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A Psychotherapist Looks at Depression

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1. Depression is not an illness, but a psychobiological reaction which can be provoked in anyone.
2. It is much more easily provoked in some people than in others.
3. Vulnerability to depression is partly dependent upon social factors, as George Brown has demonstrated. It is also determined by internal factors in the personality.
4. There is increasing evidence to show that the child's attachment to his mother is an important determinant of future mental health.
5. It will be argued that children who make 'anxious attachments' to the mother, as described by Bowlby, are less likely to incorporate her as a 'good object' within the psyche, and that this renders them more vulnerable to later depression than children who form 'secure attachments.'
6. Many features of depression in adults resemble or are related to 'anxious attachments.'
7. The way in which psychotherapy can alleviate vulnerability to depression is described in terms of this hypothesis.
8. Reference is also made to the fact that effective action can be a source of self-esteem as well as love. Many of the great creators were partially effective in dealing with vulnerability to depression by work.
9. Freud affirmed that mental health depended upon the capacity to love and the capacity to work. It will be argued that the former capacity has been over-emphasized at the expense of the latter.

Years ago, when I was in training at the Maudsley Hospital, we were taught that there are two kinds of depression, reactive and endogenous. I am glad to say that I never accepted the validity of this distinction. All it seemed to mean was that, in cases labelled reactive, the doctor could define an obvious external cause for depression, like bereavement or bankruptcy, which he could see might cause depression in himself. Where no such obvious circumstance could be discerned, the doctor concealed his ignorance by calling the patient's condition 'endogenous'. The word 'endogenous' ought to be forbidden in psychiatry. Its implication that the condition so described is rooted in the patient's genetic structure discourages research. Much the same strictures apply to the use of the phrase 'depressive illness,' or 'affective disorder.' The assumptions underlying this use of language have prevented us understanding depression. Depression is not an illness which one catches, like influenza, but a psychobiological reaction which can be provoked in any of us, given appropriate circumstances, and which may have some positive uses. Today, one encounters patients who refer to 'my affective disorder' as if it was as unrelated to their personality as measles, which seems to me quite ridiculous. Every time I encounter George Brown's work on *Social Origins of Depression,* I blush for my profession. We have allowed a sociologist to discover what psychiatrists ought to have found out years ago, but failed to do because of their pseudo-medical assumptions.

Depression, so it seems to me, varies in degree, but not in kind. That is, the severe cases which require anti-depressant drugs or ECT, and which are beyond the reach of psychotherapy, are extreme examples of the kind of cases which are referred to psychotherapists, but are not suffering from a different kind of disorder. Even the most robustly 'normal' human being is vulnerable to depression of psychotic intensity, given enough provocation. This is born out by the ordinary response to the techniques employed by the police in Communist countries. If a man is arrested in the middle of the night, removed from those he loves, rendered ineffective by separation from work and society, given no information either about his supposed crimes or about what is going to happen to him, and kept incommunicado in solitary confinement, he will become severely depressed. Hinkle and Wolff (1956) reckon that it takes from four to six weeks to produce a condition resembling psychotic depression in a newly-imprisoned man.

What has happened to such a person? He has suddenly been deprived of everything which made his life worth living; more particularly, of everything which sustained his self-esteem.

Fortunately, most of us will never be exposed to such extreme and sudden loss; but all of us, at different times, experience bereavement, disappointment, and failure. Some people, in response to losses which are normally regarded as minor or transient, develop severe depression. I call such people 'depressive

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personalities'. Such people are particularly *vulnerable* to depression. For example, a severe depressive reaction may be provoked by failure in an examination, or by a quarrel with a loved person. Failure induces feelings of total hopelessness; the passing disagreement implies that the relationship is irreparably damaged; that the loved person is lost for ever.

