THE HUMAN DIMENSION OF DEPRESSION

A Practical Guide to Diagnosis Understanding and Treatment

Martin Kantor

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To M. E. C.

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Great events make me quiet and calm.
Only trifles irritate my nerves.

Queen Victoria

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Contents

Preface

PURPOSE

This book describes the depressive in his natural habitat, studies the everyday problems that cause his depression, and develops treatment approaches directed to his real-world plight. It explores the borderland between the sacred and profane, the academic and the popular, the scientific-but-impractical and the practical-but-unscientific, the academic/formal/inhuman and the underground/informal/human, the disease and its metamorphoses to normality and to creativity. It relies as much on common sense, anecdote, and individual insight as on such accoutrements of formal science as case histories and psychological test protocol.

COVERAGE

The book is in four sections: diagnosis, cause, prevention, and treatment. The section on diagnosis presents the mental status abnormalities in depression, includes a differential diagnosis of "classic" depressive symptoms, indicates when so-called "classic" symptoms of another disorder are in fact depressive, lists the physical complaints that are the product of depression, discusses normal depression, and touches briefly on hypomania.

The section on cause recognizes that common things are common and rare things are rare, with real troubles common and chemical troubles rare. It suggests that people do not become depressed because they are "stressed," "suffer losses," "introject anger," or "have interpersonal problems"; instead they become depressed in simple English: because their boss threatens to fire them, their wife threatens to leave, their cat dies, or every night on the way home the conductor on the train tells them to move forward for their stop and refuses to

give them a chit for their train ticket, and then another conductor meets them in the head car to ask them for their ticket and when they do not have one accuses them of not having paid the fare. This section faces the problems therapists and patients alike find unpalatable, shameful, and threatening—the things to which they close their eyes entirely, of which they speak in remote euphemisms, or about which they develop a socially and therapeutically sanctioned "politically correct" paranoia. This paranoia lets them blame external for internal problems—citing stress, loss, and trauma to cover their own masochistic fate-tempting, blaming their stars to obscure their role as their own worst enemy.

The sections on prevention and treatment are not attached to any one school of thought. They are formulated and expressed simply and humanistically, and offer commonsense solutions to the depressive's everyday problems with himself and with his world.

AUDIENCES

There are three potential audiences for this text: (1) the professional in clinical practice to whom the practical/academic approach appeals; (2) the depressive himself. Although self-help approaches are not a main concern of this text, they can be inferred. Within limitations a layman can profitably use the text to understand and help himself.

In recent times self-help has gotten a bad name, sometimes because the real subject of the self-help is the author, whose proposed strategy for living is really a strategy for promoting and selling a book. Of course there are important limitations to self-help approaches. For one, because depression does not arise in isolation from other people, it may not improve implicitly (i.e., by thinking about it without the help of a corrective emotional experience that involves another person). But self-help approaches can often be efficient, inexpensive, and useful for prevention of depression, for preventing minor from developing into major depression, for treating minor depressions, for stubborn, oppositional people who cannot accept what others tell them, for independent individuals who want to control their own destiny, and/or for those for whom formal psychotherapy is unavailable, unaffordable, or ineffective.

Some depressives are abandoned by friends, family, and professionals because they are off-putting: excessively needy, angry, difficult, and simply no fun to be with. For these people the book can tide over, serve as a companion, be a source of solace, an inspiration, a comfort, a source of support, and a giver of the illusion of company.

(3) The targets of the depressive. These are the family and friends who want to help him, but instead find themselves defending themselves against his devouring emptiness and need for company in his misery. Family and friends have a very bad time with people whose illness consists of seeing how far they can go in being as difficult as they can, and how long they can keep it up without backing down or killing off their target. For targeted family and friends, methods

of self-defense are recommended—not only because family and friends count as much as the patient, but because self-defense, when properly conceived and implemented, even though partly for spite, revenge, and retaliation, also helps the patient. This is because it sets limits that help him deescalate, that reduce his guilt, and that restore a degree of welcome self-control.

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Part I

DIAGNOSIS

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CHAPTER 1
Precision of Diagnosis

Depression is a term used both too widely and too narrowly. Clinicians who use it too widely apply it to diverse normal states, like sadness and grief, and diverse abnormal states, like paranoid paralysis due to fear, schizoid remoteness, schizophrenic anhedonia, and obsessive ambivalent paralysis. Some clinicians overapply the concept for neurotic reasons, perhaps because their own depression has colored their world in its depressive image. Others overapply the concept for practical, nonneurotic reasons: they run a depression clinic, have a research grant, or are caught up in a wave of popular sentiment. As for those in the popular sentiment category, each time a new cure for depression comes out we are reminded of a version of a familiar aphorism: when you have a new hammer, everything begins to look like a nail.

Sometimes it is the patient who deliberately or unconsciously misleads the therapist. He wants a depression because for him it offers an easy, convenient, though inaccurate way of organizing his self-perception and explaining otherwise unfathomable (but not necessarily depressive) experiences—especially when a psychosis is the right but unacceptable diagnosis and depression the wrong but acceptable one. Or the patient wants a depression because he wants to belong, and everyone else on the block has one. One pharmacist divined this motivation from listening to patients talk when they picked up their prescriptions for a currently popular antidepressant drug.

Some clinicians who apply the concept too narrowly deny depressive dynamics in others to hide them in themselves, from themselves. Or the diagnosis is not made because the patient disguises the illness: (1) as a behavioral symptom, like kleptomania; (2) as an attitudinal symptom, like loss of interest; (3) as a physical symptom, like headache; (4) as another psychological disorder, like pseudoparanoid depression, where the paranoid delusions are not persecutory but involve

low self-esteem. Just like any masked reveler, disguised depression nevertheless remains potentially identifiable behind its mask. If it is no longer identifiable, if there is no depressive affect aura—if not detectable, then at least suspect—another diagnosis may be needed.

This chapter's description of the clinical manifestations of depression is organized according to the parameters of the mental status examination. (The clinical manifestations of hypomania are discussed in Part I; Chapter 7.) While the diagnosis of depression is not warranted unless a significant number of the below-described signs and symptoms are present, it should be suspected even in the presence of just a few of them.

APPEARANCE

Depressives who are not seriously ill are motivated to remain in the mainstream. Such depressives allow only subtle and modest abnormalities in their appearance. Rarely does a depressed person allow regressive changes. Rarely does he look bizarre as the result of deterioration. Conversely, it is quite possible to be severely depressed without becoming dilapidated.

Depressives may dress to look muted, to suggest, "I am not a proud person." They may dress to look just a bit out of style, to suggest that they are not quite good enough to keep up. They may be messy in a controlled fashion to convey defiance. Or they may be slightly shabby to convey defeat. This abject, defeated look usually betrays the masochistic, "kick-me-because-I'm-down" depressive. It is typically underscored with mannerisms like a stoop and a shuffling gait, as well as a hangdog expression which may leave a permanent mark on the skin tone. Or the depressive may dress well but react with extreme indifference to compliments.

SPEECH

Some Purposes for Depressive Speech

Unlike schizoid speech, which ignores us, depressive speech involves us. Depressed people are fond of doing this obliquely by making sure we get to hear what they have to say, yet not addressing us directly. They thus avoid any responsibility for justifying or accounting for their sentiments. Particularly when they suspect they are being criticized, they also like to learn our thoughts by indirect means (i.e., eavesdropping), and they often surprise us by their ability to hear even the lowest whisper.

In a manner suggestive of the passive-dependent person, these people may talk to themselves for reassurance, as in this example provided by a woman patient: "Now, you really know that he loves you, don't you? Let me list how. . . ." They may hum, whistle, or sing to themselves, especially when under tension. They may also prattle to themselves, especially when mildly agitated.

Condensed Words and Expressions

The depressed person prefers words that embody not one but several meaningful depressive ideas. An example is the word "bitter," which suggests a bad taste in the mouth, a degree of ineffable suffering, and a hint of a relationship gone wrong. It follows that depressive speech is unlike the fragmented speech found in the schizophrenic group of disorders (e.g., fragmented schizotypal speech) and is unlike paranoid speech, in which a word is selected for one of its peripheral eccentric meanings, reflecting the patient's shift to an unusual, unexpected, often persecutory point of view. An example of this is the paranoid patient who used the word "want" to mean "steal," as in her criticism of her family, "You are another of those who want something." Instead of finding new ways of looking at things, depressed patients prefer, as one of them put it, "to beat a few of the old ways of looking at things to death."

Words That Express Favorite Topics

Favorite words express the content or subject matter of favorite recurrent themes. Words like "alone" and "rejected" can be related to such typical depressive topics as "my sad story"; "my quest for vengeance for unrequited or insufficient love"; "my torment (from always being ignored, from being pestered by difficult or impossible people that I can't get away from)"; and "my lifelong inability to attract and hold love."

Words and Expressions Borrowed from Drama

In their effort to convey their special depressive affect, depressive patients make heavy use of emotional words and expressions. An example is the dramatic word "angst."

Use of Sounds

In depressive speech, words are chosen for their sound as well as their meaning. This use of sound bears a certain resemblance to the clanging of hypomanics, who also prefer the sound of words to their meaning. Examples: Certain consonants, notably *s* and *t*, are often sharply stressed to accentuate the sinister implications of such words as vicious, terrible, or tragedy. Open sounds may convey primitive, although highly subdued, responses. Thus "eh" may be a primal shriek and "oh" a moan or cry of pain as in the onomatopoeic "woe." Patients may also mimic baby talk, using the familiar lisping *w* for *r*.

THOUGHT PROCESS DISORDER (AMBIVALENCE)

Description

Ambivalence is the inability to make up one's mind. Depressives are of two minds about many things. Any topic is fair game for this uncertainty, and it appears in equal but opposite attitudes both toward others and toward the self. Like obsessionals, depressives become paralyzed in thought and action when they shift between these equal but opposite attitudes. (Their victims also get depressed when, called upon to help, they are defeated at every turn. Victims can best defend themselves by refusing to act until the patient has stopped wavering and come to a decision about the direction he wants to take.) Examples of equal but opposite attitudes toward others are now being dependent and now independent; now needing relationships and now wanting to be alone (often with relationships in dreams but not in real life); and now being hostile, now loving. Equal but opposite attitudes toward the self are exemplified by the familiar stricture, "Do as I say, not as I do." A consequence for depressives is that they often treat themselves and others according to different standards, approving of behaviors in themselves that they criticize in others, or the other way around, or thinking it is all right for them to criticize themselves but not allowing others to criticize them for the same thing.

Ambivalence is illustrated by the following cases:

A depressed patient felt guilty for the way he neglected his parents and at the same time resentful of them for what he believed was the sadistic way in which they had treated him.

A doctor admitted that he sometimes felt that his fees deprived the poor of money they needed and at other times was equally convinced that his poor patients, simply by being poor, deprived him of the money he needed.

A patient drove his boss, his wife, his therapist, and himself to distraction because he could not decide whether or not to quit his job as a newspaper reporter and go free-lance. His ambivalence also showed in his attitude toward taking vacations. He would schedule a vacation, then cancel it because he felt he could not afford it, then reschedule it because he regretted his inability to be good to himself.

One patient remembered how his father's right hand would give while his left hand would take away. The father would tease him by promising to buy him something he wanted badly, like a new radio, then pull the rug out from under him, saying, "That is, next year, as soon as the new models come out."

An altruistic patient felt angry about depriving himself excessively, asked himself, "What's in this for me?" and resolved to become more self-centered. Then he felt guilty because he was depriving others of what they needed. In his daily life he alternately stinted himself of one thing, like food, as a reaction to feeling self-indulgent, and overindulged in another, like collectibles, as a reaction to feeling deprived.

The rapid alternating between such depressive symptoms as insomnia/hypersomnia and anorexia/overeating, and even the mood swings themselves between depression and hypomania, may be in part manifestations of ambivalence. Ambivalence is also apparent in the attitude of depressive people toward their depression. Even those who recognize their depression as an affliction and express the strongest desire to be rid of it demonstrate on the unconscious level a persistent attachment to their condition. This accounts in part for why a patient whose depression is cured can become more depressed on that account alone.

Differential Diagnosis

Not all ambivalent people are depressed. The familiar "split personality" of schizophrenics is an example of nondepressive ambivalence.

Dynamic Aspects

Dynamically, depressive ambivalence is guilt driven, in anticipation of punishment. It is sadistic, a way to torture others in the belief that pleasure and happiness are immoral. And it is masochistic, because giving and depriving at one and the same time dilutes all pleasure with pain, perhaps to remind oneself that in this life nothing comes easily.

Cognitive Aspects

A cognitive error in ambivalence is forming the composite picture from one of its parts. When applied to people, this often begins with isolating one characteristic from the pull of its opposite.

An extremist overlooked the fact that everything and everyone is a composite of good and bad. For him every person was like a chain, only as strong as its weakest link. As he put it, paraphrasing an old joke, "I judge everyone by what he did for me lately." By not integrating the good and bad, by maintaining them as separate, unintegrated imagos, he left no room for moderation, for the dispassions, like admiration and disdain, between the passions of abject love and complete hatred. Either he overestimated others and loved not wisely but too well, or underestimated them and loved not wisely but too little. As a result he began or abandoned relationships unpredictably and on slim pretexts. For example, he fell in love with one woman because she was soft spoken, then ended his relationship with her because she used too many clichés.

THOUGHT CONTENT DISORDER

The following trends are associated with depressed mood:

1. Blaming. Someone is to blame for everything. Nobody gets sick, and nobody dies, without someone, often everyone, partially or wholly responsible.

A depressive whose mother had died, blamed himself for hastening her death by not visiting her frequently enough before the end, blamed his mother's doctors for giving her inadequate treatment, and blamed his mother for not taking good enough care of her health.

2. Hypersensitivity. Hypersensitive patients overreact to minor irritants, each of which they view as the last straw. When the minor irritant relights a previous major irritant, remembered or forgotten, there may be a catastrophic reaction, like that found in the post-traumatic stress disorders. In the crisis-of-the-day-or-week variety, the patient selects one minor reversal or frustration each day or each week to put himself in a turmoil. Even a minor bad mood can itself serve as the irritant.

3. Negativism. Pessimistic depressives overelaborate the negative possibilities in a situation, while suspending their own ability to distinguish the possible from the likely.

4. Paranoia. Untoward chance events are perceived as personal provocations at the hands of presumed enemies.

5. Anger. When we speak of the depressive we often speak of his internalized anger. The anger to be internalized may be of the appropriate or inappropriate/excessive variety. Appropriate anger is often internalized because the patient blames himself for being angry, exonerating the person or situation actually inciting the anger. Inappropriate/excessive anger, in contrast, is often internalized because the patient recognizes its inappropriateness and excessiveness. Both appropriate and inappropriate/excessive anger may be internalized when the patient recognizes that unless he splints himself from the start he is in danger of completely losing control; when others tell the patient (often inappropriately) that it is not good to get mad; when the object of the anger is someone needed, someone dead, or there is no one (except perhaps God) who can be held responsible; and when the patient actually prefers not to express any anger at all. For the latter group of patients, suppressing anger is often a conscious decision, part of an ego-syntonic personality style, part of the belief that turning the other cheek is resolving, not stifling, anger. (Anger may itself be a suppressive force, as when it defends against a loss. This is illustrated by the case of the man who lost his mother and became angry with the mother, to defend against the loss by saying, in essence, "I don't miss you because I hated you as much as I loved you.")

6. Low self-esteem. Low self-esteem may be due either to introjection or extrojection of anger. In the case of extrojected anger, low self-esteem is the result of feeling controlled, violated, or persecuted, lending a paranoid threat to the depressive cloth. (If the illness is woven mainly from such thread, then it is a paranoid, not a depressive, illness.)

7. Zero-sum belief. Depressives view the world as a closed system in which satisfactions are neutralized by the prices that must be paid. They also believe, "What I get is at your expense" and the other way around. The fact that some

(though by no means most) human interaction involves zero-sum tradeoffs—wherein one party's gain is another's loss—too profoundly influences the thinking and actions of most depressives.

8. Brooding. Some rumination, even with typical depressive subject matter, is not necessarily abnormal. Normal persons, however, control the activity, rather than the other way around. Their ruminations are less intense, and broken off more frequently and for longer periods, than those of depressives. Typically in depressives brooding consists of an inability to be reassured about some worry. This inability to accept reassurance is occasionally overlooked by supportive, cognitive, and behavioral therapists, and by well-meaning friends, in their eagerness to change the patient's thinking by telling him that he has nothing to worry about.

One patient characteristically brooded about the past, present, and future all at once. For example, he was convinced he had entered the wrong field professionally, certain he was about to be fired, and sure he would never find another job.

Depressive brooders have a tendency to fix on existential dilemmas. They become obsessively preoccupied with the abstract-unresolvable. A typical problem might be the impossibility of a fair and just application of ethical or moral principles to the practical concerns of life. One example: How can I live in a society that is hypocritical because it tolerates practices and conditions that are at variance with its professed ideals? Such questions are valid in a social or philosophical context, but in patients they often have little relevance to real needs and are screens or surrogates for other unresolved problems. For example, agony over the inability of society to combine equitable distribution with free-market incentives may unconsciously relive one's own conflicting needs for dependency and independence.

Depressives pay a high price for the luxury of ruminating. Intensive rumination detracts from concentration on external matters, so that the patient tends to achieve below his potential and is less likely to become involved in activities from which he might derive normal pleasure.

Why do depressives let this happen to them? A principal reason is escape into fantasy. The ruminating, however painful, represents escape from an even more painful reality where they have to confront situations with which they are unable to cope. Another reason originates in the ego ideal. Depressives believe their brooding to be a worthy pursuit, not for everybody, but for the intellectual elite they see themselves belonging to. In essence they say to themselves, "Only a smart person like me would realize the universal importance of these matters." Finally there is masochism, the pain-pleasure of unremitting self-flagellation.

BEHAVIOR

Chapter 2 is devoted to a discussion of depressive behaviors.

MOOD

Because mood is nonverbal it is often described using such analogies as those with weather (rainy day), color (blues), and direction (down). Depressed mood tends to be felt in the head as a pressure; in the thorax—beneath the sternum—as an empty gnawing; and in the abdomen as a hungry empty feeling.

The central theme of depressive mood is boredom, a feeling that nothing is worthwhile (i.e., Hamlet's "stale, flat, and unprofitable"). Often the devaluation is generalized and the activities and concerns to which it applies show an overall tendency to decrease. An attitudinal note of apprehension can be detected, a sense that things are going downhill.

Depressed mood is closely associated with anger and the way it is expressed. For example, the depressive who favors the controlled, attenuated expression of seething over outbursts in order to show his anger without unduly provoking others to retaliate, pays the price of feeling endlessly angry, a feeling that in turn predictably intensifies the depressed mood.

