and again that nothing had occurred between him and Eloise. Walter, Elsie, and Roberta sided with their father. They felt their mother was making too much out of nothing. This Eloise was a poor woman desperately seeking a companion on the cruise. Father loved only mother. Walter, Elsie, and especially Roberta tried to reassure her that he had always been faithful to her in spite of her illness. Their words "in spite of her illness" infuriated Doris. She thought, "I have been in the hospital for about three years, and nobody thought I would ever return. Who knows what would have happened if I had not come back soon? Had Dr. Arieti not made that announcement that I would leave in June, and if he had not helped me to leave, what then? Eloise would be living here."

I joined the children in pointing out that she was making much too much out of this episode. I must admit that at times I am too prone to believe people's affirmations and on a few sporadic occasions I have been sorry about it, but in this case I was and still am inclined to believe that nothing sexual or of any spiritual significance occurred between Eloise and Andrew. Perhaps Andrew responded to the attention of another woman, but to what extent he responded is hard to say. Knowing his extreme unaggressive attitude, it is probable that nothing intimate occurred; but that is what irritated Doris even more. If at least something sexual had happened! But Andrew was his old self, interested only in platonic love and companionship. And another woman could easily replace Doris in what she meant to her husband; not sex and love, but companionship. The episode was disturbing to Doris because it gave a new perspective to her whole marriage and compelled her to do some serious thinking. What could she do now, at the edge of old age, if she could not trust Andrew? She could do a lot, I told her. At the same time that she should try to improve her marriage, she should become less dependent on her husband and rely on her own inner resources. She did: after she left the hospital, she did not use tranquilizers or antidepressants of any kind. She won other battles. For instance, from the chain smoker that she used to be, she stopped smoking entirely.

As I have already mentioned, at times she became too self-assertive. On some occasions her remarks, although correct and always to the point, were

too strong and irritated people. Whereas she used to appear weak and frail to the members of her family, now she seemed a “rock of Gibraltar” and they resented her new attitude. Roberta would often tell her that she had been “too psychoanalyzed.” But Doris did not any longer need the approval of everybody. She was capable of autonomous gratification.

Doris’s treatment continued mostly for the purpose of preventing her from slipping back into a mood of depression when small disappointments occurred. After all, it is easy to reacquire a mood which has been so basic to one’s life. Doris, however, became capable of distinguishing disappointments from sadness and depression. Her attitude toward her marriage changed. She realized that she herself had easily assumed a submissive role, put her husband in the position of being a dominant other, and accommodated herself to a patriarchal type of society. She had been prepared to do this by the events of her early life. Her husband was not a tyrant, but a nice man who had become insensitive to her needs, to some extent because she herself had not revealed them to him. It is true that her husband was not as sexually adequate as the patient would have wanted; however, his inadequacy was not due to lack of interest in her, but to his own sexual patterns. Doris even started to teach him some romantic habits like holding hands, and he proved accessible to the new ways. She learned to accept taking the initiative sexually, without feeling guilty or inappropriate. Once she took the initiative, Andrew was able to function.

Although this state of affairs was not ideal, it proved to be a satisfactory compromise. I was always aware in the treatment with Doris that, because of her age when she started treatment with me and her almost constant state of depression since the age of thirty-two, it would be almost impossible to eradicate all the problems, or to erase all the early ferocious imprintings that had caused so much suffering. I also was aware that in some areas we would be able to obtain only satisfactory compromises.

Nevertheless the treatment seemed to exceed the expectations. She became proud of having been a mother of three nice and successful children, now themselves expecting to be parents. Once the serious period of depression lifted and Doris became able to be self-assertive, she could also show the brilliancy of her intellect, her sensitivity to psychological nuances, and her deep understanding of human relations and life in general. She had a practical knowledge of many subjects, ranging from real estate to antiques, which she put to good use. She won several bridge tournaments. Her way of talking acquired an incisive quality which was striking both for the originality of her remarks and for her occasional, surprising touches of humor. Here is a verbatim example. “I can say my life has been unusually interesting. I have witnessed three things which were beyond my wildest imagination: the first, the foundation of the state of Israel after a span of two thousand years; second, with my own eyes I saw on television human beings walking on the moon; and third, one day I picked up the phone and I heard the voice of a

woman saying to my husband, on another extension, 'Hello, Andrew, do you remember the *Aurora*?' "