We know, from the work of George Brown (1973), some of the social circumstances which render women liable to develop clinically definable depression in response to traumatic events, and these are so familiar that I will not repeat them here. But one of Brown's factors refers, not to present social circumstances, but to the past. He found, you will recall, that women who had lost their mothers before they were eleven years old, were particularly liable to develop severe depression in response to unfavourable life events.

Severe depression is characterized by a disastrous loss of self-esteem, which manifests itself in hopelessness, helplessness, and self-reproach. George Brown's finding suggests that self-esteem is somehow connected with the subject's relation, or absence of relation, with the mother. I think that we are now in a position to propose a viable, and ultimately testable, hypothesis about persons who are particularly vulnerable to depression, which links together both clinical observation and psychodynamic theory, and which also provides a basis for treatment.

The hypothesis is that self-esteem varies greatly from person to person: that those who have a good deal of built-in self-esteem are less vulnerable to depression in the face of adversity than those who have not; and that what decides whether a person acquires a built-in sense of self-esteem chiefly, but perhaps not entirely, depends upon his or her childhood relationship with the mother.

The notion that the child acquires a kind of built-in self-esteem from an early, positive relation with his mother, and that this is protective against developing severe depression in response to trauma in later life, seems to me to be a common factor underlying a variety of opinions expressed in different terms by different authors. Thus, a behaviourist might see an early, positive relation with the mother as providing the setting for repeated positive reinforcement, conditioning the child to expect rewards in life, and enabling him to tolerate short periods in which such rewards were not forthcoming without distress. Erik Erikson is surely referring to the same thing when he discusses the development of "basic trust." "The infant's first social achievement, then, is his willingness to let his mother out of his sight without undue anxiety or rage, because she has become an inner certainty as well as an outer predictability" (Erikson, 1965). Erikson's description seems to accord closely with the Kleinian view that the infant strives to acquire, to introject, and to keep inside itself, a 'good object.' Winnicott is using a similar concept in his well-known paper 'The Capacity to be Alone.' This capacity, he states, "depends on the existence of a good object in the psychic reality of the individual," (Winnicott, 1965) which in turn depends upon the infant's previous experience of love and care.

One of the most notable characteristics of adult depressives is the absence of an inner source of, or base for, self-esteem. This means that they remain dependent on outside sources for maintenance of self-esteem, and if deprived of an outside source, relapse into depression. Diabetics who cannot manufacture their own insulin require injections of it. Depressives, who have no inner source of self-esteem, require repeated injections of reassurance, love, and success to maintain emotional stability.

We can fruitfully link this idea with Bowlby's concept of attachment. It seems highly probable that children who form secure attachment to the mother in early life introject her, or build her in to their system, and thus acquire inner resources of self-esteem. Children who form anxious attachment do not acquire such inner resources. This is born out by recent work on 'Attachment and Maternal Depression,' reported by Andrea Pound. Young children of depressed mothers tend to be either tyrannically demanding or else unable to separate from the mother. Some survive by precocious independence, become closely orientated to the mother's mood, and become an attachment figure for her before they have completed their own development. Andrea Pound observes that a child in this predicament is "precipitated into what Winnicott calls 'the stage of concern' before he has fully completed the earlier stage of using and sometimes misusing the attachment figure to establish his own sense of identity." She confirms my own finding that, if a child becomes orientated primarily to the needs of the other too early in life, he becomes unable to identify his own needs. Pound writes: "They are unaware of most of their own impulses and emotions and have to construct their behaviour on the basis of conventional expectations, with a resulting sense of emptiness, frustration, and dissatisfaction" (Pound, 1982). She might have added that some people with depressive personalities continue to minister to the needs of others in adult life, just as they had to learn to minister to the needs of a depressed mother when they were young. Those of us who have had in treatment psychiatrists, social workers, and other members of the 'helping' professions know that this is one reason for entering such professions. Depressives often become expert at identifying themselves with the needs of others, and develop sensitive antennae which tell them what others are feeling. This is partly because it is

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necessary for the potential depressive to avoid offending people, in order to be sure of continuing to obtain repeated assurances of their good opinion of him. The helping professions are occupations in which, most of the time, the helpers do in fact obtain recurrent affirmations of their own worth from the gratitude and dependence of those they are helping. It is a truism to state that analysts need their patients.