Only in severe cases does depressed mood slow thought and produce such motoric or somatic behavioral changes as agitation, insomnia, constipation, and anorexia.

One reason for mood cycling, or the discontinuity of depressed mood, is its self-limited nature. Often the only reason for mood cycling is that it is difficult to sustain depression indefinitely. Depressed mood comes and goes in one or both of two cycles.

Intraday

In intraday (diurnal) cycling the depressed mood waxes and wanes within a twenty-four-hour period. Occasionally, for example in patients with a severe illness whose problems are both real and chronic, the patient is equally depressed morning and night and the expected cycling does not appear. In diurnal cycling the depressed mood may either be worse in the morning than in the evening or the other way around. Depression that is worse in the morning than in the evening is characteristic of the primarily chemical depressions and of those reactive depressions that have prominent chemical consequences. Purely psychological factors occasionally contribute to the early morning severity, as when the patient has tried to sleep on a problem but has instead had nightmares about it. Depression that is better in the morning than in the evening is seen in patients who have real problems to face as the day goes on. The patient wakes up fresh each morning, then gets bruised and battered and winds up exhausted and depressed each evening.

In favorable cases the patient perceives diurnal variations in himself, senses whether he is a "morning or evening" person, and adapts, often creatively. For example, patients whose depression improves each night adapt by planning activities like important conferences for late in the day.

Interday (Course)

In the interday cycle, or "course of illness," the depressed mood waxes and wanes over a period of days, months, or years. A nonremitting depressive mood may not be depression but instead a personality disorder, schizophrenia, or a medical disorder such as hypothyroidism. And rapid mood cycling may be not true cycling but the mood lability characteristic of schizophrenia.

Five phenomena that resemble mood swinging/cycling and have to be distinguished from it are: grief coming in waves, delayed depression, transitional pseudonormality, flight into health, and remission/cure.

1. Grief coming in waves. There are periods even in severe grief when it is forgotten and the individual feels better temporarily. Then the grief returns, often suddenly, as if spontaneously, and for reasons not always immediately apparent.

In one patient waves of grief were churned by internal psychological associations, so that a wave of grief represented an association to a preceding thought or feeling. A wave of grief seemed spontaneous, but only because the association process was hidden or, if revealed, quickly reburied. Because the associations were hidden, the mood swings appeared to be endogenous.

2. Delayed depression. This is depression withheld only to appear later to look like an unprovoked mood. In some cases there is a loss, but it takes time for the loss to sink in. In others it sinks in, but the patient is too busy at the time to respond to it.

In one patient operated on and given chemotherapy for cancer of the breast, the emergency conditions that initially prevailed prevented her from getting depressed. Depression appeared only one year later, when as she put it, "Now that I seem cured it's safe to collapse."

3. Transitional pseudonormality. In cycling depressives the intervals between depression and hypomania may simply be like the eye of the hurricane, like a stopped clock that tells the right time twice a day, or like the normal temperature between temperature peaks in malaria. Here the normality is an appearance, a sham, a zero point on an s-shaped curve. At times of transitional pseudonormality, though not in the throes of a definite abnormal mood, the patients have suggestive characterological tendencies. They often show a projection of tension, an impression of being about to burst at the seams, and a touchiness sometimes to the point of paranoia. Hints of continuing pathological mood are attitudinal mood equivalents, like selfishness; behavioral mood equivalents, like gambling or bulimia; and somatic mood equivalents, like some irritable bowel syndromes. (These are discussed further in Part I, Chapter 2.)

A woman who suffered from cyclothymic disorder when in the transition between depression and hypomania made an effort to be warm and friendly, but at best the impression

she created was of mild remoteness. She spoke a bit rapidly, as if she were afraid of not having enough time to get out her thoughts, and exhibited the typical hypomanic tendency (found in many normals as well) to jump from thought to thought without bothering with all the logical connections and to ignore time frame in narrating events. She was tense and irritable. She was unable to enjoy herself, as her peace of mind was continually threatened by an unruly conscience and by obsessive worry, both of which prompted her to annoy her friends by repetitively posing such difficult-to-answer questions as "Will my marriage work out?" and her therapist by repetitively asking whether this was or was not the right time to stop treatment.

4. Flight into health. The individual uses a transitional improvement to entirely deny his problem.
5. Remission/cure. Patients may stop cycling and go into remission/cure. It is unwise to urge them to continue treatment though they want to stop, especially if patently self-serving reasons are given. (One therapist overdid by suggesting a deep analysis to prevent relapse.)

INSIGHT

Even acutely depressed people may not recognize their depression, and many chronic depressives feel not "I am depressed" but "I'm having trouble getting over my breakup," "I hate my job," "This is the usual way I feel," "I have trouble waking up in the morning," "I have no energy or desire," "I have chronic fatigue," "I guess I'm getting old," or "I usually feel this way, though now it's worse." Any insight they have is readily co-opted into the depressive rationale, reinforcing the depression rather than providing a basis for reducing it. As an example, one patient said, "I know I'm depressed and I know why, so my problem must be that I don't have a strong enough character to stop feeling depressed."

Also, even the most enlightened depressives seem unable to contemplate any alternative to their condition. And manipulative depressives use self-knowledge not to change themselves but to strengthen their case for special treatment.

Even a modicum of insight may take months or years to develop.

For one patient it was months afterwards that he was able to say, "I guess I hit bottom and acted like a baby in front of the doctor, only now I wonder, what was I getting all upset about anyway? I won't do that anymore."

Another only after many years was able to refer to a time when "things were dancing in my head, as I later saw, nothing important, but the music seemed very loud at the moment."

While some depressives are aware of their effect on others and carry the full burden of guilt for their actions, some are not, or are but do not care. Some instead blame others for being intolerant, while a few actually enjoy making others squirm.

JUDGMENT

Mood-influenced judgment is often defective because it is unguardedly emotional and subjective. Examples of judgment defect include:

1. Inadequate/excessive trust. Lack of caution and mood-influenced inability to judge character make depressives overly distrustful when they should be trusting, and the reverse. As a result they either seem excessively paranoid or so passive that others, particularly psychopaths, take advantage of them.

In one case, a depressed psychotherapist became an easy target for a psychopath who, knowing of the doctor's distaste for forced hospitalization, declared, "I need love, not abuse." The therapist set the patient free, then put his life in jeopardy by inviting the patient to his home "as part of the process of resocialization." In a typical reaction, the therapist became more depressed when he realized he had been taken in.

2. Value distortion. The tendency to symbolize erratically and illogically plays havoc with personal relationships. Personal ties do not flourish when they are subordinated to material objects or when one person's actions are subject to another's quirky or irrational (often transferential) interpretations.

One patient told his psychiatrist he was just as depressed over losing a valued book as he was over his teen-age daughter's serious illness.

3. Compassionate sadism.

One patient contemplated killing his wife to relieve her arthritic pain. He justified his fantasy as a well intentioned, altruistic, compassionate, loving desire to dispatch her to a better land.

4. Resigned resentment. Depressives triumphantly prove that the world is a hurtful place, instead of rearranging matters to get what they need and want. Thus a valued friendship may be sacrificed because of a petty misunderstanding that could easily have been adjusted. A common example is the resigned attitude (actually a wallowing in delicious despair) of some parents to the resentment of a child when they at no time addressed the causes of that resentment.

MEMORY AND ORIENTATION

True disorders of memory and orientation are not characteristic of patients with a mild depression. Pseudomemory disorders can exist as the result of inattention, anxiety, or hypochondriasis.

A hypochondriacal patient worried about developing Alzheimer's tested himself so often and with such difficult tests that he was guaranteed to fail at least occasionally. When he failed he convinced himself that his worst fears had come true. For example, he expected himself to recognize classical music selections he had not heard in years from brief excerpts, and within a matter of seconds.

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CHAPTER 2
Depressive Behaviors

CLASSIFICATION

While depression should not be diagnosed in the absence of depressed mood, in some patients the depressed mood is either well hidden or expressed only in derivative form as attitudinal, behavioral/acting-out, existential, and/or physical mood equivalents.

Attitudinal Mood Equivalents

Weltschmerz and excessive optimism are examples of attitudinal mood equivalents. Attitudinal mood equivalents may be manifest in the personality or as sociocultural behaviors, as in the following case:

One man's sociological theories originated not in his assessment of external reality but in his inner suffering projected outward. This led him to view the world as a terrible place, rationalized as "man's inhumanity to man," "world poverty," or, less loftily, "bureaucratic bungling." After he remade the world in his own image it was the world, not himself, that was pitied and condemned, and it was the world, not himself, that needed fixing, even though he, not the world, had the problem.

He became an activist, whose activism was not only less altruistic than it appeared but never addressed the problems that needed addressing. Also, because changing society when he should have been changing himself was a subtle, though powerful, way to be unkind to himself—by not giving himself what he should have—he was as ineffective in repairing his internal as his external world.

In treatment he was told to change himself, to master his own depression, and to give himself a vote of confidence by feeding himself a little pleasure. He was told to do this not merely symbolically, not merely in a roundabout way—by giving it to others with

whom he identified—but directly, at least until his depression lifted. Then he was to be permitted to fix society, but by then he had lost interest.

Behavioral/Acting-out Mood Equivalents

Behavioral/acting-out mood equivalents express depressed mood in action: directly, or as an implementation of the above-described attitudinal or below-described existential mood equivalents. (Though they overlap, acting-out differs from impulsivity, which is due as much to an absence of the thermostatic control of guilt as to the depressed mood.)

One man's resolute optimism, when implemented, took the form of making a potentially rewarding but risky investment; his resolute despair, when implemented, took the form of irreversibly severing important personal ties.

Behavioral/acting-out mood equivalents are not only a way to express but a way to relieve depression. For example, gambling is not only a nonverbal expression of the typical depressive hope for something for nothing, but because losing is guaranteed, a way to relieve intolerable guilt and with it the depressed mood. (Of course, the relief is only temporary because losses mount, debt deepens, and depression worsens.)

Behavioral acting-out is illustrated by the following depressive job choices:

One man entered a profession because he wanted to get close to his distant father, also in that profession.

Another man, depressed because he felt he compared unfavorably with his father, entered the same profession not to get closer to him but to compete more effectively with him.

Another man used a job with cachet to impress his critical father and get love from his distant mother.

All these unhappy professionals not only felt their jobs were selected for them, not by them, but were also in the wrong fields.

Existential Mood Equivalents

Despair is an example of an existential mood equivalent.

Physical-Symptom Mood Equivalents

The literature often calls physical-symptom mood equivalents "depressive equivalents" or "vegetative symptoms." In mild depression we might see mild insomnia, where a night of insomnia is followed by a good night's sleep, and/or mild, short-lived "tension" headaches responsive to over-the-counter pain medications. In contrast, in severe depression we might see severe headaches,

severe insomnia, anorexia, weight loss, extreme fatigue, or severe constipation. Physical manifestations of depression are discussed further in Part I, Chapter 4, which deals with the physical manifestations of depression.

Differential Diagnosis of Mood Equivalents

Pathological attitudes, behaviors, existential positions, and physical symptoms are not always depressive in origin. For example, loss of interest has a differential diagnosis. It is not a depressive attitudinal mood equivalent when it is neither attitudinal nor depressive, as when it is from the schizophrenic spectrum, the result of anhedonic slowing or thought-disordered inability to pay attention and/or concentrate.

DESCRIPTION

The remainder of this chapter concerns itself with mood equivalent behaviors. These are grouped, for didactic purposes only, as disabled, agitated/upset, self/other destructive, regressive, addictive, eating-disordered, obsessive, narcissistic, and psychopathic-impulsive.

Disability

Loss of Interest

Depressive-spectrum loss of interest is one manifestation of a generalized clinical or subclinical depressive retardation.

In a simple schizophrenic who complained of his loss of interest in women, fantasies about women seemed absent, while in a depressed patient with the same complaint all the feelings were there but a sense of guilt prevented him from feeling them. As a consequence he limited his interest in women to those who were unavailable because they were remote, from a different social class, or on film (depressive pornophilia).

In many depressives, side by side with loss of interest, even overshadowing and obscuring it, is a compensatory/hypomanic heightened interest, which is typically too brittle to be sustainable.

One patient, to deal with his depression about past professional failure, worked all day to make something of himself. Eventually, however, he found himself unable to work at all, because he viewed every minor difficulty in his work as a calamitous signal that he was about to fail again.

Inability to Enjoy Oneself

Inability to enjoy oneself may be physical, for example due to the slowed metabolism of a chemical imbalance, or psychological, as it was in the maso-

chistic patient who was only able to enjoy his depression, and the asexual patient, whose inability to enjoy himself was part of a plan to protect himself from being humiliated, criticized, punished, and rejected for his sexual desires.

Depressed people usually retain the ability to enjoy something about their lives. This is characteristically expressed in the negative, as "something I don't mind doing," "the lesser of two evils," "something I do, not because I want to but because it's good for me," or in the fatalistic "at least . . . " illustrated by the following case:

One patient said, "I may not have a sex life, but at least I have a nice apartment and enough money to support myself." This patient would not pay for the recreation that might relieve his psychiatric problems, though he willingly paid for psychiatric care because it was "good for him." "At least," he said, "though I can't afford a vacation I can afford to go to the finest doctors in New York City."

Inability to Function

Some degree of inability to function due to apathy is not unusual even in mild depressives. Characteristically, mild depressives win their struggle with apathy, while severe depressives with the same degree of apathy will lose their struggle. With many depressives apathy tends to be selective; for instance, it may affect their capacity for socialization but not for work. In endogenous depression, not the main concern of this text, generalized apathy can occur and the inability to function can last for extended periods.

Inability to function due to depression often presents as a work inhibition. While the work inhibitions of early life may not be depressive, most of those that occur later in life are depressive in origin. Depressive work inhibition may take one of two forms: (1) adolescent-style acting-out unreliability, where a formerly reliable worker begins to call in sick on a regular basis, say absenting himself from work to get drunk, take drugs, or have sex during the day, or (2) a creative or functional block, where the worker goes to work but finds it difficult to do his work well, or at all.

Work inhibition and depression that are the *result* of job-related stress follow a different scenario.

A worker who was not at first clinically depressed became depressed after a superior criticized him for an error he made. The worker's modest contribution was a sensitivity to rejection, an excessive need for a vote of confidence, a dislike for even constructive criticism, and a tendency to personalize superiors as castrative fathers and rejecting mothers.

Upset

Dissatisfaction

Dissatisfied depressives lead constricted lives because they complain constantly no matter who or what they have. The complaining usually originates

simultaneously in the grandiose belief that they are too good for everything they get and in the depressive belief that what little one has is a reflection on what little one is. Regarding the latter, there is often a double standard, exemplified by the lonely patient fond of telling his psychiatrist that he would never date a woman who saw a psychiatrist.

Crying

Some depressives cry because they are pleasure oriented and enjoy crying; some because they are pain oriented and enjoy suffering; some because they are not hostile and want to suffer to spare others; and some because they are hostile and want to attack others with their tears.

Other depressives try to cry but cannot because they are too rigid; because they cannot be good to themselves; because of shame or guilt about displaying emotions; or because their tears are dried by conflicting emotions, such as hate contaminating love.

Agitation

Clinical agitation is manifest in such symptoms as insomnia, pacing, crying, moaning, and spreading gloom. Depressed people often become agitated when flooded by anger that is inexpressible because it is deemed forbidden and/or excessive. One depressed person put it this way: "I wouldn't be so agitated if I could go over and punch out my boss."

They also become agitated because their needs are not being met. This happens whether the needs are legitimate or excessive and whether the needs are not being met because they have not expressed them or because having expressed them they have not been able to see them gratified.

Agitation is never the impersonal matter the patient usually claims it is. It is always an interpersonal statement, an attack on others. In particular, moaning is a way to induce guilt by implying that others are the cause of one's pain and suffering.

Self-destructiveness

Self-destructive depressives court disaster in order to obtain the moral reassurance that guilty desires will not go unpunished. Examples are kleptomania, where being apprehended is the goal; gambling, where losing is the goal; and bulimia, where deadly potassium loss from vomiting is the goal. (The patient learns about potassium loss and its dangers from his doctors.) Typically there is self-deception, with the self-punitive motive covered with its opposite, as when the patient thinks his kleptomania is to be good to himself by giving himself some little thing he wants, or when the bulimic attributes his behavior to a desire to lose weight.

Kleptomania, gambling, and bulimia may be neither self-destructive nor depressive. For example, bulimia is more likely to be hysterical than depressive

when the intent is not disturbed physiology but weight loss to enhance sexual appeal.

Vicious Cycling

In vicious cycling the patient works himself into a depression. Vicious cycling is discussed further throughout.

Suicidal Behavior

Being suicidal is the self-destructive behavior that first comes to most clinicians' minds. Suicidal thoughts are universal in depressives. Usually these thoughts remain confined to fantasy, or if expressed behaviorally are limited to such symbolic expressions as accident proneness. In this view suicide may be said to tempt all depressives, while only some yield. In other words, there is a distinction to be made between the thought, the revelation/threat, the intention, and the behavior. This is difficult to do because most patients remain silent about at least some aspect of their suicidal thoughts, generally because they are aware of the danger they put themselves in if they speak up.

Reasons for suicidal fantasy/activity include

warranted or unwarranted pessimism about the future;

a desire for relief of painful mood and the inner pressure that accompanies it;

a wish for relief of obsessions and compulsions;

self-hatred due to guilt or identification with hateful others;

internalization of justified or unjustified anger with others;

encouragement by manipulative provocative people who put the patient up to it for reasons of their own;

transferential dereism, as exemplified by the patient who imagines everyone is his feared and/or detested parents; defensive dereism, as exemplified by frightening projective persecutory delusions and hallucinations; and

judgment diminished by euphoria/denial during hypomanic shifts.

Possibly more than one factor must be present before a suicidal thought becomes a suicidal gesture/act.

We often hear that the depressive is most at risk for suicide at two points in his depression: when the depression is getting worse and when it is improving—the former for obvious reasons and the latter because as the mood lifts the patient has more energy to act on his suicidal wishes. However, sometimes the so-called lifting mood is merely the pseudoalertness of increasing agitation, hence a sign not of improving but of worsening depression.

Other-destructiveness

Depressives mistreat others as they mistreat themselves. For example, they double-bind to inflict pain. With this in mind they issue mutually exclusive

commands, followed by a stricture to prevent the victim from escaping. One wealthy patient badly needed treatment, but though willing to come, refused to pay, while threatening suicide if not seen twice a week.