When I started to collect the notes for this report, I thought the case would end here. For nine years Doris was totally free of depression. She participated more and more in the various activities of life and appeared happy and industrious. After nine years she developed a severe case of herpes zoster, with excruciating pain. Shortly afterwards she started to bleed frequently during defecation. Cancer of the colon seemed certain. She underwent all possible physical examinations and the experts concluded that she was suffering from a rare but benign condition which does not require treatment, but which occasionally produces bleeding. Doris became depressed again. Treatment had to be resumed and had to be even more intense than it was originally. In the beginning, she believed that the doctors were lying to her and did not want to tell her her real illness. She eventually was convinced that her illness was benign, but she remained terribly depressed for a few months.

It was eventually found out that when she became ill, she thought her life had come to an end and she felt she had not fully lived. Actually, she had had a premonitory depression of only a few seconds' duration a year earlier when she went on a cruise with her husband and she realized that the ship was not so beautiful as the Aurora. She said to herself, "Is this what life is for?"

and she became unhappy. She was able to overcome the few moments of depression, but when she became physically ill, she could no longer resist. The old feelings began submerging her again. She believed she was lost and incapable of doing anything. She was like a dead body. All her complexes or cognitive constructs, which I hoped had been weakened to the point of not disturbing her again, came back. We had to reexamine again her whole past, the relation with the mother, the burden of guilt originating with the accident of the brother, her marriage, the difficulties she still had in believing her husband cared for her, and so on. All her pathogenetic cognitive constructs proved not to have been extinguished by the previous treatment, but only weakened, and potentially capable of reemerging in situations of psychological stress. Although her relationship with me as her therapist was fundamentally good, I at first had greater difficulty in assuming the role of a significant third. Doris in a certain way felt disappointed in me because she had believed me, and yet after nine years she had become ill again. Sessions were very frequent. A tape recorder was used so the patient could hear the session a second time during the day.

Finally all the cognitive constructs which had to be reexamined were eventually altered and deprived of their pathogenetic effect. Although approximately sixty-nine years old, Doris again became able to trust life and to believe that even at her age living could be worthwhile. She understood that in her inner self she did not really believe life was worthless. She would

not be depressed if she thought life was worthless. Life was very important to her. She became depressed when she thought she was very sick and would die without having fully accepted the essence of her life. The cruise ship, not as beautiful as the *Aurora*, stood for an unattractive, worthless life; but every life can be attractive if the person cultivates it. I told her that she had to accept being dependent on me again for a few months. When we again explored her past, she came to the realization that her adult life, although difficult, had proved not only her weaknesses but her strength and values. When we discussed her problems, we also stressed that she had been able to master her problems. She had been able to become a very good mother and grandmother, had helped her husband immeasurably in his business, and had become proficient in many aspects of life which she cultivated exclusively for her own sake. Instead of concentrating on how unhappy she had been, she focused on the little progress she made every day. Thus in the treatment of this last attack we concentrated not just on reexamination of the past from different points of view, but also on a detailed reconstruction of her present life.

I frankly told Doris that at the end of her first treatment with me I should have been more cautious and prepared her for the possibility of a recurrence. However, I explained that her physical illnesses did play an important and unpredictable role. Again, they were interpreted as meaning retribution for her alleged guilt. It meant dying without achieving any

worthwhile goal, and without the fulfillment of an intense love.

Doris has recovered again. Her husband, who incidentally also has learned a great deal by listening to the recorded sessions as Doris advised him to do, has become capable of communicating fully with her and of being more expansive. He also seems to have lost some of his inhibitions. It is never too late. Doris and her husband plan to go on a cruise around the world. The *Aurora* does not exist any more; it has been dismantled. They will go on another ship.

If I may conclude this case with my own free associations, I wish to say that *Aurora* means dawn, but a sunset is often more beautiful than the dawn. The sunset of the Fullmans' life promises to be beautiful and serene.