I suggest that it is not only depressed mothers who foster insecure forms of attachment, and who thus deprive their children of built-in self-esteem. Clinical observation suggests that mothers who are chronically physically ill may have the same effect in causing their children to be watchfully overconcerned when they ought to be carefree and self-absorbed; and I suggest that those who are pursuing research into origins of depression ought examine this possibility. Depressed mothers and physically ill mothers seem unable to give their children the kind of love which fosters secure attachment and subsequent incorporation of self-esteem. The love which they can give is too conditional upon the child being 'good,' and not making too many demands upon them. Self-esteem seems greatly to depend, at the beginning of life, upon being irrationally loved merely for existing, without any conditions or qualifications. When Lord Melbourne remarked that what he liked about the Order of the Garter was that there was "no damned merit about it," he was referring to the same phenomenon; and part of the appeal of Royalty undoubtedly depends upon their being loved and idealized for their mere existence, irrespective of whether they deserve it.

Freud remarked that "if a man has been his mother's undisputed darling he retains throughout life the triumphant feeling, the confidence in success, which not seldom beings actual success along with it" (Clark, 1980). This was, you will recall, Freud's own experience. He was his mother's first-born, and she referred to him as "my golden Sigi." I have no doubt that it was because Freud carried within him an unshakeable conviction of his own worth that he was able to surmont the difficulties of his early years, maintain his point of view in the face of much opposition, and resist with such fortitude the recurrent, malignant growth which required so many operations and plagued his later years.

Although the most important source of self-esteem may derive from loving and being loved, it is not the only one. Another source is the sense of being effective, more particularly, of being autonomous. Anxious attachment makes autonomy difficult to achieve because it fosters dependency, and inhibits aggression, both in the sense of the expression of anger, and, more importantly, in the sense of self-assertion and effectiveness. The child who has not acquired a built-in sense of self-esteem dare not disagree with, complain to, stand up to, or quarrel with his objects, because to do so might mean cutting off his source of supply. Hence the well-known difficulty which depressives have in disposing of their aggression, which they turn against themselves in reproaches which, as Freud pointed out, should often more genuinely have been addressed to their nearest and dearest. When Bruno Bettelheim spent a year in Dachau and Buchenwald, he noticed that those who came to feel that they were entirely at the mercy of their terrible environment, who abandoned any attempt to influence events, rapidly died. Such prisoners were known as 'Muselmänner;' a reference to the supposed fatalism of those professing Oriental faiths. To cease all autonomous action is to cease to live. Bettelheim decided that he would make use of his incarceration to observe and enrich our knowledge of the behaviour of human beings in extreme situations, and triumphantly achieved his aim in his book *The Informed Heart* (Bettelheim, 1961). I think that Seligman's experimental work on learned helplessness reinforces what Bettelheim observed. The dogs who, in the face of unpredictable trauma, give up and merely whine, are the 'Muselmänner' of the laboratory. Learned helplessness is also a feature of the apathetic variety of chronic depression which accompanies institutionalization and which, if prolonged, unfits the individual for ordinary life.

Self-esteem can be at least partially maintained by effective action, even in the absence of loving relationships. Most of the depressives who come the way of the psychotherapist are somewhat helpless as well as hopeless; but there are others. When we encounter patients whose interpersonal relationships have gone wrong, but who maintain their self-esteem by being effective, we are apt to refer to their efforts, pejoratively, as 'manic defence.' Of course, effective action can be frenetic, or even exhausting. Mourning can be pathologically avoided or postponed by the overactive and by those with too stiff an upper lip. But the concept of manic defence is too facilely employed. We do not fully understand the relation between the ability to love and be loved, and the ability to be effective. Interpersonal relationships are not the whole of life, and it is often forgotten that Freud defined mental health in terms of the ability to work as well as the ability to love. Some depressed patients have to be admitted to hospital; but we should not forget that, by depriving them of the opportunity to work, we are depriving them of a source of self-esteem which might have sustained them.