Depressive homicide is often the product of projective identification, really a killing of the bad self. It is to be distinguished from psychopathic homicide—for gain—and schizophrenic homicide, a response to delusions.

Regressivity

Regression

With positive regression, or regression in the service of the ego, positive, conscious, volitional, and purposeful reasons for retreat prevail and the regression is an effective, productive activity, pleasurable, restful, and healing, even the beginning of a new life. As part of the regression the patient may abandon his old relationships and develop new ones, or he may become completely isolated. But even when the patient retires totally from active life, the ability to function on some level is retained, if not enhanced. The withdrawal is based on the patient's knowledge that he will not become a charge to others. Often with ambivalent shifting there is, in time, a yearning to return to one's old life, this time to get it right.

Negative regression is maladaptive, counterproductive, and self-destructive. An example of overt negative regression is the negative retreat, where there is a progressive infantilism, a turning inward, a removal from relationships and even the world, and in unfavorable cases even a taking to bed. An example of a more covert but also dangerous negative regression is television addiction. Another is telephonophobia, where there is annoyance or even alarm when the telephone rings because the ring is deemed an intrusion from the outside world.

Another is the hypomanic episode that is really a negative retreat. The hypomanic, instead of disrupting relationships, abandons substantial relationships for pseudorelationships: temporary, superficial, inappropriate, static, and ultimately unrewarding.

Dependence

Depressed people sacrifice their independence to pursue the comforts of dependence.

A patient tried to turn her friends into an emotional and professional support system. She hardly ever waited to be asked how she was before pouring out her catalog of grief. One sample: "My marriage is failing, my hypoglycemia and yeast infection are worsening, my periodontal problems are threatening, my finances are deteriorating, and I have had a series of fights with my brutal husband who always takes his mother's side." The message was always clear: "I need your help; what can you do for me?" The woman never inquired about the well-being of her listeners.

For the depressive in a nonsymbiotic relationship, the concomitant of dependence is a reluctance to be depended on, a resentment of the demands of others as a burden, and a fear that dependency of others is a retaliation for his own dependence, with the legitimacy of others' demands only deepening his resentment and intensifying his egocentricity.

Mutual dependency with vicious cycling is the mark of the symbiotic relationship.

A patient's mildly organic mother exaggerated her organicity to give her self-sacrificial daughter what the daughter wanted—an invalid to care for, while the daughter subtly encouraged the mother's organic mode by keeping her at home, using as an excuse the need to prevent her from falling and breaking her hip. This isolated the mother from external, organizing clues and made her memory worse. The mother now became confused and needed more attention from the daughter. The daughter obliged her by becoming more self-sacrificial, to which the mother responded by further withdrawal and increased organic behavior.

Isolation

Depressives are isolated for a number of reasons.

1. They have driven others away or made enemies by beginning adversary relationships and/or not breaking them off expeditiously; by demeaning others by treating them with the same accurate, though partial, negative view they apply to themselves; by broadcasting inferiority feelings, making others think them not worthy of their consideration; and more generally, by being annoying.

A patient pleased with any little sign of attention returned over and over to give effusive thanks, such as, "Great, I'm so happy, I appreciate what you have done for me, believe me," becoming annoying, disrupting schedules, looking peculiar, impaling others on his low self-esteem, and finally managing to make his victims wonder if he really did not mean the opposite.

Another antagonized his friends by meekly cleaning dirty silverware in a restaurant instead of returning it, and considering aloud eating an underdone pork chop served him, so that he might avoid upsetting the waiter and cook.

2. They have selected others who reject them or provoke them to leave. Examples are hostile passive-aggressives and grandiose hypomanics.

3. They have retreated from the world into mutually symbiotic, mutually self-sacrificial relationships.

4. They are remote. Remoteness may be due to paranoia. One paranoid depressive stayed away from others he believed could read his mind and see him blush revealingly. Or remoteness may be from the anxious/phobic spectrum.

One anxious/phobic depressive could not attend cocktail parties unless he knew most of the other people there; another could not use the men's room because he was humiliated

to be seen urinating in public; and another, more obsessive, stayed home because he feared contamination by germs.

The degree to which relationships are abandoned in reality bears a varying relationship to the degree to which relationships are retained in fantasy. Some isolated depressives envy those who have relationships, some do not. Some relationships are first abandoned, partly or entirely, in reality, then replaced in fantasy by delusional relationships. An example is the individual who believes he is loved by, or actually married to, a famous figure. In common parlance this is often referred to as an obsession. This is incorrect because the conviction that something is true when it is false is a delusion, not an obsession.

Less characteristic of depression and more characteristic of schizophrenic spectrum disorders is abandoning relationships even in fantasy, so that the individual becomes thoroughly self-preoccupied, narcissistic, and autistic.

Addiction

Alcohol and Drug Addiction

There are several possible ways in which addiction and depression can be interrelated.

1. An addiction treats a depression, usually ineffectively and counterproductively. The following cases detail the multiple reasons why patients might treat their depression with an addiction.

One patient used addictive substances to recreate early rapture.

For another the bottle and pill were his friends.

Another enjoyed the social behaviors associated with drinking and taking drugs. He equated cafe society with having a family and patronized only those pushers who treated him as family. For example, one pusher sold drugs from his home to capitalize on his customers' need for social contact, entertained them with the latest music, and even asked them to stay for dinner.

For another patient it was the identification with the bartender that counted. This identification allowed him to treat himself as the bartender treated him, feeding himself a little pleasure.

In another case there was an enhanced relationship with the self; times of intoxication were times of passionate fantasy and narcissistic self-exploration—times for the patient to reveal himself, to himself.

For still another it was the actual drug effect: the pleasant hallucinations and the reduction of such unpleasant sensations as "pit-in-the-stomach emptiness."

2. An addiction begins for other than depressive reasons. Depression, should it appear, is a secondary emotional consequence of losses—of job, friends, and money.

3. The physiological effects of the addiction are manifest as a pseudodepression, the drug effect and/or symptoms of withdrawal mimicking symptoms of depression.

Antidepressants might be effective in treating those whose addictions are preceded by depression (Situation 1, above), but perhaps less effective in treating those whose depression is instead a result of their addiction (Situations 2 and 3).

Smoking

Depressive smokers relieve their depression with oral gratification (sucking), anal gratification (tic-like ash flicking), and phallic gratification (posing with the cigarette). The nicotine and tar in cigarettes and cigars are weakly antidepressive. Finally, deep inhaling is a tension-relieving tic.

Eating Disorders

Two examples of the similarities between eating disorders and depression: (1) in both obesity and depression there is excessiveness leading to guilt, and (2) in both anorexia nervosa and depression by a process of pathological identification, others are cared for and fed in place of the self. But as with the addictions, the similarities between eating disorders and depression have been allowed to obscure the differences. Indeed, there is a significant differential diagnosis of eating disorders, including paranoia, hypomania, obsessiveness, and hysteria.

Paranoia

Paranoid eating disorders are characterized by a tendency to disavow responsibility for the over- and undereating. One paranoid overeater blamed his obesity on the fattening food in the cafeteria and on those who did not handle him with sufficient sensitivity, saying it had the reverse effect.

Paranoid eating disorders are often characterized by a tendency to use the eating disorder for self-justification, like the erring computer operator who blames his bad results on his computer. For example, one overeater justified his chronic fatigue and inability to function by invoking his obesity, and an undereater did the same by invoking his anorexia. Finally, some paranoid patients with an eating disorder are delusional. Some anorexics do not eat because of a belief that the food is poisoned.

Hypomania

Hypomanic overeaters deny the overeating itself ("I eat like a bird but I still get fat"); concern for the consequences of the overeating ("I don't care how I look; I'll never diet again"); or actually welcome the pathological weight change ("An advantage of being fat is that no one tries to rape you.")

Obsessiveness

Characteristic for obsessive bulimia is binging and purging, a doing and undoing, with the doing the instinct discharge and the undoing the guilty retribution. One obsessive anorexic did not eat to produce less feces in order to master the fantasy that his body was filthy.

Hysteria

Hysterics overeat or undereat to deform their bodies to avoid sexual encounters or to reform them to win sexually. In some bulimics the vomiting itself has a sexual significance. Finally, in one anorexia nervosa patient the intent of not eating was to induce amenorrhea so that she could form and maintain a fantasy of being pregnant.

Obsessive-Compulsive States

Obsessive patients handle the depressive fear of being depleted by being retentive. In typical cases ordinary thriftiness becomes retentive miserliness.

One patient shopped compulsively but never used his purchases because he was afraid he might ruin them.

Another took sugar packets home after restaurant meals on the spurious grounds that they were paid for, and compulsively stole hotel towels to make up and retaliate for the hotel bills even when deemed not excessive.

Another case of retention is the case of the businessman who had accumulated five houses and found that they were a continuous source of anxiety. He had overextended himself to buy the houses, and they had turned out to be a maintenance nightmare. Something was always wrong; at one point no fewer than three of the houses needed extensive emergency repairs. It was impossible to keep them all rented at the same time, and the financial burden was serious.

The businessman was urged to sell one or more of the buildings, but he steadfastly refused on the grounds that the investment would in the future prove inherently sound. In fact, it was obvious to everyone but him that his attachment to the houses was essentially irrational. (The nearest he came to acknowledging this was his jocular description of the houses as "an inexhaustible source of human anecdotes.") The sources of that attachment lay (1) in his childhood yearning for a comfortable, friendly, secure neighborhood, unlike the impoverished, crime-ridden one he had lived in, and (2) in his bachelor loneliness, for which he could find solace in his "family" of tenants (whom he often referred to as "his people.")

Of course, the houses failed to cure his depression. Instead, the problems he brought on himself merely re-created the central elements of his long-standing depressive condition. His distress at times reached acute proportions, with wild lamentations and threats of suicide. When he calmed down, he was unsparingly critical of himself for his lapse into self-pity. Had not life on the whole been good to him? How many people can afford five houses?

The businessman was on a self-destructive course from which he could not escape.

The imbroglio with the houses was eroding his self-esteem, yet he feared that the impact of letting go, of losing the palliatives for his impaired self-esteem that the houses represented, would be far greater.

Narcissism

Depression can take the form of narcissistic pride in being worse than every one else. Narcissism in depressives may also be a secondary self-love that substitutes for relationships missing, lost, or destroyed.

Psychopathic-Impulsive States

Manipulation

Depression is psychopathic when it is created and sustained primarily for its effect on others. Psychopathic depressives often manipulate by mesmerizing others with stories that are skewed to touch the heart:

A patient tried to convince his psychiatrist to lower the fee by claiming poverty. To claim poverty he relegated his six-figure yearly tax-free gifts from his mother to the category of "money I have to save for a future made uncertain by the recession."

Though they feel almost the same to the sufferer and look almost the same to the observer, the despair depressions are not primarily manipulative. They are created not for their effect on others but by the effect of others on the patient. In other words, despair depressives react mainly to rejection, whether this be self-created or fortuitous. That the same depressed mood appears in the first, manipulative depressions as in the second, despair depressions may simply mean that depressed mood, and depression, is a common final pathway: a single, efferent response provoked by multiple afferent inciters/irritants.

Stealing

Some depressive stealing is prompted by a depleted and empty feeling, in which case what is taken may be a symbolic prop for low self-esteem. Other depressive stealing is to recreate a rosy past believed lost. One depressive embezzler said, "I want now what I had when I was a child. Then I had maids and was driven everywhere by limousine and never had to take the subway." The rosy past some recreate is the relationship with the mother. The embezzler viewed the bank where he worked as a mother with munificent supplies, while a shoplifter viewed the store owner and his shop in much the same way.

Sometimes stealing is a product of depressive delusions of poverty. A patient believed himself poor, based on his conviction that his mother would change her will, though she was senile and incompetent to do so, cutting him out of it entirely.

Finally there is learning, where the child learns that the mother's unguarded purse is fair game or, in really unfavorable cases, learns from his parents that stealing is the easy way to get what he needs.

Just because stealing (or any other potentially criminal activity) can be explained does not mean it can on that account alone be excused.

One depressive could not help himself because he was under the spell of the depressive mood. But this "driven depressive" himself admitted that he had passed up many opportunities in the past to treat his depression. "That," he said, "is what they should hold me responsible for."

Stealing is not depressive but hysterical when the intent is castrative—to deprive others of what they have; or psychopathic, to see how much one can get away with. (In psychopaths any true depression is a secondary depression, the result of getting caught.)

Gambling

The relationship between gambling and depression is often the relationship between trauma and depression.

One patient who felt traumatized by fate gambled to become untraumatized by fate, trying to reverse a bad thing that had happened in the past, when least expected, with a good thing happening now, also when least expected.

Promiscuity (Don Juanism, Satyriasis, and Nymphomania)

Promiscuity may be an antidepressant diversion; a way to use the pseudopod of sex to relate; a way to increase exposure and so the chance of connecting for those who believe themselves unappealing; a way to replace an acute loss or undo a chronic sense of loss; or a way to increase self-esteem when self-worth depends on the number of conquests—displayed as trophies for self-approval or for approval from others, often others from a similarly promiscuous peer group.

Not all promiscuous people are depressed. As with other behavioral manifestations, there is a differential diagnosis of promiscuity. In hysterical promiscuity the promiscuity is a compulsive search for the parent of the opposite sex. In hypomanic promiscuity there is a rebellion against a tyrannical superego in the hope of obtaining a pleasurable release, which can be compared to the release of laughter. In adjustment-disorder promiscuity the promiscuity is essentially a way to relieve pressure. In normal promiscuity the promiscuity is a transient peak on a developmental curve, as it is with some adolescent experimentation and in some unattached middle-aged denial of aging. (In the attached middle-aged individual it is usually not normal, but symptomatic of interpersonal difficulty or sadistic personality disorder.) It can also be normal when it is a response to a change in the environment, as when the once-deprived individual discovers new opportunities upon moving from a small town to a big city or traveling to

a foreign country with more relaxed morals. Finally, some promiscuity is iatrogenic.

One depressed borderline patient formerly isolated and unable to work was able, after twenty-five years of treatment, to get married, have satisfactory sexual relations with her husband (though only about once every two weeks), get a job (though she detested the job she was able to keep it and do it well), and visit her family on holidays without excessive protest and even with pleasure.

Because of her improvement her husband, until now a paralyzed depressive, emerged from his "depressive sleep." But the husband's therapist was reluctant to leave well enough alone. Proclaiming, "I never thought any patient of mine would have so little sex at such a young age," the therapist insisted the husband attend sex therapy to remove his inhibitions and pressured him to bring his wife. According to the wife the sex therapist charged ahead "like a bull in a china shop, telling me and my husband to 'let ourselves go.' "

The patient and the husband, thinking they were complying with treatment protocol, each had an extramarital affair. Afterwards the wife became severely depressed and had to be hospitalized, and as a consequence her husband's depression also returned.

Infidelity

Infidelity differs from promiscuity, in that a real or fantasied third party is present; suggesting nonsexual motivation. One patient's promiscuity was retaliative against a wife whom he suspected of being unfaithful to him. Another patient's promiscuity was a sadistic humiliation of his wife.

Characteristic of depressive infidelity, our present concern, is that the individual tries to relieve his depression with another, different person. The cry is, "I can find someone better than you." The other person would be more kindly, caring, concerned, give positive not negative feedback, admire not criticize, and welcome not reject. In some cases a depressogenic spouse participates by unconsciously or deliberately provoking the infidelity, creating the very thing he says he fears the most. The motive may be an emotional one, to prove, "You started it, not I," or a practical one, to come out ahead in a contemplated divorce.

CHAPTER 3
Normal Depression

It is possible to be depressed without having a depression. First, a certain amount of moodiness occurs in everyone. Second, everyone uses such depressive mechanisms as internalization of anger. Third, everyone commits such cognitive errors as making mountains out of molehills. Fourth, everyone has a collective unconscious with a protodepressive legacy: for example, in both men and women the maternal instinct suggests or compels self-sacrifice. Fifth, everyone shares such protodepressive individual developmental problems as oedipal fear of success. Sixth, everyone has self-preservative instincts responsible for protodepressive avoidance and aggressiveness. Seventh, for everyone there is reality, with the world full of depressogenic people who make life a struggle. An example is one patient's composite New York City depressogenic denizen.

He views anyone with talent as a potential rival to be defeated. He knows how to make his rivals so depressed they cannot retaliate: by turning their assets into liabilities, virtues into faults, as when outspoken originality is condemned as making trouble and creative self-expression is condemned as inability to get along with authority.

Eighth, depression is helpful. As a defense it relieves anxiety, and after a calamity it is a retreat for the purpose of regrouping forces. And ninth, continuous normothymia is not only unattainable but can even be undesirable. This is seen in the productive depressions/hypomanias found in people who, aware they reach their peak level of functioning during one phase of a mood cycle, whether it be depression or hypomania, deliberately maintain whichever mood is most favorable to them.

A man with a routine job sorting mail functioned best when and because depressed, and another with a job as a salesman on commission functioned best when hypomanic.

In normal depressives clear thinking survives and slowing of thought is minimal. The ability to forge conceptual links between events, to treat related events as if they are related, for example as part of a chain of cause and effect, is retained. The selective attention/inattention that accounts for the dereism of severe clinical depression is minimal. Normal depressives also appreciate at least some of their own contribution to their fate. For example, they do not blame everything on external stress, do not overemphasize the persecutory aspects of relationships, and do not regularly make victimizer-victim interactions out of appropriately unequal relationships like the one between employer and employee. They are relatively temperate, diluting extreme pessimism with optimism so that the future is not only what can go wrong but also what can go right. If they are alarmists, or crisis-of-the-day people, they at least do not permit the crisis to entirely rule their lives. They may be overcritical, but they see the positive as well as the negative and do not view others as being equal to the sum of their defects.

Normal depressives continue to function. In this they are like "normal phobics," who have phobias but do not permit themselves to be paralyzed by them. In a sense, the normal depressive who keeps his depression away from work by confining it to home is like the normal phobic living on an island accessible to the mainland by bridge and ferry who allows himself either a bridge or ferry phobia, but not both.

If there are mood swings they are less pronounced than the mood swings of cyclothymia. Clinical hypomania/depression is usually linked to life events and only appears with severe stress.

When there has been a loss, sadness and grief are displayed more than depression. Though sadness, grief, and depression are distinct emotions, clinically they are often found together, and which is paramount often depends on what the person intends.

For example, two patients were terminated by a psychiatrist giving up his practice. One had a compensation disorder (i.e., was suing for a nonexistent post-traumatic stress disorder). The other was a simple dependent who feared abandonment. Both felt a mixture of sadness, grief, and depression over the termination. But the compensation patient, wanting the psychiatrist's favorable testimony, ingratiated the psychiatrist with his sadness and grief, while the dependent patient, wanting to continue in treatment, tried to manipulate the psychiatrist with his suicidal depression.