Henry Tusdori

Dr. Henry Tusdori, a forty-seven-year-old physician, requested treatment on account of a depression which had already lasted seven years. Being a physician, he had been able to prescribe all sorts of antidepressants for himself, but there was no improvement. Recently the depression had become worse and he was wondering whether he should be hospitalized. The exacerbation of his depression had occurred after his divorce. He said that Phyllis, his former wife, had become unable to accept him because he was a discouraged and beaten man. After the divorce he felt abandoned and without

love. In reality he had already found a girl friend named Peggy who was very devoted to him, but he did not appreciate her love very much. He felt that if she cared for him it was only because he was a physician and she considered herself intellectually and economically inferior to him. He was still mourning the loss of Phyllis, who had become tired of him and had abandoned him. Phyllis knew how to love, he didn't; Phyllis knew how to assert herself, and he didn't. On the other hand, it was true that he had wanted Phyllis to submit to all his wishes, but she would not.

Although considered by others to be exceptionally competent in dermatology, the specialty in which he had made noteworthy contributions, Henry Tusdori said that he disliked medical work. As a matter of fact, in the last two or three years his work had become less satisfactory, he had lost patients, and he felt ready to give up his profession. He felt tremendously frustrated, dissatisfied, and unwilling to continue any of his undertakings. He did not know whether life was worthwhile.

Relatively soon in the treatment he disclosed that he did not want to be a dermatologist, but always had aspirations of being a great writer. Since his adolescence he had devoted several hours every day to writing fiction and poetry, but the publishers rejected all his work. He did have a considerable talent for writing but, since he was involved with his medical work, he could not cultivate his literary ambitions. Still he had daydreams of winning the

Nobel prize for literature.

He actually lived for the dominant goal of becoming a world-renowned writer. Everything else in his life was subordinate to this goal. Not only did he neglect some aspects of his clinical work, but his relations with women left much to be desired. They counted in his life only inasmuch as they enhanced his writing aspirations. First Phyllis and then Peggy had to listen to his poetry recitals until very late at night. They constantly had to reassure him that he would succeed at writing. When they protested or would not accede to his taxing requests, he would become angry. He never became violent but, according to his own account, on a few occasions he had a hard time controlling his aggressive impulses. Suicidal ideas occurred every time he concluded that he was a failure both as a writer and as a physician.

Henry was born in Italy. When he was four, his parents sent him to live with friends in a distant city. His father had been a notorious antifascist and the parents felt persecuted by the fascists. They wanted to be sure that their child was safe. Henry could not understand all this very well and felt that he was being punished; that they were sending him away because he was bad. The family reunited later, and Henry always tried to do his best so that his mother and father would never again “reject” him. Mother, and especially father, always stimulated him to become a “great man,” commented on his intelligence, and incited great ambitions in him.

Because Henry had to divide himself between his literary and medical work, he never achieved the high goals to which he aspired. Although he and his family emigrated to the U.S. when he was twenty, no linguistic difficulties interfered with his literary ambitions. He knew English well, but he could not fulfill his literary aims. As a doctor he was always found to be more than satisfactory. Still, he felt that only if he became great in the literary field would he deserve his parents' love, or the loves that later replaced parental love. Although he very much needed the love of a woman, the dominant goal of his literary aims actually prevented him from attaining a genuine intimate relation with a woman. Until the conflicts were discussed and to a large extent solved, Henry continued to suffer frustrations and to nourish hatred for the medical profession.

Eventually he decreased his literary ambitions. He accepted himself as a worthwhile person even if it did not mean becoming a Dostoevsky. More and more he came to value being a competent physician, capable of helping many people. He also became able to apply his unusually high intelligence and inner resources to many other aspects of life. His relations with Peggy improved greatly as he started to consider her as a person in her own right, as a person who loved him dearly but who did not want to be treated as an object for the sake of being loved. Henry continued to write for his own pleasure. He recognized that the medical profession had not been imposed on him; he had chosen it, and not just in order to make a living. Actually it was the literary

work that lost some importance because he came to recognize the role it had played in his life. In other words, he understood that he used the fantasy of becoming a great writer in order to recapture the loss that in childhood he imagined he had sustained. Suicidal ideations disappeared and there was no longer any thought about hospitalization. Occasionally, however, he continued to experience mild fits of unhappiness when the idea presented itself again that he had to abandon his life's great ambition. This dominant goal was so ingrained in the fabric of his psyche that some of its effects could not be totally erased.

