

Deconstructing Depression

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Mr. Smith enters the room with a slow, shuffling gait, his head bowed and shoulders slumped in a dejected posture. His sad expression has a glowering quality that makes you uneasy. He speaks slowly, volunteers little, but gives the impression that beyond his sparse words are volumes of dark thoughts. You wonder if his self-deprecating utterances are the tip of a delusional iceberg. You look for ways to assess his potential for suicide.

Your first thoughts are diagnostic. You run through the diagnostic alternatives for obvious depressive illness, take some additional history and consult with the family to help narrow down the possibilities, check for comorbidities, make a five-axis diagnosis, decide that hospitalization isn't imminently warranted, and reach for the prescription pad. After discussing the slow onset of medication benefits, the side effects and precautions, you make another appointment in a week or two, mindful of the danger of suicide during the initial period of therapy.

The process described above is part of the task—the beginning of your work. From the start you are trying to gain Mr. Smith's confidence, to encourage him to trust and open up to you, and to get a feeling for what is making him so miserable. As you get further engaged, you move beyond the global view of Depression with a big "D" into a welter of conflicting emotions and thoughts. I have come to view this process as "deconstructing depression." Depression now becomes a very individual and uniquely human matter. Psychotherapy becomes highly relevant, fundamental to effective patient care and treatment.

What is the source of this person's hell? Even in the most biological-seeming of depressions there is something to be learned about the depths of pain and self-deprecation. At the least, these patients need help with acknowledging the fear they feel about the catastrophic change that has come over them. They have abruptly plummeted into a strange and threatening world in which their self-esteem and optimism have been devastated. Their thinking is clouded and slowed, and their usual sources of pleasure in food, sleep, social relations,

work, and sexuality have become foreign to them. Their experience of living has profoundly changed, and death may seem like the inevitable escape. Added to this overt response to terrifying change is their unconscious response to internal danger, emotions, and impulses beyond their awareness.

Broadly speaking, the subjective experience of depression can be broken down into aspects of sadness, anger, guilt, despair, and diminished self-esteem. The patient's relationships figure heavily in the emotional picture, as do many dimensions of personality and life experience. Losses—immediate and long past—often play a precipitating role. While depression may be an unaccustomed state for the patient, the emotions are those of a person with a life history. Depression does not occur in a vacuum.

Psychotherapy plays a crucial role in the treatment of depression.¹ Interpersonal psychotherapy (IPT) focuses particularly on the patient's relationships and roles in regard to others. Cognitive behavioral therapy (CBT) seeks out underlying "automatic thoughts" and "schemata" that stimulate the painful affective state of depression, while teaching active behavioral techniques to manage anxiety and dysphoria. These structured therapies have been studied in manualized, randomized controlled trials that have demonstrated their effectiveness as "specific" therapies.¹ Psychodynamic psychotherapy focuses more broadly on the person as a whole and has a long-established experience base. In a flexible approach that meets the patient where he or she is, it may work with any or all of the issues outlined above.

Loss. What may be obvious to the therapist is not always obvious to the patient. Sometimes the patient needs help in identifying the loss or injury that precipitated the depression. This may be the death of a loved one, or a rejection; being terminated from a job; retirement; moving from a longtime home; surgical removal of a body part; an ominous diagnosis; loss of status—in

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sum, loss of almost anything important to the patient. Yet, not everyone who experiences such a loss goes into a clinical depression. Much depends on the person's personality makeup, the presence of other sources of satisfaction in his or her life, the manner in which the loss occurs, associations with previous major losses, the importance of what was lost to the patient's self-esteem, and other variables such as biological and genetic risk factors. When these meanings become clearer to the patient, working through can occur and the patient may feel less mired in a non-specific anguish.

Sadness is, of course, a natural feeling after a serious loss. There is a distinction between normal grief and depression. As Freud described in the classical paper, *Mourning and Melancholia*,² mourning is a natural process in which memory representations of the lost love object are visited again and again, often with recall of old feelings of all sorts, in addition to the sadness that goes with appending the new information about death or loss to the memory trace. Only after processing the huge array of memories of the lost one can the mourner really believe that the loved person is now gone. Often the mourner identifies with some aspects of the person being mourned, without being particularly conscious of doing so. The process takes months, a fact that has been recognized socially in religious observances that acknowledge that a year has passed since the death of a congregant.

The natural process of mourning can become derailed when the relationship with the loved one has been a stormy or excessively dependent one, and then depression (melancholia) is more likely to occur. Helping the patient accept mourning as a natural process and sorting out the issues that interfere with it is a major aspect of the specific psychodynamic treatment of depression.*

Anger and guilt. These emotions follow from the interference with mourning that occurs when the lost relationship has been powerfully ambivalent—where strong attachment has been intermixed with control struggles, intense dependency, past injuries, or even hate. Sometimes the patient has neglected or done harmful things to the loved one, about which he or she appropriately feels guilty and now has no way of atoning directly to the injured party. Almost invariably there are

things one failed to do or did badly that are part of normal life but now cannot be undone. In addition, the patient may have cause to be angry with the loved one about recent events, even the event that led to the death or loss of the relationship—and anger at a time of mourning feels unseemly. Ventilation, support, and recognition that such imperfections are part of everyday life help to assuage the pain.