Uncharacteristic for normal depressives is excessive and meaningless activity, like staying up until dawn on weekends, and excessive self-destructive activity, like staying up until dawn on weeknights. Vegetative and equivalent symptoms (described and explained in Part I, Chapter 2), if present, are modest (i.e.,

limited in scope, unlikely to intensify, or if severe, transient). Apathy, if it occurs at all, is mild and intermittent, and manifest less in withdrawal than in such characterological tendencies as the tendency to give up easily or the tendency to be unpredictably involved and then disinvolved. Major regressive symptoms, such as severe dependency and marked infantilism, are rarely present.

However, even normal depressives still have a depression to endure. Depression is never pleasurable, and even the mildest depressions, if nothing else, have mildly unpleasant consequences, as when judgment that is compromised by bad mood tempts the patient to make hasty telephone calls best left unmade or write letters best left unwritten.

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CHAPTER 4
Physical Manifestations of Depression

At least eight mechanisms account for the physical manifestations of depression.

1. The physical manifestations follow upon such classic depressive symptoms as boredom or anorexia, so that a patient who is bored experiences chronic fatigue or a patient who is anorexic feels weak and debilitated.

2. Depression makes Deutsch's "mysterious leap from the mind to the body," a psychosomatic jump the sophisticated and largely unknown mechanism of which is given unsophisticated concrete form by patients when they make statements like "My pain in the neck tells my mother what a pain in the neck she is," "My headaches express my need to hurt myself by deliberately banging my head against the wall," or "My toothache is punishment for my biting sarcasm."[1]

3. Physical mediators, such as the histamine, autotoxin, or immune system.

4. Delusions. When a false idea directly or indirectly involves the body, the resultant physical sensations/complaints resemble sensory hallucinations. Examples are the conviction that rays are permeating the skin, felt as formication, or a crawling sensation; that rays are permeating the external sexual organs, felt as persisting, unrelievable genital sexual sensations or pain; and the conviction that worms are crawling about in and stuffing up the intestine, felt as bloating or abdominal pain.

5. Hypochondriacal thoughts, which mimic physical symptoms when they express a depressive worry in physical terms. Often this physical expression is a combination of autosuggestion, elaboration of an actual (normal or mildly abnormal) physical sensation, and a failure of communication.

A patient was so worried about having a stroke that he talked himself into feeling numb—autosuggestion. He also elaborated normal muscle spasms to convince himself that his

peripheral nerves were dying—elaboration. Then, instead of telling his doctor that he worried about having a stroke, he reported his symptoms as if the stroke were a fait accompli (i.e., he told the doctor that his arms and legs felt numb)—failure of communication.

Another example of an elaboration of a normal physical sensation is the elaboration of normal spasms to become "rigor mortis is setting in." An example of an elaboration of an abnormal physical sensation due to a minor physical problem is elaboration of flu to become AIDS pneumonia.

6. Depressogenic emotional-physical trauma combined. For example, patients whose depression can be traced to early trauma from radical surgery may express a later depression not as a mood but as a physical sensation. The physical sensation felt now originates in a physical sensation first experienced then, at the time of the surgery.

7. Hysterical mechanisms. For one patient headaches represented a pregnancy fantasy, along the lines of Zeus giving birth to Athena.

8. Simple dependency. A lonely patient developed symptoms of multiple sclerosis just so that she could belong to a group of people similarly afflicted. Some patients convince themselves they have a currently popular illness for the same reasons, with some so-called autoimmune deficiencies and questionable cases of Epstein-Barr belonging here.

FATIGUE AND HYPERSOMNIA

Depressives who complain of fatigue and hypersomnia are often stating an emotional concern in physical terms.

One patient who complained of fatigue really felt bored, angry, and depleted. He said, "I can't stand all the oral demands the world makes of me. I am emotionally exhausted from being sucked dry by all those phone calls from salesmen wanting to sell me something, from my wife who always wants money, and from my pets who always want attention and more food. I feel like the world is a giant mosquito on my chest, with its sucker inserted in my heart, inhaling."

INSOMNIA

Lying Awake

Some patients lie awake because they are unable to think the pleasant thoughts needed to lull themselves to sleep. Either the thoughts do not come, or after appearing, they are submerged by unpleasant, arousing thoughts. Two categories of these arousing thoughts are the following:

1. Obsessive-compulsive worry and brooding.

The above-mentioned patient who worried that his mother would cut him out of her will also worried all night that his sister would convince the mother to change her will by

removing the mother from the mother's home, taking her to live with her, and wooing her emotionally.

A second patient compulsively used the early morning hours to do a life search, rehashing his life and wondering how he could have done better. This looked purposeful but was actually a form of self-recrimination and self-torture: an inability to forgive and forget for himself in the same way he forgave and forgot for others. He was unable to let it go with reflection that he had done the best he could when he was young, knowing what he knew then. Everyone could have done better if hindsight were foresight (i.e., were they possessed then of the clearer vision they have now, through the retrospectroscope).

A third patient fixed on the baneful side of life. Instead of responding positively to his lover's snoring as a sign that he was not alone, he resented his partner for making noise. He became angry and depressed and could not sleep himself, not because of the noise but because of the agitation about it.

2. Paranoid fear and blame. Many depressives lie awake collecting injustices, projecting the resultant anger, and fearing counterattack. They also lie awake thinking of ways to exonerate themselves by affixing blame on others.

Middle Awakening

Some patients fall asleep easily but awaken early and are unable to get back to sleep. Dreams are often the central problem here. The bad dream that wakes the depressive up after he has fallen asleep may be the familiar nightmare, or it may be a depressive nightmare, a dream that good things are happening to a bad person. One such patient dreamed he was "afflicted by success," another dreamt he suffered from "two years of unspeakable bliss."

PAIN

The mechanisms of depressive pain include the following:

1. Muscle tension. The origin of depressive pain in muscle tension may account for some of the usefulness of massage-oriented therapy/chiropractic.

2. Vasoconstriction/vasodilation, themselves somatic expressions of anxiety. Muscle pain and headaches are among the phenomena that can be caused by vasomotor "instability."

3. Somatic metaphor. Depressive pain is often a somatic metaphor for anger ("You give me a pain, and this is the pain you give me"). Stomach pains that are not really pains but "emptinesses" can be metaphors for unfulfilled longing. Because depression is a *thoughtful* illness with *visceral* impact, we see pain in the head associated with pain in the stomach, for example painful, pounding headaches associated with gaseousness, a combination often referred to as a "sick headache."

4. Somatic delusion. One patient's abdominal pain expressed his belief that his insides were rotting away.

5. Identification. One patient's back pain represented an identification with her nieces' similar affliction, while another's jaw pain represented an identification with the symptoms of a friend who died of tongue cancer.

6. Regression. Regressive pain is a somatic statement of disability and a plea for care.

7. Excuse. The pain is imagined or overemphasized so that the patient can begin or continue a drug addiction.

8. Polysurgery addiction. Polysurgery addiction is a form of self-abuse employing others as the instruments of torture.

Years ago one patient, in a pattern typical for the time, seduced her surgeon into an appendectomy, gall bladder surgery, a hysterectomy, a bladder suspension, then a lysing of the adhesions that were the inevitable complication of the other surgical procedures.

In conclusion, finding out the fantasy behind the pain can be simpler, less invasive, and as precise a diagnostic tool as a CAT scan, magnetic imaging, or exploratory surgery. Use of this simple diagnostic tool may help avoid giving unnecessary addicting medications and/or doing unnecessary medical or surgical procedures.

DIARRHEA AND CONSTIPATION

Depressogenic life events can be responsible for some diarrhea and constipation. One patient became constipated after every loss, then diarrheic after every reunion.

Diarrhea and constipation can also be associated with a pervasive depressive characterological attitude.

A stubborn patient's constipation was due to a refusal to give others what they wanted simply because they wanted it, extended to herself as a refusal to give herself a cleansing bowel movement. Her gaseousness also served as an expression of self-disgust.

NOTE

1. Felix Deutsch (ed.). *On the Mysterious Leap from the Mind to the Body*. New York: International Universities Press, 1959.

CHAPTER 5
The Association between Depression and Other Symptoms/Syndromes

DYNAMIC ASSOCIATION

The dynamic association between depression and other symptoms/syndromes is illustrated by the fluid interaction between depression, paranoia, anxiety, and obsessiveness in the following cases:

The earlier-mentioned patient who feared that his mother would change her will and disinherit him was anxious, obsessive, and paranoid as well as depressed, which he expressed, respectively, as a fear of being disinherited, a worry about his financial future, and a suspicion of what others had in mind for his money, as well as a feeling of despair about the poverty he deemed certain in his old age.

Another patient could express himself in the anxious, obsessive, paranoid, or depressed mode equally well. When expressing himself in the anxious or obsessive mode he would say, "I might ruin myself with people I like and depend on, and they will leave me." When expressing himself in the paranoid mode he would say, "My new-found enemies are talking about me, criticizing me, and planning to hurt me." And when expressing himself in the depressed mode he would say, "I have no one and no one loves me."

Factors of reality (type of provocation) and intent (secondary gain) often determine what leads the way and shows the most. As for reality, a threatening letter from a finance company might produce a depression more paranoid than a rejecting "Dear John" letter from a lover. As for intent, people who want sympathy might emphasize how traumatized they are, while people who want reparation might emphasize the malignancy of others.

ASSOCIATION BY CLINICAL SIMILARITY

Paranoia and Depression

The many ways depressives and paranoids are alike are cited throughout. For example, both depressives and paranoids are motivated to conclude that others are ill disposed to them and overlook the distinction between major and minor in order to make their adversarial point.

Post-traumatic Stress Disorder and Depression

Post-traumatic stress disorder can resemble depression under at least two circumstances:

1. When there is a depressogenic element in a current trauma. In the following cases the depressogenic aspect of the trauma was disregard for others.

A couple was trapped in an appliance store during a shoot-out because the store owner had locked the escape door at the rear. They tolerated the sounds of gunfire and the sight of blood and dead bodies better than they tolerated the owner's carelessness. Properly believing that only a cruel person would lock the escape door, they took the owner's actions as evidence of selfishness. Their subsequent depression was less a response to the actual trauma than to the store owner's "poor parenting."

A doctor learned he was moving from his sublet office when the new tenant knocked on his door during office hours to ask him when he would be leaving. The selfishness, lack of caring, and insensitivity of the landlord were as instrumental in creating the hard feelings and depression as the trauma of the eviction itself.

When there is litigation, it is the lack of caring/poor parenting that is as inciting as the trauma itself.

2. When the current trauma reactivates an earlier trauma, one that resulted in a depression when it first occurred.

A throat operation reminded a patient of a tonsillectomy he had had during childhood. At the time the tonsillectomy had been associated with depression because the parents presented it as a punishment for misdeeds, even warning the child that he might be abandoned at the hospital.

Personality Disorder and Depression

Depressive behavior can resemble behavior characteristic of other personality disorders, as follows:

Borderline

A characteristic overlap between depressive and borderline pathology is seen in the similarity of borderline and depressive devaluing and overvaluing. Both

depressives and borderlines make yesterday's overvalued idol into tomorrow's devalued worthless person, and both do so for essentially the same reason, to feel better about themselves. But there are significant differences. When the borderline overvalues he does so to blend and merge, and when he devalues it is because, having gotten close, he fears for his individuality and his identity. In contrast, depressives overvalue not to abdicate but to create an identity, one that depends on occupying a central place in the affections of overvalued others: the identity of being special and superior that comes from being loved by an important person, like the fisherman who feels superior by virtue of having landed the biggest fish, the boss by virtue of having the most impressive title, the leader by virtue of ruling more of the world than his rivals, or the bigot by virtue of hating the most. And when depressives devalue they do so not from fear of loss of individuality/identity but:

because a projective identification that begins as loving others in the way the patient wants to be loved himself ends as hating them in the way he hates himself;

because depressive ambivalence reasserts itself and a hypercritical attitude appears and needs reasons for its existence;

because when the hypercritical attitude appears the patient thinks he looks bad by association and devalues to get away;

because the never-satisfied narcissistic depressive presses on to find someone better than the one he already has.

Passive-Aggressive

Depressive expression of anger resembles passive-aggressive expression of anger in a number of ways. Depressives, like passive-aggressives, express anger obliquely. Both complain not necessarily about those they complain to, provoke arguments by undermining, cling to others in an angry way, attack others by deflating their self-esteem—as the patients' own self-esteem is impaired—and attack others by making them feel guilty, sometimes for nothing worse than being happy. Also like passive-aggressives, depressed people are fond of the apparently innocent remark that dampens a festive mood, the purportedly amusing anecdote that expresses a hostile truth in jest, honesty and frankness that covers the motivation to hurt, and the sadistic refusal on a flimsy pretext in response to an urgent need.

As for hurtful honesty and frankness an example is the patient who, told to say anything that came to her mind, said that "In my opinion your new office has an awful stink."

As for sadistic refusal on a flimsy pretext there is the contrast between two people handling a dog with a paralyzed leg. The nonsadist rubbed the leg when it went into spasm, while the sadist, impatient to walk on, pulled the dog along even harder.

Sadistic

Many depressives are basically sadistic, with the attack on the self but a disguised attack on others. When the disguise fails, temper tantrums/homicidal ideation-behavior can appear.

One father was angry with his son for being younger, stronger, and healthier than he. Instead of expressing the anger directly, he claimed to be depressed about his son's physical condition—his headaches, which he feared might be a brain tumor. When the disguise failed he expressed anger directly, on the sadistic model, the expression running the gamut from verbal denunciation to crude insults to actual neglect. Verbal denunciation also appeared later in life, when he cursed the son both for being homosexual and for living with another man. Real neglect was exemplified by a childhood incident when the father let the son play on the beach for six hours without adequate body covering, then neglected the severe sunburn that resulted.

Not all depressions are sadistic in intent (i.e., are meant to be instruments of torture). Nonsadistic depressions are motivated less by hate than by loss. A clinical distinction is this: in sadistic depressions the individual complains about how bad he feels, with the complaint "I feel depressed" directed to those he complains to. In contrast, in the loss depressions the depressed person does not complain if he can avoid it. Instead he tries to hide his depression, thinking, "If I show it, I might drive people away. They will give up on me, then I will feel more depressed." If he does complain, to avoid driving people away he complains to those who are not the real target of the complaints.

Masochistic

Depressives look masochistic when they live out their guilt by playing a one-down role. A woman who felt worthless relinquished a lover to a rival in the belief that she had no more right to him than the other.

Depressive altruists behave masochistically when they overlook their own needs. A patient dying of cancer and unable to pay her hospital bills nevertheless continued to donate 10 percent of her income to charity.

Histrionic

Hysterics, like depressives, overvalue and then devalue. Overvaluing is hysterical, not depressive, when the other already resembles or is remade into the image of an idealized parent. Devaluing is hysterical, not depressive, when the other is criticized/abandoned because he is too like the parent for comfort (the incest taboo) or too unlike the parent to serve as an adequate substitute.

So-called hysterical Don Juanism in men and nymphomania in women is really depressive when it is not a seducing and abandoning but an attempt to "connect" with others in the sexual mode in individuals who are unable to relate in another way.

Psychopathic

Depressives look psychopathic when they deliberately try to arouse guilt toward themseives by playing on another's sympathy.

ASSOCIATION BY CAUSALITY

Secondary depressions may be the product of another, more primary, disorder, which may be paranoia, obsessive-compulsive disorders, borderline states, hysteria, or psychopathy.

Paranoia

Paranoids become depressed when their fantasied persecutors become real-life enemies and when their paranoia improves too late or not at all, leaving in its wake if not a wasted life, then a reputation permanently impaired.

Obsessive-Compulsive Disorders

A little-noted reason why obsessive-compulsives become depressed is that their behavior easily provokes others to humiliate them.

One patient, afraid the window washers could peer in and see him performing rituals, became the laughing stock of the building when he strung sheets of paper towels on his windows to hide their view.

Another produced the same effect on visitors when, afraid the basement washer and dryer were contaminated by germs, he put his wet clothing out to dry on his glass-top coffee table.

A patient who believed his fate depended on his purchasing the jar of prunes with the thickest syrup (he turned each jar upside down to observe the rate of fall of the prunes and so the viscosity of the prune syrup) found a guard following him down the aisles of the supermarket. The guard understandably thought not that he was performing compulsive acts but that he was stealing.

Borderline States

Borderlines get depressed after overvaluing. In a typical scenario they have imaginary love affairs with such strangers as the beautician or therapist, affairs that are consuming but ultimately disappointing. They also get depressed after devaluing. In a typical scenario they feel lonely and rejected even though they did the rejecting. Also the falling in and out of love inherent in cyclic overvaluation and devaluation makes a borderline's life a depressing nightmare of whirlwind marriages and bitter divorces.

Hysteria

While hysterical behaviors can be gratifying and productive in adolescence and early adulthood, with advancing age they usually become unsustainable, unrewarding, counterproductive, and off-putting. Unless the person changes his style, disappointment, loneliness, and depression await, as one patient put it, "the fate of the faded movie star." In particular, hysterical teasing and rejecting work only for the very young, handsome, and/or wealthy.

Psychopathy

In a common sequence, depression is the consequence of failed psychopathy, appearing because the free ride is over.

ASSOCIATION BY DEFENSE

In association by defense, another symptom/syndrome defends against depression, often incompletely/ineffectively.

Paranoia

As an example of paranoia as a defense against depression, the delusional "you take from me" avoids the depressive "I don't have what it takes." Patients also feel better merely by having a reason for feeling distressed, what one paranoid patient called "my organizing hook."

Obsessive-Compulsive Disorders

Obsessive worry, ambivalence, and perfectionism can all defend against depression.

1. Worry is paradoxically reassuring. One hypochondriac who worried about getting sick confided that the hidden reassurance in a worry about what might happen was that nothing had yet happened. Worry also provides structure, if only by passing the time. Finally, trivial, unrealistic worries can divert from more serious, realistic concerns.

One patient, told he might have a carcinoma, took his mind off his illness by worrying about how he would get to Boston for a second opinion. He worried not about his possible tumor but about the most convenient plane schedules, the cheapest fares, and the best hotel accommodations.

Another patient, depressed because he had no woman companion, worried about finding the ideal summer resort to meet women. Speaking of his need to make the perfect plan and his conviction that any plan less than perfect was no good at all, he said, "There is no place convenient to New York. If you fly it's too expensive. If you take the train it

takes too long. A bus is too confining and I hate the people. I don't have a car and don't like driving. And finally, any place that's close by New York is by definition uninteresting."