There are many aspects of depression which I have no time to mention, but I think that the hypothesis which I have outlined, and which is gradually being

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more and more supported by work on attachment, can help us to understand what psychotherapy is able to do for the depressive personality and how it works.

First, those who are prone to depression are helped by insight. If they come to appreciate the origins of their tendency, it becomes less irrational and therefore less threatening. They also become more able to tolerate periods of depression, and more competent at avoiding situations which trigger depression. The realization gradually grows that even the worst attack usually comes to an end. Second, the therapist can, at any rate partially, become introjected as a good object, and thus become an inner source of self-esteem. the process is exactly analogous to that which we suppose takes place in the small child. The therapist's repeated acceptance of, tolerance of, and, dare I say, love for, the patient gradually allows his incorporation into the patient's inner world so that he continues to exist there even when the patient is no longer seeing him. My evidence for this is necessarily anecdotal, but I see no reason why the phenomenon could not be experimentally investigated. Unfortunately, this process generally takes a very long time. I cannot see it happening in brief therapy.

The third way in which improvement can occur is controversial, for it will be seen, by some analysts, as merely strengthening, or enabling the patient to make better use of, his defences. It especially applies to patients with some talents or capacities. I have been fortunate in having as patients a number of creative people writers, musicians, painters and the like. They come in a state of depression provoked by a work block. If they get over their work block, they tend to cease to want therapy. It is well recognized that some of the greatest creators were people of depressive temperament. Michelangelo, Robert Schumann, Balzac, Virginia Woolf, John Stuart Mill, and Winston Churchill all had that in common, even if nothing else. They varied considerably in how well they dealt with their disorder. Schumann attempted suicide, and ended his days in a mental hospital. It is probable that his lifelong tendency to depression was exacerbated by organic brain disease. Slater and Meyer (1959) have charted his productivity in relation to his mood swings. Virginia Woolf, after several psychotic episodes, finally drowned herself at the end of their beautiful garden in Rodmell. Balzac effectively coped by means of hypomanic overactivity. He died at the age of fifty-one; and gross overwork probably contributed to his death. John Stuart Mill's account of his attack of depression is a classic which everyone should read. He became intensely critical of both his parents, succeeded in finding himself a woman to adore, went on working, and remained reasonably well so far as I know. Michelangelo's chronic state of depression is amply attested by his sonnets, as well as by his self-portrait upon the flayed, empty skin held up by St. Bartholomew in 'The Last Judgment.' He worked unceasingly until six days before his death at the age of eighty-nine. Until old age, Winston Churchill was usually successful in warding off what he called his 'Black Dog.' When he was not busy with the cares of high office, he was writing history, or building walls. When he became depressed after the failure of the Dardanelles enterprise, he took up painting. But, when he was imprisoned by the Boers for only three weeks before he escaped, deprivation of his power to act plunged him into a depression which he never forgot.

These highly gifted people are rather different from the general run of depressives whom psychiatrists treat. But their way of coping, or partially coping, with their temperamental difficulty does raise the possibility that analysts have been too much concerned with love, too little with work. Where object-relations are defective or virtually absent, work can be a resource upon which to depend, and repeated successful achievement can also be incorporated as an internal source of self-esteem. I know that, in our particular culture, we suffer from the Protestant work ethic, and that unemployment is going to force us into changing some of our assumptions. But few can maintain self-esteem on love alone. Candide said that "we must cultivate our garden." I feel sure that, if the garden were not the habitual resource of English men and women, we should have far more cases of depression to treat than we already deal with.

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