11 The Psychodynamics of Depression

The assessment that a human being experiences a state of depression is made on psychological grounds. Whatever bodily manifestations may accompany the psychological state, such as a loss of appetite, loss of weight, loss of sleep, loss of energy and other such manifestations, they are clearly possible consequences of an emotional state. The underlying causes of these bodily manifestations could as well be physical. However, it is a remarkable fact that a large number of psychiatrists not only assume that depression is primarily an organic condition and that the content of depressive thoughts is irrelevant, but consider that the onus of proof that it is not so is entirely a matter for the psychologically minded. In fact, it is the reverse which is true. The diagnosis of depression is made on psychological grounds and the organicists postulate a causal underlying physical substrate. The psychodynamically minded in no way deny this physical substrate. They observe the psychological picture, they follow its evolution, and they investigate the possibility of psychological methods of influencing the typical, repetitive, prototypical mental processes always present in depression.

Before dealing with the description of this picture and the mental structures or mental substrate involved in the state of depression, I will briefly examine a particular aspect of the role of the brain in a depressive experience. I shall examine only one aspect, namely, the brain as support.

Consider the room in which you are at the moment. Without its floor, for instance, there would not be the chairs, without the chairs there would not be the possibility of being seated, and your body would not be in the position you occupy. These states are not causally related yet they are not unrelated. We could say that a certain electrical activity is one factor that distinguishes other cells of the body from brain cells. We could imagine the brain cells as the support of this electricity, and we could postulate brain electricity as the support of thought. However, it is not thought *per se*. As a result of studying manifestations of brain damage to the frontal and temporal lobes, it has been suggested that during the growing stages, damage to the frontal lobes

resulted in certain functional disorders of the temporal lobes. However, once certain functions were acquired by the temporal lobes, damage to the frontal lobes did not matter any more. I call this an example of a supportive function during a certain phase of growth, and structuration of the neuronal structures. I wish to consider the concept of the supportive function in more detail; in other words, to examine how a disorder of the supportive function may affect the psychological state.

If we postulate a disorder of support, we know that we have to explain the differences in the psychological picture of, say, schizophrenia and depression. Either the difference lies in the organic disorder of support being different in both conditions, or the psychological organization is different and the same disorder of support results in a different clinical picture. Finally, both support and psychology may be contributors.

The meeting place of both aspects of the problem may be profitably looked at in the phenomena of sleeping and of dreaming. Leaving out gradations of one kind or another, there are three main states in which we can exist: alertness, sleep proper and dreaming. Ordinary thinking processes are abolished in sleep proper; thinking in the state of maximum alertness is as distant as possible from brain support in the model defined above; thought and bodily functions are more closely related to the dreaming state. It is during the dreaming activity of the paradoxical phase, as opposed to dreaming in the other phases of sleep, that the closest connections between psyche and soma exist. To understand this statement, something must be said about the phylogenetic and ontogenetic development of the paradoxical phase of sleep. There is an increase in the importance of the paradoxical phase from birds to man, which seems to be proportional to the increase in the complexity of higher nervous functions.

Ontogenetically speaking, towards the end of pregnancy, in the foetus there is an increase of the REM phase of up to 40% of the sleep cycle, which diminishes to 20–30% at about ten months.

The paradoxical phase is accompanied by a number of well-studied somatic activities which are not present at other times, especially processes dependent on the autonomic nervous system. The important point is that these somatic activities exist even before and independently of a proved psychic content. However, as soon as the infant can talk, a content can be traced. The behaviour of infants during the paradoxical phase and on waking up also seems to indicate that dreaming could be taking place before language. It is through the mental content that meaning is given to the increasingly rich psychosensory phenomena of the REM phase. Freud himself pointed out differences between children's dreams and adults'. He pointed out that often with children the dream was very simple and did not appear very different from external reality, dream-work and symbolism being hardly necessary. His ideas on the day residues and experiences being incorporated in the dream-work indicate that the psychological mechanisms

of the dream become increasingly more controlled by the meaning of the dreamer's experience. That is, there is a closer integration of somatic and psychic phenomena, the latter gradually playing a more important role.

I have gone through this development in some detail in order to describe the emergence of psychic meaning and its controlling function. We thus have not only biochemical or molecular structure, but also thought structure to take into account. It is the study of those thought structures which should be called the study of the psychodynamics of depression. According to the circumstances, the depression may or may not have an independent depressive activity of its own within its own psychic domain. It is repeatedly said that the depression should first be treated by drugs and then, if necessary, psychotherapy can be provided as a sort of extra. It is less known that in cases when anti-depressant drugs have failed they may become efficient after psychotherapy has altered the depressive psychological structures but where the organic element does not respond to the psychic changes. That is because the state of depression is over-determined psychologically in those cases.