2. Ambivalence. For those who have been disappointed, ambivalence provides a refuge. The person who fails can reassure himself, "It's not what I wanted anyway." And in an emergency the patient on the fence has two escape routes—one on either side.

3. Perfectionism. Depressive perfectionists divert themselves from themselves by performing trivial activities perfectly. For example, one patient avoided feeling lonely by spending hours in the supermarket searching for the best possible low-fat, low-calorie dessert, and another learned to identify all 104 symphonies by Haydn.

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CHAPTER 6
Positive Aspects of Depression

EMPATHY AND HUMOR

There is a bright side to many depressions, as one patient put it, "A purple heart for every wound." Depressive hypersensitivity contributes to empathy, while depressive ability to pit the self against the self contributes to a good sense of humor.

An example of how the comic ability can originate in the capacity to mock the self is provided by the patient who, after losing most of his money in the stock market, joked, "My stocks must have known I bought them."

In fact, depression can be broadly defined as a failure of the sense of humor, when in the absence of nihilistic, black, mocking, self-impaling self-satire, one's foibles and peccadilloes assume excessively bleak proportions.

ENHANCEMENT OF RELATIONSHIPS

Many depressives have an enhanced capacity to form and maintain relationships. They form them quickly and maintain them tenaciously because they need them, say, to improve their self-esteem. This neediness makes them more, not less, forgiving of others and prompts them to take their hostility out on themselves to spare others from the worst of their anger. However, this defense is not completely effective, because even unsophisticated victims intuitively understand that they are the real objects of the patient's self-directed anger, that the self-attacks are but roundabout attacks on them, that anger expressed at the self merely uses the self as one example of who is making them angry, and that much of self-hate is merely an apology for hatred of others.

Depressives get along well with others because they flatter them, their low self-esteem making others' self-esteem high by comparison. Depressive passivity appeals to competitive people. Some bosses like depressed workers because they are so desperate for love they will take anything they can get, and are so passive and compliant, at least superficially, that they seem not to mind abuse. Of one depressive a boss said, "He doesn't know the meaning of 'nobody treats me that way and gets away with it.' " Finally, one person's depression can relieve another person's guilt.

A patient for years believed his mother did not love him because of what he was and what he did. He blamed himself as completely as she blamed him. As she got older his mother became increasingly depressed, elaborating what had seemed to be merely antagonisms and prejudices in her earlier years into fixed depressive delusions, such as "I know you hate me." Now the patient could view her earlier behavior as a product of the same depression. For this reason, as the mother's depression became worse, his depression improved.

These are among the reasons why the depressive's friends and family can act in antitherapeutic ways to maintain his illness and can themselves decompensate should his depression lift.

PLEASURABLE ASPECT

Depression is a wallowing in delicious despair. (Patients with few alternatives should be allowed to enjoy this pleasurable aspect of their depression.)

DEFENSIVE ASPECTS

There are defensive virtues of depression, such as relief of anxiety, but these are too often counterbalanced by depressive passivity, withdrawal, self-condemnation, and suicide.

ENHANCEMENT OF CREATIVITY

In some cases the more depressed the more creative the author, painter, or musician. Creativity refers both to creative talent and to the creative initiative implicit in the willingness to implement that talent. (Admittedly the two may be difficult to separate.) As to creative talent, in depressed people we see a concentration of perceptive faculties that may go hand in hand with two creative abilities: the ability to forge new and striking connections between disparate ideas and concepts and the ability to separate heretofore connected ideas and concepts and view them in isolation. In either case, the result can be a vision of the world that is as original as it is narrow. As to creative initiative, while some patients are too depressed to create, in others there is, at least in the beginning, a favorable response.

In one patient a high level of creativity was primarily restitutive, a compensatory reaction to selective withdrawal of interest from other people and reattachment of this interest to the creative opus.

Another patient wrote books to improve his self-esteem by arousing other's interest and love. However, this left him vulnerable even to constructive criticism, which was perceived as nonsupportive. As he said, "My talent and initiative vaporize in the fish eye's glare."

In Part II, Chapter 11, it is suggested that writer's cramp can be a symptomatic response to negative criticism. It is hypothesized that because all art is at least partly restitutive, all art is stimulated by love, grows poorly in the dim light of disdain, and is stunted by hate. And it is suggested that critics have a social responsibility to feed and nourish, beyond their critical responsibility to assess, evaluate, and condemn.

GROWTH ENHANCEMENT

Because a search for satisfaction can be motivated by a feeling of dissatisfaction, as when an abused depressive looks for someone to treat him better, in favorable cases criticism enhances growth. Typically there is a biphasic response to criticism. The first reaction is resentment and counterattack, along the lines of "he doesn't know what he is talking about" and "he'll pay for that." After the patient has calmed down, perhaps only after months or even years have passed, the criticism may be viewed as both justified and helpful and the patient may become willing to change.

CATHARSIS

A spell of depression, though hard on others, "gets the poison out of the system" and clears the air. At least the patient feels better for it.

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CHAPTER 7
Hypomania

While depression can occur in the absence of hypomania, hypomania usually cycles to depression (and back again). Normal moods can intervene, but though the periods of cessation may be substantial, the cycling is almost always renewed.

Because hypomania is pleasurable, patients see their mood disorder solely in terms of the depressive state and do everything possible to perpetuate the good feeling. Thus, when cycling patients see the depressive phase approaching, they intensify the activities associated with the hypomania to try to force themselves to stay happy. Still, hypomania is a symptom, for the following reasons:

1. It has a forced, concocted, self-induced, unspontaneous quality that makes it less than sublime.
2. It is geared not to express joy but to deny despair, to say not "how glorious I feel" but "I'm not sad" or "I'm not mad."
3. It betrays its origin in the depression that it defends against. For example, like the depression it is an abrasive, intrusive, unwelcome attack on others.
4. It obscures problems and in this way diverts the patient from solving them.

One patient called his hypomania "my bar-and-restaurant euphoria," where the joy from warm, welcoming neon, the friendship of the "motherly bartender," and the back-slapping crowds gave him a feeling of well-being, unfounded because his isolation and loneliness continued and counterproductive because he took no steps to change them. He continued to cruise bars even though he recognized that "the people there are like me: not there to enjoy themselves and meet other people but there to treat their depression."

5. It gives way to depressive fatalism, the down mood consuming the up because of the sense of impermanence inherent in shifting moods.
6. It interferes with the development of solid relationships. Though we think of hypomanics as relating as well as, or better than, most, they can be as impaired

in their personal relationships as are narcissistic remote depressives. First, their relationships are often geared to quantity, not quality. They collect approval, not relationships, and collect people as one might collect trophies, and for the same reasons—for a self-approval or approval from others that depends on head count. As might be expected in this pursuit of numbers, marital fidelity is an early casualty. Also, instead of relating they become unabashed crowd-pleasers subject to fads.

One patient invited people to his home to get their approval for his decorating skills; with this in mind he subordinated his personal preference to the notional tastes of a cross-section of the public. As might be expected, depression inevitably appeared because the applause inevitably faded.

7. It leads to psychic exhaustion, paid for in the currency of depression.

For all these reasons some loss of hypomania is the quid pro quo for reduction of depression, and over the long term it is desirable to try to flatten the mood swings.

DESCRIPTIVE MENTAL STATUS

Appearance

Hypomanics maintain the controlled excess typical of their condition. Though there may be a definite larger-than-life showiness, outlandish extremes are the exception. The attention-getting features of dress or grooming—too much brightness, stylishness, and so on—represent exaggeration rather than total departure from convention. Thus a hypomanic individual might wear several large rings with fake stones. Underlying anger appears as a note of defiance, as with the angry divorcee who wore a ring on every finger of her left hand except the finger reserved for the wedding ring. In the hypomanic individual who finds dress or grooming inadequate vehicles for visual self-expression and uses display props or devices like buttons or bumper stickers, depressive defiance can crop up in messages that while meant as humor are in fact tastelessly offensive.

Speech

Unlike the taciturn depressive, the talkative hypomanic prattles under stress, and when the stress is acute his prattle may give way to logorrhea. Instead of showing depressive self-preoccupation, the conversation of hypomanics may consist of the opposite: reported conversations of others, long passages of which may be repeated as if they were plays. There may be frequent quoting that is not overheedful of relevance or accuracy. Instead of self-effacement there is hyperbole, and in place of passivity there is a clear preference for active words like "go" over passive words like "said" (thus "I went . . . then he went. . . . ''). Hypo-

manic jokes are often puns. Favored puns are those that avoid or trivialize personal reference to avoid or trivialize painful insight. As an example, one patient used the pun, "choclothymic cyclothymic" self-descriptively, to describe himself only in terms of his addiction to sweets during depression.

Thought and Mood

The hypomanic mood reflects a conviction that it is impossible to be serious about life itself, a defensive attitude that denies the substantiality of life, for were it to be recognized, this would mean an implicit affirmation of the substantiality of death.

The cycling may be a manifestation in shifting mood of the depressive fixation with the idea of change, of impermanence, the depressive theme that "if there is anything you can count on, it's not being able to count on anything."

Cycling can sometimes be traced to an earlier time when the infant first became aware of the "sorrowful instability" of gratification in the dependent state. A more up-to-date reason for cycling is alternation between guilt and freedom from guilt. In other words, the cycling represents a freedom where once there was a constraint, and back again.

Finally a going from hypomania to depression may be but the inevitable comeuppance for prolonged denial, the refusal to worry, the inability to take matters seriously, and the overlooking either of the early warnings of real disaster or of real disaster itself.

A hypomanic patient neglected his physical condition by not having physical examinations. His reason: he did not want to worry about his health. Another ignored rectal bleeding from colon carcinoma, convincing himself it was due to hemorrhoids until it was too late.

Behavior

Sometimes opposite behaviors appear as the result of hypomania alternating with depression. For example, hypomanic overgenerosity might alternate with depressive stinginess. But as often behaviors that occur in the hypomanic phase are found in the depressive as well, so that the same individual can exhibit a particular behavior in both phases. However, the significance of any one behavior is different with the different moods.

One patient, when high, acted out sexually because nothing stopped him; and when depressed he acted out in precisely the same way, because then he felt pressure to "connect with others."

Another patient when hypomanic isolated himself because he wanted things more than people, and when depressed did the same thing, but now to avoid expressing angry thoughts.

Excess, not shortfall, is characteristic. In their spending, their relationships with others, their studying, their work, their sleep, their eating, and their sexuality, cyclothymic individuals exceed normal standards just as depressives fall short. This overshooting is not only mood related, it is also purposeful (i.e., readily understandable in light of the already mentioned tendency patients with affective disorder have to concentrate certain activities and functions into one mood phase, to the detriment of these same activities in the other phase).

Another sign of excess is work hyperactivity replacing work inhibition. Here we encounter once-diffident people who now seem unable to rest—putting in long hours, taking on new responsibilities before discharging old ones, or holding down two jobs instead of none. There are two factors that keep these people from realizing their full potential. The first is distractibility (more on this below), and the second is a motivational weakness based in the narcissist's dependence on money or status for self-esteem. This occurs in individuals who are simultaneously uncompromisingly dedicated to their work. Such people are often candid in claiming such dedication, but they fail to recognize the superficiality of a satisfaction by visceral self-indulgence supported by earnings or income, rather than by self-sacrifice, creativity, or other transcendental motivations/goals.

Usually social hyperactivity replaces depressive isolation. Social hyperactivity is characterized by restlessness and impatience, a breaking off of existing attachments and forming of new ones. This is due to an inability to be alone, which is as characteristic of hypomanics as it is of depressed and borderline patients.

Inconsistency is another characteristic. Underlying the inconsistency is depressive-style ambivalence plus distractibility, resulting in weakness in concentration. In addition there is a different and broader-based inconsistency produced by phasic reverses in attitude due to mood swings.

Hypomanics are aggressive people who, like many depressives, show a preference for obliqueness in their expression of aggression—at least until they have the inevitable temper tantrum. Thus hypomanics will trample on people's fondest beliefs in an attack made to look ideological and impersonal, rather than denounce them directly. Especially popular among aggressive hypomanic patients is the obscene gesture or tasteless anecdote, enabling them to give vent, however indirectly or euphemistically, to previously unspeakable topics like matters of body function. There is a generally hostile, intimidating jocosity, as exemplified by the following fragment, overheard on a train by a patient:

"This woman and her friend came in a Mercedes to look at my sister's house, and right away the woman tries to cut us down. You tell me how a woman can afford a $50,000 car and won't pay $78,000 for a house. Tell me that! I said, I said to her, 'Stupid person, get the hell out!' Yes, that's what I said. I said to that stupid person, 'Get the hell out. You say you can't afford to pay, so get the hell out.' "

Hypomanics can behave like obsessive depressives in their devotion to material things. However, the reasons for the devotion are different in depressive obses-

sives and hypomanics. While the depressive obsessives use material things to create a positive self-image dependent on order, precision, perfection, and balance in surroundings, hypomanics use material things to create a self-image dependent on impressing others—like the executive who decorated his apartment in mid-Victorian style, cramming it with costly bibelots and turning it into a museum uncomfortable to live in but much talked about. Also, in the hypomanic the relative importance of material considerations increases, and things are overvalued in relation to people because the emotional value of a personal relationship has diminished.

Insight

Both hypomania and depression can go unidentified, but while depression often goes unidentified because it is hidden, hypomania more often goes unidentified because it is ego-syntonic and enjoyable. A patient who bought two houses she could not afford with checks that bounced was hospitalized, then a day after her release reopened the contractual negotiations, because "the houses are 'me.' "

Hypomanics manipulate insight to stay high. They use introspection to avoid responsibility, blaming their misbehavior on irresistible impulse, on not knowing right from wrong, or on stress beyond their control. They use insight not in order to understand themselves but to continue not to resist their impulses.

ADVANTAGES OF HYPOMANIA

Hypomania can increase creativity in several ways. Shared with depressives is the acute and special ability of the pervasive mood to collect and unify diverse concepts under its spell, to connect disparate ideas and concepts in new and original (though often idiosyncratic) ways.

Another feature in common with depression is its defensive capacity. Hypomania is protective. Hypomanic insensitivity prevents others' negative reactions from interfering with and decelerating the creative flow. Also protective is hypomanic avoidance. One patient avoided self-criticism by never reading his publications after they were published and avoided criticism from others by never reading his reviews.

Hypomania confers special aptitudes on its sufferers. One is an aptitude for politics. Hypomanic detachment is an advantage, if not an essential attribute, of political leadership. It gives the politician the ability to forge impersonal ties of loyalty and affection with an unlimited number of people. For this reason we should think twice before unmasking a politician's affective disorder and on that account alone recommending his defeat when he is running for election or, if he is already in office, forcing him to resign.

However, hypomania can have the reverse effect. Some descriptions of the composer Gioacchino Rossini as a gourmand suggest hypomania later in life, perhaps as a reaction to his father's death, and imply a relationship between his hypomania and his inability to create during the latter half of his life.

Part II

CAUSE

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CHAPTER 8
Introduction to Primarily Internal (Self-Created) Depressogenesis

The following discussion of depressogenesis supplements the holy, abstract, sacred, scientific, and formal with the mundane, concrete, profane, intuitive, and informal, goes beyond the highfalutin, such as "anxiety-provocation"; the general, such as "losses" or "stresses"; the obvious, such as death of a loved one or the "big mortgage"; the overdone, such as "codependency"; and the how-many-points-for-a-problem superficial and narrow checklists that caricature rather than characterize depressogenesis. Instead it will emphasize:

1. The unexpected, such as victimization by depressogenic individuals who treat their own depression by making others depressed instead, or their own paranoia by blaming others for being their persecutors though the others' intent is benign and positive.
2. The overlooked, such as that invariable accompaniment of aging, depressive ennui—the feeling that everything is flat because it has been said, done, and seen before.
3. The trivial (but important). For depressives the trivial is the important thing, because depression is a much-ado-about-nothing illness that spares the capacity to handle major, while affecting the capacity to handle minor, stress.

An individual who lived in a beach resort, close to but not on the water, became depressed whenever his friends predictably asked, "Do you live on the water?" a question he believed was intended as a put-down. Hinting at the origin of his problem in sexual humiliation, he reacted by becoming "crestfallen," feeling as if he were "a worthless person whose impoverished surroundings symbolize how I have done nothing useful in life."

An artist did not get depressed when the critics panned his work, but did get depressed when people called him by a diminutive version of his first name.

4. The (to some) unappealing, unpleasant, unpalatable, threatening, and shameful. Many studies of depressogenesis avoid giving or taking offense by downplaying or entirely avoiding such potentially dangerous material as forbidden homosexuality or a spouse's truly murderous fantasies, as long as they are sugar coated and expressed in thinly veiled passive-aggressive verbal or behavioral disguise—such as a suicide attempt that is really a homicide attempt with the other spouse in mind.

OVERLOOKING INTERNAL/EXTERNAL EVENTS

Patients can ignore internal and/or external factors in their own depression, emphasize one over the other, or confuse cause with effect. Three examples are:

A patient who overlooked externals and blamed his plight on himself because he wanted to create a sense of mastery to give him a feeling of being in control. He could control himself but not the world, which, as he said, "didn't know he existed." (This, as much as the need for punishment, is the reason for masochistic self-blame.)

A depressed patient who blamed his plight on his stars, his fate, his malignant family, and other vague or specific stress even though when insightful he recognized that he himself "was the real pilot of my ship, now sunken." For example, he attributed his depression to disappointment with elected officials (particularly the president, whom he thought incompetent) rather than his disappointment with elected officials to his depression. Here the inversion had some basis in projection. The individual was chronically disappointed with himself, thanks to expectations that he consistently set too high, and he made authority figures his scapegoats.

Another patient who confused cause and effect and complained, "Whenever I do not sleep I look terrible the next day, and that depresses me." She discovered through psychotherapy that her not sleeping was the result of a chronic, rather intense depression, instead of the other way around.

Clinicians also overlook or neglect reactivity. Here-and-now-oriented clinicians sometimes do a superficial reactivity profile limited to catch-all concepts like "stress," "provocation," or "reality." They may overplay external factors, like the stress, and downplay internal factors, like anger. To illustrate, anger is listed only once in the index of the American Psychiatric Association *Treatments of Psychiatric Disorders*, and that as a side effect of neuroleptic treatment of schizophrenia.[1] Psychoanalytically oriented clinicians, by emphasizing infantile sexuality, aggressivity, and hidden meaning, overlook the way depression often makes a simple statement, means what it says, and stands for itself, with its manifest, conscious, and current aspects no less momentous than its latent, unconscious, early determinants. In taking people apart to view the pieces, they overlook the final evolutionary shape taken by the primordial ooze and forget that the character of the tree comes as much from its bark and branches as from its roots.