Sandra Carquois

Sandra was a 24-year-old married woman who, three months earlier, on awakening one morning felt that she could not get up from bed. Her husband, whom she had married a year and a half previously, urged her to get dressed but she insisted that she couldn't. She felt miserable and wanted to die. And yet the night before when she retired she felt everything was all right. During the night she felt restless, but she did not remember having unpleasant dreams. At the suggestion of the family physician, she sought psychiatric treatment.

Sandra was quite an attractive young woman, spoke without hesitation, and repeatedly said that she felt depressed to the point of having no desire to

live. She did not know why she had become depressed all of a sudden. She loved her husband George, whom she had known for three years before deciding to marry him. All this she told me during the initial interview.

During a few of the following sessions, she repeatedly described an interesting phenomenon which she did not know how to explain. It was still very difficult for her to get up in the morning. Everybody knew that she was ill and her mother came from a nearby city to help her. Sandra was an only child. In reality the parents had had another child, a boy, who died a few days after his birth. Sandra's mother became fully devoted to her after her birth and would do anything for her. But in the presence of her mother, Sandra became even more helpless. She acted like a child; or rather, like a baby. She did not want to do anything. She had no energy to move, and she needed help to get dressed. When her mother went away she felt helpless, lonely, and a complete invalid. But if the mother was around, she underwent complete infantilization and wanted to be treated like a baby. If her mother refused to do anything for her, even giving her a glass of water, she felt resentful, rejected, and angry. Thus there was no way for her to get out of this predicament. She felt hopeless and wanted to die. This behavior in front of the mother lasted several weeks. Later it continued to be difficult for her to get up from bed and to come for the sessions, but nevertheless with the help of George she managed to do it. Once she was up, getting out of the house was relatively easy.

A brief history of the patient follows. The mother was described as an extremely overprotective person, an overloving mother who would do everything for the patient. She actually lived through the patient in a vicarious way. Mother was an extremely anxious person and Sandra seemed to have "inherited" her anxiety. When Sandra was a little girl she was not allowed to practice sports for fear that she would hurt herself. She wished she could be like her father, her preferred parent. She never understood why her parents got married, because they seemed to be so poorly matched. Father was a well-to-do man who treated Sandra like a princess and provided for all her financial needs. The patient and her husband had recently moved to a rather elegant part of New York City. They used to live in a town in New England, but since her husband wanted to be a physicist and had to go to school, it was easier to live in New York. Sandra too wanted to continue to go to school for her master's degree in English literature, but recently she had dropped out.

The morning in which she felt unable to get up loomed for her like the beginning of a new era, or actually the end of another era; the very end of her life. Why did she have to get up? she felt. What for? What was it all about? What was there in life to live for?

In the beginning of treatment she said that she did not know how to explain the striking experience of that eventful morning. She was apparently happy. It was true that her husband on the one side was a dreamer who

wanted to discover the secrets of the atom, and on the other side was a person who enjoyed life in a material way and did not mind being supported entirely by his rich parents-in-law. But the fact was that George and she got along well. There was absolutely nothing wrong in her life which should make her feel depressed.

Many sessions were devoted to interpreting what had happened that eventful morning. Eventually she was able to verbalize what she had never been able to say or even to think about. She insisted that even when she tried to do some serious thinking while she was alone, she was not able to say to herself the things that she could later express in the therapeutic situation.

All of a sudden life had appeared false to her. That morning even the furniture in her home became flashy, appeared *nouveau riche*, and was not to her taste. It reflected the artificiality of her life, a "pseudo-life which was filling the emptiness of her life." The night before, her husband had made love to her in a routine and meaningless manner. She herself was no longer interested in making love. Everything appeared grey, even her marriage. Even George, a man whom she had insisted on marrying against her parents' advice, appeared boring and common to her. George was not really devoted to becoming a great physicist. Now he seemed much more interested in savoring the pleasures of a mundane life. Sandra and George lived in an expensive apartment in a nice part of the city, but all that was artificial too. How much

more genuine was life in the New England town where she used to live! She could not divorce her husband; he was fundamentally a nice fellow. Moreover, what would her parents say? She had insisted on marrying him against their advice. She had given up everything, even going to school. She wanted to be a child. Mother would give her everything she wanted, but then she would become a baby again. But she did not want to be a baby.