In the same way as there is a hierarchy of supporting processes in the organic field there is a hierarchical organization in the psychological supportive system. The understanding of this hierarchical organization is absolutely vital in understanding the dynamic of depression. Depression is a mood, a sensation-feeling related to the experience of loss. But it is not only a loss; the statement must be completed. What is lost must be defined, for it is the hierarchical organization of the relationship within the psyche of the object lost which is of vital importance. In reactive depression some loss is apparent, for example, a loved one, a job, an ideal, self-esteem or money. In the so-called endogenous depression the loss may not be apparent and more bodily involvement is noted. Manic excitement comes into the picture as well.

I wish to consider the problem from the angle of: first the hierarchical organization of the personality, and then the hierarchical organization of the object relationships.

In order to convey what I mean by the hierarchy of object loss, I will start with an example from *The Soul of the Ape* (1969) by Eugène Marais, the South African author of the better-known book *The Soul of the White Ant* (1973). Marais describes how a mare that lost her foal by drowning in a river kept going back to the site where the foal disappeared. No matter what efforts were made to show her the recovered body of the foal, she ignored it and returned to the place of its disappearance. Marais contrasts this with the behaviour of an ape who had lost her baby. She showed signs of sorrow, stopped her restlessness, touched the body, made sounds of endearment, put her face and lips close to the dead infant, uttered a succession of cries, and then sat in a corner. Later she returned to her normal interest in the environment. The loss of the object in each case was experienced differently.

Compare this with Piaget's experiments with small infants with regard to disappearing objects. If an object is covered with a cloth at a certain age, the infant looks for it at the place of disappearance. Even if the object is moved after its disappearance under the cloth at site A to site B in the presence of the infant, he still will look for it at A where it originally disappeared. However, as an object becomes more and more meaningful and its mental representation in its absence becomes more permanent, the infant reacts differently to the absence of the emotionally meaningful object. Thus, we know through the work of Spitz that infants deprived of their mother *between the ages of seven and nine months* may show various kinds of separation anxiety, including a most severe state of despair called anaclitic depression. This reaction does not occur at an earlier date.

We have a hierarchy of physical processes supporting other physical processes and more closely connected with mental processes. We have seen how in the paradoxical phase of sleep, physical states and mental representation or meaning are more closely linked in a psychosomatic union than in deep sleep or in the state of maximum alertness. Now we are seeing the possibility of a series of hierarchies within the psychological series itself and in its own rights. We have to find where in the hierarchy the system 'reaction to object loss' is situated to produce the well-known clinical picture of depression.

Once more we must point out the error of a Linnaean classification in rigid categories as applied to mental illness and substitute a Darwinian approach. There can be no doubt at all that we see patients who at times show a schizophrenic picture and depression at other times. We know of mixed states, of schizoaffective disorders and of recurrent cyclical states where schizophrenic and depressive manifestations alternate. Even Kraepelin has described intermediate states. Assessed in the light of the hierarchical psychophysical organization of the personality, it has been suggested that a schizophrenic breakdown proceeds from a schizoid stage of development, and depression from a depressive organization. These are not just words but refer to the behaviour of the infant during the sensori-motor preverbal stage of development. What matters to us is the nature of object relationships during this phase. They are of primary importance in determining whether a loss in later years will result in one case in a breakdown of the self, and in the other case in a breakdown of object relationships characterized by the syndrome of depression.

In the uterus, the death of the mother brings about the death of the foetus: self cannot survive the absence of the mother. During the first few months of life the mother or substitute mother, reconstituting an external womb by her care, mainly exists so that the baby can preserve its existence. Only slowly does she acquire psychological meaning. After six or seven months the situation is different: the mother, biological or substitute, becomes emotionally meaningful and her loss produces severe separation anxiety

known as anaclitic depression, as previously mentioned, although the infant could survive biologically through a substitute.

This is the second birth, the birth of what is human in terms of a meaningful emotional attachment, however primitive it may be. Unfortunately, the term 'depressive position' used by Melanie Klein has been the source of misunderstanding among psychiatrists, research workers and even psychoanalysts. It does not mean that the child goes through a depressive illness. It means that at about the time of the organization of the self and of object relationships the infant can react with moods of either sadness or depression to the loss of the object. The distinction will depend not on external circumstances alone but on what goes on in the internal or psychic reality of the infant, as opposed to what happens in the external situation or external reality.

It is essential to stress here the difference between internal or psychic reality and external reality. The situation in the mind of the infant must be understood. One factor of immense importance is the degree of anger that the infant feels when frustrated. It is important to note whether or not the anger is accompanied by phantasies or infantile attacks and revenge towards the mother. When the aggressive frustration arising from either within or without is strong enough, a primitive sense of responsibility or primitive link between anger and loss brings about the mood or syndrome of depression, as opposed to sadness.