All clinicians tend to downplay or overlook the way internal events are the

playwright that writes the play of self-created stress, as happens in (1) the philosophical depressions of people who are too idealistic; (2) the masochistic depressions of people who drive away potentially suitable companions and then feel alone, or who are trauma-hungry injustice-collectors who blame the collection, not the collector; (3) the innocent-victim depressions of overtrusting patients who unknowingly hand others the sword that stabs; (4) the hypersensitive/paranoid depressions of patients who read hidden messages that do not exist or are meant to be kept hidden; (5) the altruistic depressions of patients who put others first and themselves last; (6) the malcontented, narcissistic depressions of patients who believe nothing and nobody is good enough; and (7) the hostile guilty depressions, where guilt about hostility is projected to appear as fantasied or real comeuppance for hate-filled thoughts and/or actions.

Finally, many clinicians overlook vicious cycling entirely or begin and end with either the external or internal leg of the cycle. For example, much stressology (the study of stress) presumes the primacy of the chicken (external matters) over the egg (internal matters), prematurely and arbitrarily settling an age-old problem. Humanely/politically justified settlements may not be scientific, as when the vicious cycling between masochism and external abuse is settled in favor of the latter over the former—which is better humanity/politics than psychology.

In the following case a stressologist incorrectly blamed a patient's depression entirely on her breast cancer:

A patient was guilty about her father's suicide, which had occurred when she was in her teens. She believed it was her rejection of his sexual advances that had caused his suicide. In adult life her guilt appeared as a persistent blue mood, manifest as somatic symptoms that, though not due to physical disorder, significantly limited her ability to function. For example, she had difficulty walking because of painful feet and difficulty leaving the house because of constipation. The constipation was so severe that she had to sip hot water and strain at stool for several hours each morning just to have a small, inadequate bowel movement. When she developed localized breast cancer and had a mastectomy, a reactive depression crippled her further. The worry about a recurrence made her mood worse, and the somatic symptoms from the bad mood created the worry that she was having a recurrence, the two intensifying each other in a vicious cycle.

ECLECTIC APPROACH TO CAUSALITY

Many authors explain all depression according to a single theory, such as a biochemical defect or oedipal conflict, sometimes in the face of compelling evidence to the contrary. This text, however, advocates a limited eclectic approach, avoiding on the one hand the reductionism of the god of the Unconscious and on the other hand the reductionism of the god of the Chemical Imbalance. It views depression as a Rome reached by a number of roads: chemical, experiential, learned, conditioned, interpersonal, cognitive, and developmental, and it integrates as far as possible the contribution of the different schools of thought to the understanding and treatment of any one depression and any one depressive.

Of course there is little to be gained by an eclectic view of a depression that is at one or another end of the endogenous-adjustment spectrum. There is little sense in stretching the point to invoke masochism or the theory of the instincts to explain a depression after a bad accident; and as little in stretching the point to blame stress for a depression that is the result (as one patient put it) of "self-destructively greasing my own slide into oblivion." In other words, there is little reason to give equal say to everything that clamors to be heard when one voice is louder, or more rational and sensible, than another.

But perhaps a majority of depressions are a combination of manipulative-interpersonal intent, along the lines suggested by Walter Bonime,[2] self-directed rage over oral deprivation along the lines suggested by Freud[3] and Karl Abraham,[4] self-disappointment along the lines suggested by Edward Bibring,[5] injustice collecting along the lines suggested by Edmund Bergler,[6] and true stress or crisis, with existential and real despair over one's bad luck, along the lines suggested by Rado.[7]

Two current forms of reductionism seriously limit a clinician's therapeutic options:

1. Contemporary reductionism. There is eclecticism, but contributions from the past are excluded. There is a synthesis, but only of current thinking and practice. To counter, this text makes a deliberate effort to exchange new lamps for old, reviving now dormant but still useful theories to reapply in new ways. An illustration is Gregory Bateson's double-bind theory,[8] once cited as a theory of schizophrenia but also useful to explain depression.

A dentist with musical ability became depressed because he was put down in opposite ways by his friends. First they suggested his dental practice was a sell-out and encouraged him to compose. Then they humiliated him for composing, on the grounds that even his successful compositions earned him hardly anything.

2. Biological reductionism. In biological reductionism all depression, and not only that with a positive family history, a tendency to recur, and a good medication response, is viewed as a genetic/biochemical abnormality.

A clinician eager to prove a patient's depression nonreactive took at face value his patient's denial of external factors in his responses to a self-assessment test, though he knew that the depression itself had markedly altered the patient's view of himself.

A clinician confused cause with effect to convince himself that because nonverbal interventions (antidepressants) had cured depression, therefore depression must be a nonverbal (biological) disorder.

A clinician lived out his own problems with intergenerational/peer rivalry, a remnant of his unresolved oedipus, and an acting out of his unresolved negative transference to his own analyst. As his weapon he used the biochemical hypothesis of depression. He viewed himself as the child-hero leading the struggle between chemistry versus psychoanalysis, really the rivalry between the young (chemistry) and the old (analysis). One manifestation was a tendency to begin each of his journal articles with an attack on, instead of the

more customary quote from, Freud. The attack was the real, not incidental, purpose of the article. With his patients he diverged from the issue at hand by beginning each consultation with a vignette from his life history, in essence, "my story of how and why I gave up doing psychoanalysis to cure people with medication," which was not quite the point.

NOTES

1. American Psychiatric Association. *Treatments of Psychiatric Disorders: A Task Force Report of the American Psychiatric Association*. Washington, D.C.: American Psychiatric Association, 1989.

2. Walter Bonime. Depression as a practice: Dynamic and psychotherapeutic considerations. *Comprehensive Psychiatry*, 1: 194–98 (1960).

3. Sigmund Freud. *Introductory Lectures on Psycho-Analysis*. In James Strachey (ed.), *Standard Edition of Complete Psychological Works of Sigmund Freud*, vols. 15 and 16. London: Hogarth Press, 1961 and 1963.

4. Karl Abraham. A short study of the development of the libido. In *Clinical Papers and Essays on Psycho-Analysis*, vol. 1. New York: Basic Books, 1955.

5. Edward Bibring. The mechanism of depression. In Phyllis Greenacre (ed.), *Affective Disorders*. New York: International Universities Press, 1953.

6. Edmund Bergler. *1000 Homosexuals: Conspiracy of Silence, or Curing and Deglamorizing Homosexuals?* Paterson, N.J.: Pageant, 1959.

7. Sandor Rado. *Psychoanalysis of Behavior*, vols. 1 and 2. New York: Grune & Stratton, 1956 and 1962.

8. Gregory Bateson. Personal communication, 1961.

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CHAPTER 9
Internal Events

In the following discussion of depressogenic internal events it is recognized that internal events are often disguised as external events and that vicious cycles between internal and external events make it difficult to know which is primary and which came first.

In the section on treatment we will see that it is not always necessary to know this before instituting treatment, because to be effective, treatment need only disable one leg of a vicious cycle. We will see that it matters less than we think which leg is disabled, or how. An analogy is to a racehorse. Just as a racehorse cannot race with any one of its legs disabled, for whatever reason, depression is unsustainable with any one of its legs disabled, for whatever reason. And we will see that different treatments can effectively disable different legs of the cycle, each in its unique way.

INFANTILISM

Infantile patients are unable to completely sever emotional ties with the earliest developmental stages. Typically, they expect people to go out of their way to care for them, and they become depressed when they do not. One patient became depressed because his doctor would not stay in his office beyond his office hours to suit the patient's easily changed schedule.

POISONOUS INTROJECTS

Poisonous introjects are internalized hate-filled objects, often one's bad parents. Parents of depressives tell their children that the children have no rights. They call their children's legitimate desires excessive, their legitimate complaints

unjustified, and their appropriate reactions idiosyncratic. An only child was criticized for complaining after the birth of a sibling that he was no longer number one, a normal enough reaction.

Later in life such a child mistreats himself as if he were his own abusive parent, saying the same cruel things to himself that were said to him without questioning their wisdom and without considering the fallibility of the original source. He operates automatically in terms of crime and punishment, sin and guilt, deed and retribution.

The treatment for poisonous introjects is antidote introjects, such as new identifications with kinder people.

RELATIONSHIP PROBLEMS

Transference Relationships

The patient assigns the depressing qualities of people in his past to people in his present, selects new people who resemble depressing people from his past, and/or provokes new people to behave like depressing people from the past. This way, instead of having a new, pleasant, supportive relationship, he recreates an old, unpleasant, traumatic one.

Projective Relationships

Two types of projective relationships are typical of depressives. In the first type, the relationship with the other is really the relationship with the hated self.

A patient attributed his own hated passivity to a healthy lover who seemed phlegmatic because he was able to put things in their proper prospective. Instead of admiring the lover for his calm the patient condemned him, as he condemned himself, for excessive neutrality at times of crisis.

In the second type of projective relationship the individual cares for others in the way he wants to be cared for himself—an aspect of what is sometimes called "codependency."

The presence of transference/projective elements in a relationship is not per se an indication of immaturity or pathology and does not mean the relationship is on that account alone not viable. In the beginning of a relationship, when one does not know the other well, he has to relate using transferential/projective guideposts or building blocks, and caring for another in the way one wants to be cared for can be a healthy thing for an isolated depressive, a way to start over again, a first step out of a self-involved quagmire. In short, what some therapists identify as pathological transference/projective relationships and discourage should sometimes be called healthy transitional relationships and encouraged.

Ambivalent Relationships

Ambivalent depressives alternate between love and hate, an alternation often manifest as a shifting between adoring and abusing:

A middle-aged homosexual man took on an 18-year-old lover to care for, as his own rejecting mother had never cared for him. But instead he abused the lover, as his own mother had regularly abused him. The young man retaliated and left him because his needs were not being met and because the mistreatment was intolerable. A double depression resulted, because the patient's abandonment now by the lover resembled his rejection then by his mother.

A homosexual patient fell in love whenever he sensed he could recreate his wish to have a "virgin mother" (i.e., one not sexually tainted by having had sexual relationships with the father). The objects of his affections were men who "were not the type to think obscene thoughts or do obscene things." He became disappointed and angry when his lovers showed their human side by having sexual thoughts and needs. He criticized them unmercifully for showing sexual interest even in him, abused them for being "sluts," then drove them away for what he called their "unfaithful thoughts."

It is notable that while the capacity for love to replace hate presumes the capacity for ambivalence, the reverse is not true, since the capacity to cover love with hate, while technically also an undoing or a reaction formation, can exist in people with so little capacity for love that there is no real ambivalence.

MANIPULATIVE DEPRESSIONS

Manipulative depressions may be those already in place modified to be coercive, and/or those deliberately created to be coercive. As an example of the former, a depression that relieves anxiety about success (primary gain) can be used to extract care ("You do it for me, dear"). Such depressions are, to use a cliché, a way to make lemonade out of the lemon.

LEARNED DEPRESSIONS

People who have had one depressive experience can deliberately perpetuate it and have another. In such cases there is reason to believe that the person has adopted depression—which initially might have been an infantile marasmus, a childhood depression, a depressive illness beginning in adult life, or a manipulative depression—as a solution to his problems. Coddling such a depressed patient can reinforce the learning.

Such was the case with a young patient who was sent to camp by his parents, hated it, and became depressed. When he returned home, he quickly succeeded in persuading his parents to agree never to send him back to camp. That should have ended the depression, but the young man realized he was on to a good thing. By continuing to be depressed

he punished his parents for whatever displeased him and at the same time punished himself—for his mistreatment of them—by his self-destructive behavior.

COMPLETION DEPRESSIONS

The completion depressions can also be called the postpartum depressions, if the term postpartum is used not narrowly to refer to birth but broadly to refer to all creation. Here depression appears after prolonged, intense, and often, but not necessarily, successful effort. Completion depressions result from guilt over accomplishment, or in the patient in between jobs, from idleness and boredom. The id factor—sex and anger—and its derivatives—loss and bitterness—are usually minimal in the completion depressions.

Regularly occurring completion depressions are common in obsessives, because obsessives are hard workers, regular achievers, and constant completers.

One composer suffered from elation when he got a commission for a new manuscript and then again when the manuscript was finished. After the manuscript was published, he suffered from depression until he received his next commission. The recurrent nature of the depressions led his psychiatrist to diagnose a unipolar, biochemical depression, though the correct diagnosis was recurrent reactive depression, not due to any "endogenicity" such as "chemical imbalance," but due to the cyclic internal/external stress inherent in his work.

EGO DEPRESSIONS

Disorganized Ego

Ego disorganization may be manifest as an inability to forge compromises in ambivalent crises.

For one writer success and failure were equally unacceptable. He became depressed because though his works were artistically successful he was not making much money. Then he entered a profession where he could make a lot of money but became depressed because there was no artistic satisfaction. Improvement awaited his taking a part-time job for the money and writing part time for the satisfaction.

Weak Ego

Ego weakness may be manifest as an inability to distinguish misperception from perception, with depression often the result of an inability to distinguish transference from real expectations, an inability to distinguish bad luck from abandonment by fate, or in those inclined to be borderline, an inability to distinguish a professional from a personal relationship.

Traumatized Ego

Ego traumatization may appear as a compulsion to evaluate every current event in the light of a past trauma. One patient became depressed each time he heard an ambulance or a first aid siren because they reminded him of the blackout sirens that had frightened him during World War II.

Some attorneys defending the recipients of lawsuits brought by people who have been traumatized argue that the present event was traumatic because of the patient's prior experience, a nice legal point but one that in spirit unfairly blames the victim.

Ego Preference

Patients become depressed when they are forced to accept, or as many depressives put it, "swallow," something they "can't stomach."

A hospital administrator believed that "vacation reduces stress" (oversimplified theory derived from questionable hypothesis), and so "every employee has to take a two weeks' vacation a year" (simplistic solution based on oversimplified theory). The employees who preferred to do otherwise or could not take vacations because they had sick pets or lovers with different schedules became depressed, because they wasted their forced vacation sitting at home furious with the person who concocted the so-called stress-relieving scheme.

Ego Illogic

The illogical ego puts the cart before the horse and comes to the wrong, depressing conclusion, from which it derives the wrong behavior. The person who thinks, "I'm depressed because I'm not working," who is instead not working because he is depressed, should get a therapist first, a job second.

EGO-IDEAL DEPRESSIONS

Nature of and Problems with Self-Expectations

Self-expectations are an aspect of the ego-ideal. (Expectations of others are always implied.) Self-expectations may be pathological because they are too grandiose, too lowly, or flawed.

Too Grandiose

We see too-grandiose self-expectations both in those who have been spoiled early in life and in those who have been deprived early in life. The person spoiled early in life expects too much from others and as a consequence expects too much from himself.

One patient, never satisfied, responded to any achievement by setting his ideals progressively higher and higher. As soon as one goal was reached, a new, more lofty goal was established. He set his sights on writing a book, then became depressed because he did not publish it, then when it was published because it was not popular, then when it became popular because it was not made into a movie, then when it was made into a movie because it was not destined for immortality, then when it seemed destined for immortality because his other books were not equally blessed.

The person deprived early in life often undoes the lowly self-image he received from those who ignored and/or rejected him in the past by compensating with grandiose self-expectations in the present.

Too Lowly

Too-lowly self-expectations defend against the disappointment that comes from expecting too much, are learned from hate-filled others, are the result of identifying with hate-filled others, or are the product of internalized anger. Depression is the result of inevitable real-life failure and of envying others who seem to have it all.

Flawed

Flawed self-expectations are those selected for the patient by others, as they were for the patient who became a doctor because his father wanted him to be one and for another who became a doctor to avoid becoming a lawyer like his father. Or they are selected for the patient by his own neurotic conflicts, as they were for the individual who became a doctor to cure others so he could avoid killing them. Depression in later life is the inevitable result of professional dissatisfaction, resentment about being controlled by unseen forces, or self-condemnation for lack of courage, lack of self-direction, and excessive submissiveness.

Nature of and Problems with Self-Esteem

By self-esteem is meant self-approval, dependent on, but not the same thing as, self-expectations.

Developmental Origins of Low Self-Esteem

Low self-esteem, the subject of our present concern, can originate developmentally in one of two ways:

1. Parental deprivation. Deprivation can be the result of either lack of love or physical abuse. The unloved/abused child thinks he deserves what he gets because he lacks a standard for comparison and/or because he believes parents, simply by virtue of being parents, do the right thing. Later in life such children develop a consuming interest in starting and maintaining relationships with people who hate them or who are otherwise abusive (along the lines of Freud's repetition compulsion).

2. Parental overgratification. The parent who spoils his child with love can create low self-esteem later in life by setting the child up as an adult for whom nothing matches the rapture of the early years. (It is tempting in retrospect to suggest that the parents should have deprived such a child more.)

Here-and-Now Origins of Low Self-Esteem

Low self-esteem originates in low self-approval from a failure to meet self-expectations. What is being achieved is also important, for those who achieve lowly goals rarely have self-esteem as high as those who achieve lofty and sublime goals. Of course, the definition of lowly and lofty varies from person to person and culture to culture, so that one person's lowly is another person's lofty goal.

Origin of Depression in Problems with Self-Expectations/Self-Esteem

Depression is a mood appropriate to the thoughts accompanying low self-esteem, such as "I don't have what it takes" or "I am worthless."

SUPEREGO DEPRESSIONS

Excessive/Inappropriate Guilt

Excessive/inappropriate guilt can appear clinically as an attitude about oneself such as low self-esteem; as an attitude toward others, such as a Caspar Milquetoast obsequiousness or a "don't make trouble" submissiveness; as a physical symptom, such as a painful headache; as an emotional symptom, such as painful brooding or oppressive bad mood; or as a pathological behavior, such as self-destructiveness.

One self-destructive patient appeased his punitive conscience by drinking milk though he was lactose intolerant.

Another did this by nonlethal overdoses and self-mutilating wrist and arm cutting.

A third, motivated to get caught, stole a marked garment, then took it through a gate alarm.

A fourth gambled, secretly planning to lose.

A fifth was a bumbler who lost or destroyed anything that might give him pleasure—for example his airline tickets the morning of the day he planned to fly south for a well-deserved winter vacation.

Sometimes guilt is an exclusively psychic truth.

One guilty patient believed his ordinary human needs were excessive and inappropriate.

Another's guilt originated in the zero-sum hypothesis, namely that "there is a finite amount of x and anything I get is at your expense."

A third overdid retrospective recrimination for his past behavior to create a sense of guilt. Though with reason he hated his mother when she was alive and thought, "Boy, I can't wait until she dies and I inherit," after she died, he thought, "I should have known how good I had it then when she was alive. I should have accepted, overlooked, and forgiven her imperfections so that we could have enjoyed our relationship while it lasted."