Good progress was made relatively soon. The patient came to accept the fact that she was not accepting her present life. She was praised for recognizing the false values which characterized her style of living. She understood how she grew up making claim after claim which was methodically fulfilled by her parents. By satisfying all her wishes, they actually retarded her maturity. The claims that she was making now to her husband could not be fulfilled, and certainly she would have to determine which of her claims were legitimate or illegitimate. She eventually would have to decide whether or not to continue in her marital situation. She realized that she had not continued to go to school when she sensed that her husband did not really have the devotion to become a physicist as he pretended. She did not want to be better educated than he was.

During the first few weeks of treatment the patient was almost always confined to bed, but she became quite active later. At first she became involved in philanthropic activities. Then she worked for a while in a nursery

school. Soon, however, she resumed going to school in preparation for her master's degree, and did very well. Fits of depression continued, and she seemed fairly sure now that they were related to her marital situation. While she was attending school, she noticed that several teachers and often students were paying a great deal of attention to her. That did not surprise her because she had always considered herself to be very attractive. What surprised her was that for the first time since she was married she was responding to other men's attentions. After a period of a few months during which she had serious conflicts, she started to become involved with men and had a series of short love affairs. None was serious enough in her opinion to justify leaving her husband, but each of them gave new moment and zest to her life, and rekindled her desire to live. Not many months passed when she discovered that her husband too was having repeated affairs.

After a period of about a year during which there was no depression, the patient terminated treatment against advice. I felt that the patient's problems had not been solved to a sufficient degree, and that some of her solutions were questionable. On the other hand, there was no sign of depression, and depression has not reappeared since then.

José Carrar

José Carrar was a thirty-nine-year-old South American businessman

who purposely came to New York to seek treatment for his deep depression. He had been diagnosed as manic-depressive and indeed he occasionally had periods of euphoria and hypomanic state. However, these euphoric periods were very mild and rare. What disturbed him and his family most were the attacks of depression, which were long and intensive. According to the patient, he had had episodes of depression since he was twenty-one but the attacks became worse since the age of thirty-five, shortly after his father's death.

The father of the patient was a self-made man who built up a successful chain of stores over his country. He started as a porter and ended up as a multimillionaire. He stimulated his six children to follow his example. The patient was the second child, looked very much like his father, was considered the most intelligent of the children, and was expected to take his father's place in the corporation. José lived for the goal of becoming the chief of the company. He got married and had six children, just as his father had. He did well in school and displayed unusual intelligence and interest in many aspects of life.

At superficial examination it appeared that José was using the attacks of depressions in a manipulative way to provoke anxiety and guilt in his wife and to avoid unpleasant situations. It also seemed as if he would use hypomanic episodes to obtain what he wanted and to request what he did not

dare to ask for when he was in a normal condition. For instance, when he was hypomanic he acted as if he were already the chief of the company, and would give orders and dispositions which were not appropriate to the circumstances. Upon deeper analysis, however, it became obvious that his depressions started when he realized that his brother Pedro, the oldest of the children, was also the most qualified by temperament and business talent to take his father's place. Each attack of depression was precipitated by an event which indicated to José that Pedro would eventually become the chief. When the father died and Pedro did take his place, a very intense depression with suicidal indications occurred. At first the depression was interpreted as mourning for the death of the father. José denied that rivalry for the brother was at the base of his depression. He said that intellectually he knew that Pedro was the more qualified to take that position. Although it was true that José had intellectually accepted Pedro's access to the prominent position, emotionally he had not. Since childhood he had lived for the day when he would take his father's place. All the other aspects of his life were minimized for the sake of this ambition which now would not be fulfilled. It was quite revealing to observe how everything else in his life had lost significance.