A vital mistake is made in studies attempting to relate early deprivation to later incidence of depressive illness. All infants do not react in the same way to situations. The rhetorical question is what kind of an infant met deprivation, real or phantasized, and was the deprivation in external reality or was it an experience in internal or psychic reality and constructed by the infant?

It is now necessary to relate the state of affairs to the model of hierarchical supports. If this particular storey in the building – not quite the basement, which is reserved to schizophrenia, but shall we say the ground floor – is sufficiently pathologically organized, all other floors relating to object relationships will suffer structural distortions. Later in life any loss of any kind as described previously will be structurally and symbolically linked to the earlier experiences through a series of pathologically structured storeys.

A large number of psychiatrists and therapists of all sorts and denominations believe that they are treating depressive patients by therapy when chatting with their patients. In fact they are treating nothing at all. They have no regard for the specific, and do not give consideration to the fact that, under its manifold facets and varied symbolic expressions, the state of depression in proper treatment unfolds itself in a very specific way. Although in many cases the state evolves spontaneously to some sort of recovery, helped perhaps by an object relationship of a kind in the transference situation, this has nothing to do with the know-how based on the dynamics

of the depressive state, especially in cases that do not respond to drugs or kindness.

It is obvious that the state of depression can be started from either end of the hierarchical system. If it is started from the psychical end it may remain situated within the domain of psychic or inner reality, or it may spread to the physical hierarchies. If it starts from the physical side it is only when the psychical domain will be involved that the state of depression will be experienced because a depressive meaning will be provoked. I am convinced that there exist physical states which, although the same as in overt depression, are not accompanied by depression, for instance in certain biocyclical states. This is because the depressive psychic organization is missing. Without it the physical process cannot produce the psychological picture known as depression.

No physical changes in the neurones can bring about the experience of depression. Only when the depressive organization pre-exists can a change starting either in the neuronal domain or physical hierarchy at one end, or in the psychological domain or hierarchy result in depression. Otherwise the stereotyped mental structures of depression, only symbolically different in their expression, would not be inevitably found and depression diagnosed. It is possible to proceed to a precise description of the psychic hierarchy and the psychodynamics of depression.

I shall now consider some of the symptoms of depression in terms of meaning as revealed during the analysis of innumerable states of depression all over the world, irrespective of culture. The impact of early infancy later leading to depression has been described. If we take the fate of the bodily functions, for instance, the picture is impressive. In the infant both the love and hate feelings have a normal strong oral character which fits well later in the depressive as shown by the disturbances of eating, lack of appetite and resulting loss of weight; or vice versa, by the bulimia and increase in weight observed in the course of a depressive illness. This is connected with the aggressive or angry rejection of the love object or the fear of cannibalistic attacks on the breast-mother. The bulimia is an attempt to replace the mother by food, as is well known, in a greedy, envious way. The mouth is also used to attack by means of words or angry noises. The analysis of depressive phantasies has also revealed the aggressive and destructive nature of excretory functions resulting in constipation or sometimes diarrhoea.

In an attempt to control the destructive processes, depriving the patient of his or her internal objects projected in the external object, the process of retardation sets in: the patient becomes less and less active, slower, and sometimes reaches complete immobility and stupor. This abolition of activity as revealed by phantasies expressed in treatment or often spontaneously, if one cares to listen and observe, is carried on in order to try to control the destructive activities of the body as part of a psychodynamic regression to early modes of thinking and behaviour.

Movements are stopped in order to do no harm; the same applies to the mouth both for eating or for speech activities, which are experienced as aggressive, and constipation sets in to stop the outpouring of destructive faeces, and so on. The sexual impulse undergoes the same fate: libidinal impulses are dangerous as they bring the subject in contact with his loved object with possible dangerous consequences due to the destructive impulse, and also because of the need for a hurtful rejection. Regression may extend to biochemical processes such as interference with gonadal activity and many others. Thus sleep is disturbed. There is less sleep, more drowsiness or restlessness, a diminished phase IV, and a diminished REM phase and therefore less dreaming. It is tempting to suggest that what is not expressed in the dream may be lived vividly in awakeness.

It is clear that the method used in this process is a psychobiological attempt at abolition of function. This process is pathological and in a way is part of the destructive process itself. However, after a while it seems that the process of control comes to a stop and life begins to return in some cases but not in others. The blocking can be located in either the physical or the psychical hierarchies or both.