This guilty psychic truth often originates in illogical conclusion. For example, guilty people typically emphasize negative aspects of their mixed motivations to make a partially negative motivation (part truth) into an entirely negative one (whole truth).

A patient whose husband-to-be was dying said, "I feel guilty for marrying this man just to be able to say I was married once in my life." She overlooked her positive reasons for marriage—the wish to have her uninsured husband included on her major medical insurance policy and the wish to care for him in his final days.

Other patients desirous of believing themselves bad people make similar things into the same thing. Assertion becomes aggression, and desirable becomes undesirable aggressiveness or even murderous intent.

Reasonable Guilt

Not all depressives are too guilty. Those who are truly terrible, cruel, and uncaring torturers are instead appropriately guilty.

One person routinely and guiltlessly put his friends on hold by making tentative plans then canceling them, however going through with them just often enough to lure his friends into making the same arrangement with him the next time.

Another, a teacher, was competitive with his students, a destructive tendency disguised as telling people what they needed to know for their own good, no matter how cruel. He told one talented musician that he could best serve music by becoming a lawyer. When this depressive said of himself that he was a bad person, he was right.

It is wrong to tell a reasonably guilty person not to be so harsh with himself and to give himself a vote of confidence. Instead such a person should be told to put an end to the evil behavior. In the long run this does more good than inappropriate reassurance perceived as insincere; inappropriate support perceived as a misunderstanding; and inappropriate forgiveness perceived as excessively permissive, a failure to set limits.

ID (APPETITIVE) DEPRESSIONS: ANGER

The characteristic depressive affect, when not organically caused, almost always originates partly in anger, for in depressives despair is the static emotion,

anger the dynamic one. The anger in depression is often part of another primary syndrome, typically a passive-aggressive personality disorder.

A passive-aggressive husband long displeased with his wife's cats left toxic plants in an accessible place and so informed his wife on the second night of a weekend trip when it was too late to do anything about it.

In both normal individuals and depressives anger is a bridge between thought (cognition) and mood (depression).

A rather paranoid patient became depressed after licking a stamp given to him by a helpful stranger. Because the man who gave the stamp to him was "apparently homosexual and very thin," he worried that the stamp was contaminated with the AIDS virus. In relating the two, the thought and the mood, he noted his anger at "careless people of his ilk who go around contaminating innocent victims."

Anger is also a parallel manifestation of depression, because things that make people angry also make them depressed.

A homeowner became angry and depressed because the bank foreclosed on his house when he could not pay his mortgage. He became angry because he felt the bank had acted prematurely and depressed because he felt it rejected, deprived, controlled, castrated, and persecuted him.

Dynamically speaking, depression is the product of internalized anger. Guilt is the usually cited *reason* for the internalization of anger, but there are other reasons. The patient may be already a bit depressed, so too anergic and demoralized to express his anger. He may feel, "Why bother, what good will it do?" He may be afraid, perhaps with reason, of the consequences of his anger. He may feel that intense anger threatens his internal stability. Or he may become convinced that intense anger threatens to interfere with his ability to function at work and in his relationships with others.

There are a number of different theories to account for the conversion of the internalized anger to depression—the mysterious leap between the internalized anger and depression itself.

1. There is the familiar explanation: the patient takes the anger out on himself; he hates himself; his self-esteem falls; and his depression is an expression of his low self-esteem, along the lines mentioned above.

2. The anger can precipitate in the psyche, as one physician patient suggested. He believed in essence that anger precipitates in the psyche much as uric acid precipitates in a joint, producing psychic pain and immobility analogous to the physical pain and immobility characteristic of arthritis.

3. Depression is an anger equivalent, a depressive exchange, with both anger and depression alternate ways of saying and feeling the same thing. Along these lines the same physician patient suggested that anger leads to depression as

anxiety leads to sweating. He saw depression as an emotional flush, equivalent to the physical flush of embarrassment due to guilt. This nonverbal aspect of depression is reflected in the difficulty many depressives have in saying why they are depressed, a verbal silence not to be confused with true absence of explanatory thoughts. (This silence is in turn often incorrectly taken to indicate a true endogenicity.)

4. The patient destroys his mental and physical health with excessive, erosive anger.

5. The internalization mechanisms are only partially effective in suppressing anger. The person is left extremely sensitive to minor irritation, easily provoked, prone to react with a composite of annoyance, alarm, fear, despondency, and temper tantrums to real external precipitants—those that would make anyone angry—and to illusory ones—those that because of patient hypersensitivity too easily arouse or rearouse his emotions.

6. There is the return of the repressed, another way of saying the internalization/suppressive mechanisms are only partially effective, and some external anger either remains and/or is rearoused, with all the familiar depressive consequences.

7. Depression may be not the direct product of anger but the result of attempts at self-treatment for excessive/inappropriate anger. For example, a patient who tries to diminish intolerable anger with drink or drugs may suffer all the depressive consequences of substance abuse.

DEPRESSION FROM SEPARATION ANXIETY

Depression and separation anxiety are somewhat indistinguishable, first because loss is the subject of separation anxiety, and second because depression is an anxiety equivalent (i.e., one way to feel panic), especially when the patient views being alone as his punishment, as an abandonment, and/or confuses temporary with permanent isolation, so that being alone now means being alone forever.

DEPRESSION AS A DEFENSE

As a defense, depression is itself a suppressive mechanism, along the lines of "I'm too ill, weak, and ineffective to think and act."

DEPRESSION AS THE PRODUCT OF OTHER DEFENSES

We are familiar from the above with the way defensive introjection of anger can be responsible for depressive self-hate and the way defensive projection of anger can be responsible for depressive feelings of being disdained/persecuted. The following is a list and discussion of the numerous defenses that result in

depression. In each case the way disadvantages outweigh advantages is either stated or implied.

Identification with the Aggressor

Here depression results when the patient does actively what he fears might happen to him passively. For example, he deflects criticism by being his own harshest critic. Possible negative outcome is exchanged for guaranteed negative outcome.

One patient welcomed getting AIDS because having it meant he would not have to worry about getting it.

Another patient retired to avoid competing with young people he feared might prove more powerful, stronger, and better than he and take his job away from him.

A third, alerted in advance that his therapist might have to stop treating him in a year, left treatment that very day, to resume with a therapist whom he liked less, but who could promise to continue to see him.

Internalization and Introjection

On the positive side, others are protected when anger with them is converted to anger with the self. On the negative side, internalized anger creates low self-esteem. Also, the protection mechanisms usually fail and the anger is still expressed, indirectly in passive-aggressive ways or directly in temper tantrums.

The way self-esteem falls because of internalized anger is illustrated by the patient who, after envying his therapist's beautiful twenty-seven-room mansion, was given a tour instead of an interpretation. That night instead of feeling, "I hate him because he has more than I," he felt, "Even though I'm not one of them, it's nice to be in a world where such wonderful rich people exist."

Another patient expressed his disdain for his therapist by reversing it to "I feel sorry for you having to see me," a depressive altruism that followed Fenichel's formulation that pity of others is sublimated sadism.[1]

An example of passive-aggressive expression of anger is illustrated by the patient who expressed disagreement with each and every one of his therapist's points by countering with a viable alternative just to be contrary, turning therapy into a nontherapeutic debate. For example, if the therapist suggested that he go to meet someone at a singles resort in the country, he responded that he could meet people just as well in the city—true, but not the point. The therapist rose to the provocation by feeling, "I can't stand seeing this patient one more time, he is so contentious."

As an example of sudden, unexpected flashes of temper, one patient, depressed because of her chemotherapy for breast cancer, responded to her therapist's expression of sympathy, "I am sorry you had to go through something as terrible as this," by saying, "You just made me more depressed. I didn't know it was so terrible until you pointed it out."

Identification

In identification the patient can adopt a more desirable identity or, as in identification with a lost object, retain a relationship in fantasy by acting like the loved one who is lost. But the patient can also mimic others who are ill or who have died and can develop their emotional or physical illnesses. In a typical consequence of identification following a death, we see somatic complaints/symptoms that mimic similar complaints/symptoms in the deceased's final illness. A son became hypochondriacal and developed chest pains after his hypochondriacal father died of a coronary thrombosis.

Projection

On the positive side, projection is cleansing. On the negative side, projected forbidden anger often reappears as a feeling of being persecuted, and projected forbidden sex can reappear as a compulsive condemnation of moral laxity/rampant permissiveness in the world or as delusions of being seduced or raped. Projection is often responsible for what may be called the "illusion of stress"—an illusion of nonparticipation wherein self-created problems are attributed entirely to others or to circumstances beyond one's control. An amnesia of convenience is often required.

Shortly after marriage a patient looked for reasons to divorce her husband. She fixed on his critical attitude toward her, overlooking the provocation, which was her refusal to have sexual relations with him on their wedding night.

Avoidance

The depressed person may avoid contact with people he finds provocative or arousing. The benefits of relief from anxiety are outweighed by the negative consequences of isolation.

Doing and Undoing

Sexual thoughts may be replaced by asexual, angry by kind, or there may be a cross-replacement, as when sexual thoughts are replaced by angry ones. On the positive side replacement gives relief of guilt due to either hate or love in a love-hate relationship. Also, the lack of commitment either way can relieve anxiety.

A negative consequence is the effect on character, because the constant shifting makes for unpredictability or untrustworthiness.

One patient did and undid to relieve his depression by maintaining just enough distance to avoid getting too close or being rejected. First he begged his psychiatrist to continue

to see him twice a week; then, when the psychiatrist agreed, he responded, "But suppose I don't want to spend the money."

A male homosexual undid his hatred for his father with a new relationship with a lover, only to break off the relationship because the hatred reappeared in the transference to the lover.

Mood swings can be the product of undoing one mood with another, invoking depression to relieve a forbidden euphoria or invoking euphoria to relieve intolerable depression. In such cases the mood swings can look chemical, though they are in fact defensive. Still another negative consequence is the poor judgment that is the product of the conscious or unconscious need to manipulate external events to create reverses or successes to the extent necessary to justify the defensive mood swings.

Reaction Formation

Reaction formation is a semipermanent settling in favor of doing or undoing. On the positive side it avoids the ambivalence doldrums, while on the negative it limits function by suppressing an entire facet of the personality.

Neutralization

Neutralization is a *simultaneous* expression of equal but opposite feelings, so that the feelings cancel each other. In a typical scenario an individual is unable to cry at a funeral. Old anger surfaces now that it is safe to feel angry, and joins new anger from feeling abandoned. Both angers are then neutralized by pity and sorrow for the deceased. The result is that the mourner feels blank and empty during the funeral. Afterwards he may experience continuing loss of interest, withdrawal, inactivity, or in unfavorable cases, paralytic stupor.

Intellectualization

In intellectualization, an emotion is removed from a thought and made unconscious while the thought itself is retained in consciousness. The depressive complains, "I think everything, but I feel nothing." Global loss of interest can result.

Denial

A depressive may deny a death to maintain the illusion that a loved one continues to exist. For one nonreligious patient the wish-fulfilling "he walks with God" maintained a sense of well-being while he slowly integrated his loss.

On the negative side, denial purchases present at the expense of future comfort by interfering with final burial, especially when the patient goes to near-psychotic

extremes. A patient believed his deceased father inhabited his grandfather clock, and another believed he lived with his mother's ghost.

Depressives often deny the negative aspects of a lost relationship retrospectively, just so they may grieve in delicious despair.

Regression

Dependent regressive clinging results from a primary passivity or is a secondary and defensive behavior meant to avoid competition and/or sex.

A mother, dependent on her daughter, discouraged the daughter from marrying so that the daughter would stay at home to take care of her. The daughter complied not only because she was passive but also because the mother's needs resonated with the daughter's fears.

A patient avoided sexual relationships by having a close relationship with his mother, predicated on receiving an allowance from her. He rationalized his behavior as normal, saying, "I do this temporarily, taking the allowance to make me rich enough so that I can find a woman of my own." But he maintained the relationship with the mother indefinitely, using as an excuse, "I can never get rich enough because of inflation."

Somatization

In oversimplified terms, in somatization the patient uses body expression to simultaneously convey and suppress thoughts and feelings.

A patient whose therapy was decreased to once a week reacted by feeling he had a fish bone caught in his throat, by developing chest pains that he believed were from a coronary but in fact were from gas, and by feeling that his arm was numb from neck to hand due to a stroke—all to both say and leave unsaid, "I feel bad now because you are leaving me."

Another patient both expressed and disguised her disgust with her new husband in the physical mode. She did so by developing a "sciatica of the neck" on her wedding night "so that we can't do it because I can't get in those positions."

Somatization is a negative accomplishment, if only because it has a not-me quality reminiscent of paranoia.

SECONDARY DEPRESSION

Secondary depressions complicate internal physical events, like occult carcinoma of the pancreas, or internal psychological events, like schizophrenia, post-traumatic stress disorder, or personality disorder. The following is a discussion of depression secondary to attitudinal sets of specific personality disorders.

Paranoid Personality Disorder

Paranoiac hypersensitivity and illusions/delusions of criticism and attack contribute to depressive low self-esteem.

Schizoid Personality Disorder

Schizoids become depressed because they avoid anyone who tries to get close.

Hypomanic Personality Disorder

Hypomanics become depressed because, believing themselves invulnerable, they make no effort to avoid real danger.

Passive-Dependent Personality Disorder

Passive patients become depressed because they minimize real problems, allowing them to build. Also, passive-dependents fear rejection from those whom they would be dependent upon. Even a modicum of rejection is perceived as traumatic, and the trauma has a tendency to persist long after the event, to reappear in avoidant behavior during the day, associated with recurrent dreams at night.

A patient broke off a relationship with an aunt because she criticized him for being late to her grandson's Bar Mitzvah. Three years later he began to have recurrent dreams that he was allowed to attend the Bar Mitzvah but only served dry, low-calorie, tasteless food such as carrot sticks and cucumbers.

For many dependents enough is never enough and nothing is ever as good as it should be. They swallow supply after supply into their bottomless pit and constantly feel unfilled.

One patient, though actively sought by a number of friends and with a full social calendar, felt alone because she felt each person was "not a close enough friend," usually on the basis of an impersonal refusal perceived as a personal rejection. For example, a couple canceled their dinner appointment because the husband developed a detached retina. She complained, "If they were really good friends, at least the wife, knowing how I counted on their presence, would have found a way to make it to my party."

Depression often results when dependent strategies and miniretaliations misfire, creating the very losses they were intended to avoid. A patient made a suicidal threat as an appeal to his psychiatrist not to terminate treatment. The psychiatrist instead terminated him as a punishment for the threat.

While many dependent people are trapped between being dependent and being disappointed and depressed, in some cases even excessive dependency does not

lead to depression. Depression is avoided when dependency is gratified, either because the patient is very desirable or very lucky, or when it is not gratified, either because there are substitutes or because the patient converts the deprivation into an opportunity for growth.

Masochistic Personality Disorder

Masochists become depressed because they create real problems, though they only intend to make themselves suffer emotionally. Also, the masochist creates his own deprivations and losses, blames them on fate, then gets depressed because of imputed bad luck. Finally, considering that most nonmasochists try to fight depression, depression itself can be a masochistic act of self-punishment.

Narcissistic Personality Disorder

Narcissists, ruthless in their lack of concern for others, get depressed because sooner or later the others retaliate in kind.

This happened to a critic turned playwright, who was long remembered by his victims both for his pitiless criticism and for his tendency to respond to his victims' complaints by saying he honored them by calling attention to their work. His favorite conclusion: "They are lucky to have me."

Some narcissists are less ruthless than smug. Smug narcissists get depressed when, as one patient put it, "someone punctures their balloon," and when the narcissism becomes unsustainable, as due to the physical deterioration of aging.

One narcissist became seriously depressed when he developed a mild glaucoma of one eye. He called glaucoma "the old man's disease." Another, an aging man, fought desperately to retain the semblance of youth through diet, exercise, the use of wigs and makeup, and plastic surgery, finally becoming depressed when he could no longer satisfy himself that he did not appear decrepit.

Selfishness

Selfishness is one aspect of narcissism. Selfishness is a one-sided view, a view from one's own perspective only, an overlooking of other people's feelings and needs, especially when in conflict with the narcissist's own.

A patient who moved into the same neighborhood as his psychiatrist suggested he would stay north so as to avoid invading his psychiatrist's turf, while overlooking the fact that his psychiatrist had not agreed to stay south. This same patient, when asked to take off his shoes to show his doctor a sore foot, asked for a piece of towel paper to put under his feet. The doctor assumed, "This delightful obsessional is afraid of contaminating my carpet." In fact, however, the patient, an unpleasant selfish narcissist, thought, "I don't give a darn about your carpet; I don't want your filthy carpet to contaminate my feet."

Developmentally speaking, selfish behaviors may be the result of overgratification early in life that leads to an expectation later in life of more of the same (the Pollyanna paranoids). They may also be the result of deprivation early in life that leads to an expectation of reparation later in life. When early in life gratification and deprivation were whimsical, selfish overgratification and self-deprivation alternate later in life.

A wealthy patient when young was given material things but deprived of love. As an adult he alternately gratified and deprived himself: eating out every evening in the most expensive restaurants in the city, then walking home several miles even in bad weather to save an easily afforded cab fare.

Patients overgratified early in life become depressed later in life when, expecting from a cloudless past a cloudless future in which needs will be gratified completely, instantaneously, and effortlessly, they predictably find that expectations are not met and become disappointed, especially by sudden, surprising turns of events for the worse. Patients deprived early in life get depressed later in life because they expect more deprivation. In both cases the depression can take a paranoid form, when the cry that "the world is against me" is invoked to explain why things have turned out so badly.

One patient who always had everything money could buy became depressed, thinking, "They have it in for me," whenever his favorite restaurant failed to adjust the air-conditioning to a level he alone considered desirable. He concluded from this that there was a general lack of services in New York and that "New York would never be the same again," by which he really meant, "The time of my childhood when I was so well cared-for can never be recaptured." Like many such patients he assessed disappointment in terms of "what I have now compared to what I had then." Not unexpectedly, criteria that were themselves meaningful became an early casualty of living in the past.

Pseudoselfishness

Pseudoselfish depressives believe themselves selfish but in fact have modest needs that they believe are immodest, for the usual reasons of guilt and fear of punishment. They typically identify their healthy dependence as unhealthy/excessive, saying to themselves, depending on their level of sophistication, "You are a big baby," "Most people are more mature," or "You are too oral." Some so fear being selfish, needy, and voracious when they gratify any of their needs that they become the compulsive altruists discussed throughout.