The psychodynamics of this case were simple. However, it was very difficult to change the attitude of the patient and to help him to pursue alternatives. It was not enough for him to realize the implications of his great life's disappointment. He had to reconstruct his whole attitude toward life

and find other avenues for fulfillment. This was made difficult also by the fact that he had learned to exploit the secondary gains of his illness. In other words, he could say to others but especially to himself that if Pedro was more qualified for that position it was because he, Jose, was ill. Within two years of treatment there was marked improvement.

Five Depressed Women

Brief reports of five female patients are presented in this section. The outcome was favorable in four cases, although in one of them divorce was necessary. Three of the patients showed striking similarities in life history, symptomatology, and successful outcome. The fifth patient contrasts sharply with the others both in her life history and because of her negative response to therapy.

Rose Farsmith, a forty-five-year-old woman, made a suicide attempt when she learned that her husband was in love with another woman and wanted to divorce her. She took an overdose of barbiturates and was miraculously saved when even her doctor had started to lose hope. She was hospitalized for a few days and on her discharge she learned that her husband had already moved out of the house.

Rose said that she had been depressed for a long time, mostly because of her husband. He was unreliable, would not pay debts, would make

promises which he did not fulfill, and did not respect her.

An underlying sense of inadequacy and inability to assert herself had characterized Rose's whole life. A fear of being abandoned had existed since childhood when, after the birth of her brother, she felt her mother would cease to love her and possibly go away. During the first ten years of marriage she tried to devote herself entirely to her husband and two children. She tried to please the members of the family as well as she could. At a certain point in her life she came to the realization that her marital situation could not improve. She had several attacks of depression, but did not seek treatment. At the level of consciousness she did everything she could to cling to her husband, and to keep the marriage going. She was terrified at the idea of remaining alone. She felt unattractive and the possibility of finding another man seemed to her nonexistent. On another level—that is, without realizing the implications of her actions—she did things to antagonize her husband, to render herself unattractive, and to urge him to seek the companionship of other women. During treatment she became aware of the role she had played. She accepted the divorce without a sense of panic and started gradually to rebuild a life for herself.

Mrs. Lucille O., Frances R., and Marie P. had almost identical life histories. The three of them each developed in childhood and adolescence a relation of submissiveness and dependence on their mothers, who became

the dominant other. All three married self-assertive men who were moderately successful in their business activities and were good providers, but rather callous and insensitive to family relations. The three patients put their husbands in the position of being the dominant other after they had succeeded at least partially in removing the mother from that position. In one case, the mother retained a very strong role although not quite comparable to that of the husband. The three patients gave up whatever career ambitions they had once nourished and devoted themselves entirely to the family. One of the three had been a music teacher, one a business woman, and the third a secretary. They became increasingly depressed; the former music teacher also developed suicidal ideas. Hospitalization, however, was not necessary for any of them. The three insisted that their marriages were happy and their husbands were wonderful men, good providers, and excellent fathers.

The course of treatment revealed the rancor of these patients toward their husbands, the marital situation, their condition of submission, and their frustration. The three of them responded to intensive psychotherapy with complete recovery. A large part of the treatment of these patients was devoted to the study of their marital situation. They all understood the relation between the role the mother had once played and the role the husband was playing at present. After the first stage of treatment, the husbands were invited to participate in a certain number of sessions and these marital therapy sessions had excellent results. Both spouses in each of

the three couples understood the roles that they had played in assuming the respective positions of dependency and the dominant other. In one of these cases the husband was at first rigid in his ways and unwilling to change but, with the help of individual psychotherapy from another therapist, he acquired insights into his own subtle behavior and the way his wife related to him.

Quite different is the case of Louise S., a single woman and a registered nurse, who started treatment with me at the age of forty-three, after having been treated at various times by six previous therapists. Louise had had several attacks of severe depression. The first one occurred at the age of twenty-two, after her graduation. She was hospitalized then and received twenty-two electric shock treatments. At the age of thirty, she had a second hospitalization which lasted seven months. After having changed many therapists who had treated her with psychotherapy and drug therapy, she requested treatment with me.