But there may also have been a longstanding adaptation in the relationship in which the patient's anger or hate has been suppressed or denied. This may invoke the defense of turning anger against the self, manifested as a sadistically punitive infliction of pain upon oneself. The patient may be tormented by guilt that appears grossly unjustified to the therapist in view of what is known of the circumstances. The hidden part, the source of negative automatic thoughts or impulses to self-injury, is the misdirected rage behind the guilt. In severe cases, the patient may delusionally believe that he or she possesses the worst characteristics of the lost person. For example, a woman of highly moral character, claiming she deserved to die, accused herself of being an alcoholic and flagrant philanderer, when in fact it was her recently deceased husband who had behaved that way. In addition to the medications or electroconvulsive therapy that can mitigate such severe psychotic depression, psychotherapy provides an environment in which guilt and underlying rage may be expressed in words rather than destructive actions. Patients may also become more able to assert themselves actively and appropriately, rather than being passive to the point of paralysis.

Relationship issues are another way of viewing these powerful emotions. IPT focuses particularly on grief work, role transitions, role disputes, and interpersonal difficulties in the patient's current relationships. Psychodynamic therapy is also likely to do this, but with the added dimension of using the present relationship with the therapist as a laboratory for studying past and present issues.

Attachment issues. Many depressed patients feel impoverished and alone, even when there are people around them who would be supportive if allowed to do so. An empty and hopeless attitude towards life may have its roots in very early life experience with a depressed primary caretaker who could not engage warmly with the infant child. Chronic or dysthymic depression is sometimes seen as arising from an identification with a depressed parent, which may be reflect-

*The working through process of mourning that Freud described is remarkably similar to modern theories of the encoding, storage, and modification of memories in cerebral neural networks with ties to the basal structures that serve emotions.

ed in the transference, and which may be modified somewhat if the early attachment issues are recognized and worked through.

The vagaries of self-esteem also play an important part in depression. I have seen patients become depressed when an orthopedic injury prevented them from playing tennis or golf, sports in which they took great pride. Patients often feel ashamed of their distressed and dysfunctional state, and they need support and help in understanding what is happening to them—particularly that it is not the product of failure or weakness on their part. Patients with vulnerable self-esteem and high sensitivity to narcissistic injury may need to recognize this character trait and relate it to its origins in earlier relationships. The same issues may also be salient in the transference, accessible to addressing relationships between self and other right in the here-and-now treatment setting. This work places particular demands on the therapist to be tuned in to his or her own countertransference feelings, because of the ambiguities introduced by a patient's narcissistic traits. The patient may take great offense at imagined slights or projected criticisms or may relate in a very detached or self-centered fashion that leaves the therapist feeling bored, disconnected, or annoyed.

Anxiety, dread, or outright fear is a common companion of depression. Early morning seems like an especially anxious, even agitated, time that may have biological underpinnings. In my practice it has been especially notable with older people whose spouses have recently died, leaving them feeling overwhelmed with dealing with life alone. Fear of the unknown is another way to put it. There are often many practical issues that must be dealt with after a spouse dies, which the survivor has never had to undertake—whether paying the bills, looking after property, housekeeping, or preparing meals alone. Some of this could have been avoided before widowhood by both spouses learning about how to handle everything from cooking to taxes, but such a leveling of the division of labor seems to be rare. Denial of mortality is a powerful defense mechanism known to all of us. Now the patient must face the void left by the lost companion of many decades. In time, and with

encouragement and validation, people do learn how to manage and to marshal assistance when needed, so that they can accept and adapt to the change in their lives. For many this happens naturally, but for some people psychotherapy is an indispensable aide to resolution. The dependability of the treatment relationship is especially important in this aspect of the work, as for a time the therapist becomes a surrogate object of attachment.

We feel fear in the face of a known threat, such as a tiger stalking us. Anxiety is a more diffuse emotion in which a specific threat cannot be identified. It is a sign that we feel in danger of being overwhelmed by some emotion or dark realization inside us. In a depressive situation it may be a clue to unconscious thoughts that could evoke dangerous rage or devastating guilt if they came to light. Psychotherapy provides a structured, safe way in which the patient can come to terms with the disturbing thoughts and feelings, understand their origins in past and present dimensions, and deal more constructively with specific issues.

From depressive torment to ordinary human suffering. Given the complexity of human nature, this treatise cannot address every possibility as we seek to tailor our therapy to the individual needs of each patient. The central principle is that each patient brings his or her own unique version of hell, so that providing treatment that is tailored to the needs of each individual must depend on “deconstructing” depression to address the particular emotions, life situation, and personality strengths and vulnerabilities the patient presents to us. In this way, the torment and agony of depression may in time give way to the more ordinary pain of loss and grief, which can resolve through natural working through, so that the person eventually emerges into a brighter world of new interests and relationships.

References

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