Freud clearly saw those processes of dissolution and reconstruction, for in *The Ego and the Id* (1923) he compared them to processes of metabolism and anabolism. It is also clear that for him it was more than an analogy. In 'Mourning and Melancholia' (1917), Freud gave the first and most important clue to the beginning of the understanding of the psychodynamics of depression. In melancholia the object attacked and damaged is introjected and the subject identified with his object. The self becomes damaged and mood is depressed. However, Freud saw more than this. He realized that the self-reproaches of the melancholic were not to be taken at their face value. They at least have a twofold meaning: by this process of identification of the self with the object, the self-reproaches are still directed towards the object as well as to the subject. Thus, the attacks are not given up and recovery is impossible. Guilt and despair predominate. In mourning, the attacks on the object and the sense of responsibility and guilt for the damage to and the loss of the object are missing. We now know a great deal more regarding this process. That is, we know about the defences used in depression, the reasons for their failure, and we know more about the processes of recovery and of reparation. Melanie Klein and her followers have contributed a great deal to this knowledge.

Having substituted or identified himself or herself with his or her object does not mean that the attacks on the object and sufferings caused to the actual environment by the behaviour of the depressive cease to exist. Another manoeuvre is to split the object into a good and bad part in an attempt to save and preserve a good object. This often results in an inability to relate to good objects for fear of destroying them. Yet here we see an important germ of the reparative process, that is, the beginning of a caring feeling although selfishness may still be at work.

The subject often develops a sense of persecution by the bad object which negates the aim of the splitting defensive process. The more schizoid the subject, the more splitting will be resorted to and a vicious circle results. The underlying process is obvious: the subject cannot give up his aggressive impulses and his revengeful attitudes; he is governed by the law of talion: an eye for an eye, a tooth for a tooth. There is no reparation but guilt and punishment. Despair dominates the picture because not only do the attacks fail to cease but the damaged object has to be repaired in a concrete way, as in the example of the mare looking for its foal as it was before death, while only God can bring Lazarus back to life.

Therefore, if omnipotence has to take over as it does when reality has to be denied, a manic state sets in. In this state, a falsely repaired object replaces the damaged object. Instead of sadness, emptiness, guilt and despair, which are the appropriate moods in response to the state of the terribly damaged object, a mood of denial of psychic reality takes over, characterized by the falseness of everything, a mood of false activity, or elation, and the pretence of corresponding to the omnipotently created false replacing object. This state is very difficult to treat. In the manic state the replacing object is a manufactured grandiose phallus as opposed to the breast-mother in depression. The mood and behaviour in each instance correspond to the state of the internal object to which the subject is relating.

The depressive must be treated in the state of depression and not during recovery or manic elation, when everything is more difficult. By recovery I mean recovery without profound changes in the psychic organization of the self.

It must be made clear that the statement of the patient that he or she is not good, has caused damage, has brought about misery, must not be contradicted. In his or her own psychic reality everything the patient feels and experiences consciously or unconsciously is true for him or her. Reassurance that this is not so is wrong and can only increase the patient's despair of being understood. Instead he must be helped to understand this painful mood, and feelings of guilt are quite appropriate granted that his belief and experience are that he has acted and acts badly, causing misery to others. When this is understood the situation changes. Without this sorrow and regret there is no hope of giving up the destructive process in order to make reparation.

However, despair still predominates. The patient does not know how to stop the aggressive impulses and to repair the damaged object. This is because he does not trust his love impulses and because his sense of reparation is concrete and directed towards the external object, which could in fact be irreparable. The patient must then first be helped to see that the sense of regret and despair could not exist without a good, loving and

sensitive aspect of self being active, and that this part must be trusted and used more constructively than savagely to punish him or herself, which is of no use to the object. Second, since the damage can be either entirely in the inner world of phantasy or in the external world, it is the inner object that must be repaired first. The sense of compassion and caring for the object helps to diminish the aggressive impulses. The necessity for splitting into good and bad diminishes. The patient can then gradually see that the same object may at times be good and bad; he then realizes that the same applies to himself. Compassion and forgiveness replace the law of talion and revenge through the conscious emergence of his previously unrecognized aspect of the self. A new relationship emerges between the subject and his internal objects. This new attitude is then directed towards the external objects. The original distorted primal object relationship is no longer projected into and on to the external world and throughout the inner world of hierarchical organization of object relationships. A new world of object relationships may then be achieved through an internal psychic change.

It remains to mention the so-called masked depressions and depressive equivalents. They really are of two kinds. The more schizoid the patient, the more he or she will rely on the splitting, projection and denial of the depressed part of the ego. This results in a deadened sort of attitude, sometimes accompanied by depersonalization and derealization as a result of the loss of a feeling part of the self. The other defensive process is either physical or hypochondriacal somatization. Just as there are biochemical structures there are psychic structures that can also be strictly described, and whole properties must be understood in order to understand the dynamics of depression. The dynamic explanation, a great progress in itself, will also have to find its metasystem. But it is certain that this metasystem will have to take the dynamic metasystem into account, for according to the order of things it can never bypass it.