The patient lost her father at a young age. She was brought up by her mother, a perfectionistic and rigid woman who never gave her approval or comfort. Louise left her home town and came to work in New York, but it was obvious that she was more interested in finding a husband than in pursuing a nursing career. She was told that she was an excellent nurse but this appraisal did not comfort her. As a woman she felt unattractive and unable to keep men interested in her. They only wanted to use her sexually. Every time she looked

at herself in the mirror, she was horrified by her appearance. Nobody ever proposed to marry her. When she came for treatment she was very despondent. Nobody would marry her or find her desirable: she would never become a mother. Even as a nurse she was no longer good. The head nurse in her department was constantly criticizing her. The patient felt that her work was deteriorating. Occasionally a man would still sleep with her, but it was always a one-night stand.

Two events caused an exacerbation of her condition. A gynecologist whom she consulted found an enormous fibroma and recommended hysterectomy. After she consulted a second gynecologist who made the same recommendation, the operation was performed. Louise recovered very quickly but became seriously depressed and suicidal. For her, the hysterectomy was the coup de grace to her femininity. Now it was definite that she would not become a mother. Although she was forty-three, she had always clung to the idea of becoming a mother one day, and now any last hope had dissipated. This part of her history seems typical of involutional melancholia (see chapter 12), but the history of previous attacks of depression ruled out this diagnosis.

The second event which exacerbated her depression was of an entirely different kind. In the hospital where she worked, an elderly doctor started to pay attention to her. He propositioned her and made definite proposals to

her. He had an invalid, terribly crippled wife whom he could not divorce. He wanted Louise to become his girl friend, mistress, and spiritual companion. He would do anything for her except marry her. Louise's answer was a flat refusal. This was her reply to him as she reported it to me: "You offer me a piece of pie, and I am entitled to the whole pie." She became very despondent, also angry at the whole world, including me as her present therapist, and suicidal. Since she refused hospitalization, her mother had to be summoned. Louise went back to her home town with her mother, where she received another series of electric shock treatments. I heard that she did not improve.

Some Conclusions

The patients described in this chapter, and those reported in detail in chapters 11 and 12, constitute a group of twelve patients who were treated with intensive psychotherapy for a period extending from eighteen months to three years. In these cases, diagnoses other than severe depression (such as schizophrenia, organic condition, and so on) could definitely be excluded. Any patient who after the second session manifested the desire to continue psychotherapy was accepted for treatment. A preliminary report of these case studies has already appeared in the literature (1977). In that report it was stated that full recovery with no relapses was obtained in seven patients, marked improvement in four, and failure in one. That statement was to be corrected to some extent because since then one patient (Mrs. Fullman) had a

relapse.

I consider the overall result to be more than satisfactory. Of course, this type of treatment has to be tried with many more patients. The treatment that we have started but not yet completed with several other patients seems also very promising. The failure in the treatment of Louise S. is not difficult to understand. The events of her life made it impossible for her, in spite of psychotherapy, to disentangle herself from the cognitive constructs which perpetuated her feeling of hopelessness.

It is worth considering the moral issues which quite often emerge in these cases of depression. The therapist must of course respect the moral decisions made by the patient even if he personally happens to disagree with them. In the case of Sandra Carquois, her decision to embark on a promiscuous life was something to which we may object. Incidentally, I have seen similar occurrences in some recovering schizophrenics, in which a promiscuous stage (at times accompanied by definite psychopathic traits) is of brief duration and by no means so disturbing or incorrigible as the asocial behavior of typical nonschizophrenic psychopaths. The limited number of similar developments in the cases of depression which have come to my attention do not permit me to draw any conclusion.

Almost opposite is the case of Louise S., who refused “the piece of pie”

offered by the elderly doctor. Another person would have considered that piece of pie sweet and nourishing enough to be seen not necessarily with contempt, especially since the elderly doctor also was in a very precarious and unhappy circumstance and felt he could not offer anything more. The position Louise S. took certainly was tenable and to be respected, but unfortunately it became integrated and reinforced into a framework of hopelessness and depression.

Notes

[1] All names of patients in this book are fictitious and identifying data have been altered. Homonyms are purely coincidental.

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