Pseudoselfish patients must be distinguished from altruists, who are self-sacrificial by preference and needy by choice. These people are not basically depressed. They are content to ask for little for themselves, not for any of the compulsive reasons and not because of guilt or because they feel undeserving, but because they derive happiness through the happiness of others. There is no chronic disappointment and no dissatisfaction, nor are there other depressive

dynamics, and the capacity to be pleased with little is not delusional. Their altruism is instead an unwavering, clear blue light of self-direction and love.

Obsessive-Compulsive Personality Disorder

One obsessive-compulsive became depressed because he worried needlessly about such matters as matching the right stamp to the right letter.

An existential depression appeared in a ritualistic patient, who became depressed when he recognized how much time and effort he invested in meaningless activities. He had a faucet compulsion characterized by the need to count to a hundred each time he turned off the faucet. If there was no drip he could leave the sink, but if there was even one drip he had to retighten the faucet and count again, repeating the procedure until there was no drip during a 100 count. On a superficial level he was a good, conscientious person who cleaned up after himself and avoided doing damage. But on a deeper level he was hostile, tying up the bathroom and overtightening the faucet until the washer broke and the faucet leaked all the time. Successful completion of a ritual gave him no pleasure and left him depressed, first because of his fear of success; second because by tying up the bathroom he annoyed others, provoking them to counterattack; and third because there was no real satisfaction (one reason why the rituals had to be repeated).

Hysterical (Histrionic) Personality Disorder

Hysterics get depressed because they overreact to symbols. For example, one became depressed when he misperceived a haircut as a castration.

Other Characterological Traits

Gloominess

A characterological gloominess contributes to the depressive sense of finality and world decay.

A teenager became depressed because he broke up with a paramour. Because he hardly knew her the loss was insignificant, and because he was very young the loss was reparable. But his gloomy thoughts were, "She is the only one for me," "All is lost," and though his life was just beginning, "It's all over for me."

Pessimism

A pessimistic person fears the worst, confuses fear with fact, a threatened loss with an actual one, a partial loss with a total one, a minor loss with a major one, and a single loss with the loss of everything.

A lonely homosexual, who at holiday season envied those who were not alone and felt jealous of the attention others were getting, panicked when he did not have a date for New Year's Eve. Though his datelessness was clearly the result of a temporary aberration,

he thought it meant he was defective and foretold the future. To ease his suffering he went drinking, took drugs, and was promiscuous. When he contracted a venereal disease as a result, he actually welcomed it as his punishment. In a climactic positive sublimation and conversion that illustrates the growth possibilities inherent in depressive reactions, he recognized how self-destructive he had become, took a lifetime companion, and transformed his depressive acting out into still-pathological, but socially useful, workaholism.

Though the pessimistic view can be blamed for depressive emotion, like so much that is depressive it also works in reverse, with pessimism originating as much in preexisting depressed mood as the other way around.

The pessimistic depressions perversely appear when everything is going smoothly. They are marked by a characteristic hyperawareness of the somber side of life, an overdeveloped tragic sense, and a loss of hope for the future. There is a tendency to take on others' problems, in part as a way to see only the baneful side of life. They complain that they go from one problem to another and overlook the fact that many of the problems are not theirs.

Anticipatory sadness-grief-depression is different from pessimistic depression. While in both there is an expectation of trouble, in anticipatory sadness-grief-depression the patient expects trouble that is likely to occur, correctly recognizing the inevitability of a loss to prepare for it in advance. In pessimism, which is an illusionary form of anticipatory sadness-grief-depression, the patient anticipates a loss that is unlikely to occur, yet prepares for it as if it were likely.

Laziness

Some depressives are oral characters who are lazy by inclination/preference. They enjoy not working and become depressed when they are forced to work. Laziness as a cause of depression must be distinguished from laziness as a symptom of depression: from a chemical slowing, from depressive guilt that leads the patient to punish himself with failure, or as a depressive equivalent along the lines of a depressive headache. Laziness as symptom of depression must in turn be distinguished from schizophrenic anhedonia, obsessive successophobia, dependent overreliance on others, a narcissistic feeling of entitlement, and psychopathic refusal/inability to make the connection between effort and accomplishment.

Envy and Jealousy

Envy is a self-indulgent, compulsive, invidious comparison between oneself and others, with self-directed accomplishment an early casualty.

The compulsive nature of envy is illustrated by the single nurse who envied a colleague who was able to marry at a late age and simultaneously envied another who was a successful "single," able to adjust and enjoy herself even though unmarried, with neither desire nor prospects. The patient's depression was not, as her therapist assumed, the result of being unable to get married, but the result of not knowing what she wanted.

In contrast with envy, which is usually pathological, jealousy is not always pathological. Jealousy can be healthy when it is a protective mechanism to assess the progress of an ongoing relationship and the attendant risk of being abandoned. Here if there is pathology, it is not the jealousy itself that is pathological but the pathological reactions that the jealousy arouses, reactions like excessive altruism, self-destructive if only because it is too easily misunderstood as a lack of caring.

One guilty man was so laissez-faire about threats to his exclusive relationship that his partner, told once too often to "do what you think best," felt that the patient did not care about him and cheated on him just to get his attention.

Of course, jealousy is pathological, and depressive, when it expresses a wish in the form of a fear. In one patient pathologically enamored of triangular situations, a fear that his wife was cheating on him was in fact a secret hope.

Jealousy is also pathological when it is delusional, as it often is when it originates in projected homosexual wish. One man's belief that his wife was cheating expressed his own desire to have her partner for himself.

Finally, jealousy is abnormal when it is applied inappropriately/excessively to innately sharable relationships, as when sibling rivalry for a parent's exclusive love persists well into adulthood.

COGNITIVE/BEHAVIORAL DEPRESSION

Mood Induces Thought

Cognitive theory emphasizes the role of faulty thinking in mood disorder. It assigns seminal importance to the "egg" of thought over the "chicken" of mood. It emphasizes the way polar, or dichotomous, thinking, such as the tendency to see everything in a positive or negative light with no shades of gray in between, readily crystallizes into polar moods. However, at the same time cognitive theory deemphasizes the way polar moods readily crystallize into polar or dichotomous thinking. In other words, in emphasizing the way well defined attitude becomes mood, it deemphasizes the way moods become well defined attitudes: positive and optimistic in the elated, negative and pessimistic in the depressed.

A patient declared during her depression, "I hate computers; I'm so depressed that I have to use one," and later, when hypomanic, reversed herself completely and emphatically, calling them "miraculous."

One way mood induces thought is via faulty attentiveness. To illustrate, the self-concern and worry of the depressive on the one hand, and the impatience of the hypomanic on the other, alter registration so that the perception of events

is in essence regulated entirely by the prevailing mood. These perceptions, overoptimistic and overpessimistic, respectively, in turn intensify the mood itself, euphoria and depression, respectively. Another way is via acceleration or deceleration of thought. Optimism appears when the patient slides by depressing thoughts, while pessimism appears when the patient becomes stuck or mired in them.

Thought Induces Mood

More in line with classic cognitive thinking is the way primary cognitive distortions create depressed mood.

Symbolization

People tend to become depressed when they attach symbolic importance to events or circumstances that others view as merely a part of life's give and take. Thus a damaged possession may symbolize mortality (e.g., the transience of all things) or human perfidy (e.g., the carelessness of whoever did the damage). This attitude has affinities both with obsessional disorder and paranoia: the obsessional person treating a dent in a chair as if it constituted a catastrophe and the paranoid person seeing a threat of assault in an innocent gesture or intonation.

A patient drilled a hole in his kitchen wall so that his stereo wires could go from the living room, through the kitchen, and into the bedroom. Then he became depressed because he convinced himself that gas from the kitchen would get into the bedroom, a conviction associated with the admittedly unreasonable fear that the wall could never be made whole again. He called in an engineer, who assured him that his fears were groundless. Nevertheless the patient went ahead and repaired the hole at some trouble and expense, because, he claimed, the small hole "devalued" (figuratively) his dwelling. The mortality symbolism is apparent here, not only in the patient's concern over the integrity of his property, but also more directly, in his concern for his safety.

When it is applied with no logical consistency, symbolization leads to depressogenic distortion in comparative values.

One obsessional depressive missed a crucial appointment because he attached greater significance to finding a lost household article than to making the appointment, although the hunt for the article could have been postponed.

Defective Inference

There are different types of defective inference, each depressogenic for (hopefully) obvious reasons:

1. In arbitrary inference there is a process of drawing excessive or unwarranted negative and pessimistic conclusions from specific facts or events.
2. In personalization there is a taking of negative things personally, as with

someone who always assumes that overdue bills, churned out by computers, reflect the exasperation and ill will toward him of particular persons within the billing companies. Personalization depends on a suspension of intellectual discrimination, so that what one feels and what one knows become two different things.

One patient knew his job application was rejected because he did not graduate from technical school, yet saw the rejection as a demonstration of lack of love.

An author's fiction was rejected by a nonfiction publisher; still, the rejection was misinterpreted as an aspersion on his ability to write.

A man whose mother with Alzheimer's disease accused him of stealing thought, "She really hates me, doesn't she?" and became depressed even though he knew that, because she no longer recognized him and believed that it was a stranger stealing her things, no rejection was consciously intended.

3. In selective abstraction there is a part-to-whole syllogism in which the depressive justifies his critical view of himself by generalizing from the aspects of himself he does not admire and suppressing the significance of the more favorable aspects. The depressive follows the same illogic in consciously formulating his view of the world: the partial picture becomes the whole picture when the baneful side of life becomes its essence.

4. In overgeneralization, as defined by Aaron T. Beck, there is a drawing of a general conclusion across all situations on the basis of a single incident. One result is a depressive catastrophic reaction to what are merely the annoyances or reverses of everyday life.[2]

A patient met a man for the first time. He made a date with her, but subsequently summarily canceled, saying, "I will call you in a few days." The patient became depressed because her immediate reaction was to assume either that the man would not call or that he would make a date, then call to cancel again, and that she could expect this treatment from all men.

NOTES

1. Otto Fenichel. *The Psychoanalytic Theory of Neurosis*. New York: W. W. Norton, 1945.

2. Aaron T. Beck. *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press, 1976.

CHAPTER 10
Primarily External Depressogenesis: Depressogenic Situations

GENERAL CONSIDERATIONS

There are at least two important lessons in this chapter. The first is that the failure to identify and understand depressogenic external precipitants and the reasons for their depressing impact is behind much simplistic theory, incorrect self-view, and bad treatment. The second is that the more one studies stress, loss, trauma, and other so-called external depressogenic situations, the more one realizes that with only a few exceptions it is the depressed patient who is his own worst enemy, that for depressives many external events are merely internal events in disguise, and that blaming one's fate on one's stars, not oneself, is too often allowed to become a socially and/or therapeutically sanctioned "politically correct" form of paranoia.

Difficulty in Separating External from Internal

The task of understanding external depressogenesis is complicated by the interrelationship between external and internal events, a relationship that makes it difficult to distinguish an external from an internal event and to describe one without the other. The following case illustrates the need to understand how a patient's personal history, past problems, and here-and-now existential plight color the impact of even so "external" an event as a husband's terminal cancer.

A patient came to treatment because she was unable to get married. The therapist attributed this to her aloofness, narcissism, feeling of superiority to anyone available, failure-assuring successophobia, and borderline cyclical overvaluing and devaluing of others, manifest as a falling in love at first sight (overvaluing) followed by a falling out of love at second sight (devaluing)—typically devaluing the formerly loved person for some

trivial, even imagined, flaw and breaking off the relationship suddenly and unexpectedly, on a flimsy pretext.

With therapy this patient was able to meet an eligible man, fall in love, and marry. Admittedly the marriage was less than perfect, because it was marred by numerous arguments, usually ones that she provoked by humiliating her husband about his presumed imperfections. For example, she refused to change her maiden name to her married name because she believed her husband had too many debts on his credit cards.

Two years prior to the marriage the husband had had a malignant bladder tumor removed, and one year prior to the marriage had had a carcinomatous kidney removed. After each procedure he had been pronounced entirely well. However, a few months after marriage his renal tumor recurred and he was given only a few months to live.

Her reaction to her husband's fatal illness illustrated the personal impact of external events. Though she became depressed when she thought of twenty-five years of building toward the relationship only to lose it so soon, she seemed simultaneously nonchalant, even happy, because she secretly felt that his death would provide her desirable relief from an imperfect marriage. Her subsequent depression resulted at least as much from her guilt about longing for his death as from her despair about his imminent loss.

Reasons for Overlooking External Precipitants

The following case is an illustration of easily dismissed reasons for a depression:

An individual who had moved from one state to another sat at the next table from a man whose overweight and crude eating habits revolted him. He thought first, "In my old state such people don't exist," then, "Why did I move here?" then, "I am defective because I share the same restaurant and state with this man," then, "I am depressed because I have come to this." The importance of the incident was exaggerated because of the patient's history of disgust with his father's obesity and general sloppiness.

The following case illustrates some of the consequences of overlooking the external precipitants of depression:

An analyst was treating a patient who was depressed because he was being forced out of his house by an upstairs neighbor who paced at night, in effect keeping him awake by banging on his ceiling. The analyst proclaimed that the patient was depressed not because of the noise, not because he might have to move, but because the neighbor's behavior reminded him of his intrusive father's similar behavior when he, the patient, was a child. Long-term analysis of the patient's relationship with his father had no effect; it was an attorney who quieted the neighbor and cured the patient's depression.

The reasons why external precipitants are overlooked may be catalogued as follows (admittedly there is overlap):

Attributes of the Depressive Illness Itself

Sometimes a reactive depression is so intense that it creates an amnesia for its external precipitant, or obscures its origin in external event by demeaning

the significance of its precipitant. In a common scenario, depressive guilt prescribes the belief that "it wasn't the event; it was me. I should have been stronger, more tolerant, less sensitive."

When there is a combination of reactive and endogenous elements, the endogenous (internal) can get the upper hand and obscure the exogenous (external), should an external event relight endogenous potential or inflame a chronic mild endogenous depression already in progress.

Attributes of the Precipitant

A precipitant may be overlooked because it occurs over time. An example is the contradictory edicts of a double-bind issued not simultaneously but sequentially, or a double-bind precipitant that is part of official policy, presumably created by sensible people who know what they are doing.

One commuter arrived home depressed every night because the conductor first told the passengers to move to the front car to detrain, then when they did, not only asked them for tickets already taken in the rear cars, but criticized them for walking between cars while the train was moving.

Attributes of the Responder

Most precipitants are only precipitants because they are highly personal. It is the personal significance that gives realistically trivial precipitants importance. This factor alone acccunts for the difference between provocation and stress (i.e., why there can be great provocation with little stress, or great stress with little provocation, so that a depression provoked differs from a depression elaborated).

1. The cognitive attribute. Depressives overemphasize the importance of symbols, in effect equating the symbol with that which it symbolizes.

One patient felt, "I am depressed unless I have a bottle of vinegar that has less sediment than the others," then checked all the bottles in the supermarket for the bottle with the least sediment. He disliked a bottle with sediment because it symbolized his being "dirty and defective." Developmentally the behavior was a latter-day manifestation of his fiercely competitive relationship with his younger brother. Having the best bottle meant, "I have better taste than he has."

2. The revival of earlier experiences.

In one patient, affective cycling as an adult originated in an early cycling revived by a seemingly neutral latter-day event, one that referred to or represented a part of the early cycling. His early cycling was largely concerned with physical oral needs, which were alternately filled (creating euphoria) and unfilled (creating depression) in a cycle of deprivation (hunger), satiation, and deprivation of supplies both real (food) and symbolic (undivided parental love). Anything now that reminded him of past struggles to get his fill of undivided parental love and attention began an attack of mood swinging or simply of a depression standing as a representative of the complete cycle.

Another factor was his initiation of a shifting of mood now in an attempt to recreate the moods associated with the earlier pathognomonic traumatic experiences and, by implication, the earlier traumatic experiences themselves. He created them periodically and intermittently in a continuing attempt at resolution, along the lines of Freud's repetition compulsion.

In another patient, blue moods now were precipitated by the most minor of partings, because parting now conjured up and stood for the blue moods of yesteryear that appeared when, after experiencing the pleasures of being sick in bed and cared for by his mother, he became depressed when the mother left to go shopping, or when the father came home and took the mother away.

In a third patient, depressive episodes now originated with current precipitants that re-created the terror, suppressed anger, and despair felt earlier in life, when the patient was 5 years old and his mother, discovering that the patient had been playing doctor with the girl next door, cornered him behind a sofa and beat him for fully ten minutes with a riding crop. Furthermore, hypomanic episodes now originated in precipitants that reminded him of the "bookends" of that episode: first the elation of the game, playing doctor, and second the feeling of relief that followed the cessation of the beating.

3. Narcissism. Spoiled narcissistic depressives who believe they should be immune to setbacks overreact to even minor setbacks with bitter despair. When a check is late or a new piece of clothing is stained, there is a catastrophic "all or none" response and a severe depression.

4. Excessive fear of punishment out of a sense of guilt.

One patient became depressed when he was given a ticket on Fire Island for eating in public. He said that in essence he viewed his crime "as different in magnitude but not in spirit from overthrow of the government of the United States."

5. Skewed priorities. These cause the patient to forget what is really important in life.

6. Ambivalence. For the ambivalent patient, equally dissatisfied by a thing and its opposite, everything becomes an irritant.

A man disliked surprises and liked routine because it relieved his anxiety. He was irritated by having to deviate from his fixed, rigid schedule. Yet he also disliked rigid schedules, finding them straitjacketing. This patient was depressed all day long, both over his freedom and over his bondage.

Attributes of the Evaluator-Clinician

Therapists' insensitivity to their patients' troubles may be due to one or more of the following factors:

1. Having led a charmed life. Some therapists are insensitive because they have never suffered themselves. These therapists don't recognize suffering when they see it, or if they do, they feel it is excessive given the circumstances. They blame not the stress but the intolerance of stress, not the strength of the catastrophe but the weakness of the victim.

2. Not having the same problem as the patient. Other therapists are insensitive because they themselves do not have the specific problem in question. For example, nonmasochistic therapists find it difficult to see how "good for me" can become "bad for me." If they understand it at all they consider it appalling, criticize their patients instead of sympathizing with and understanding them, then proceed with therapy as if the patient's masochistic streak has been dismantled: applying inspirational techniques meant to encourage the patient upwards and onwards to patients whose intentions are in the opposite direction, and using total-push for patients who are afraid of any movement at all.

3. Scientific orientation. Still other therapists are insensitive because of a lack of interest in the human dimension of depression. Some gifted scientist/researchers are biochemically oriented or otherwise have talents and capacities that lie in a nonphilosophical and nonhumanitarian direction—because variety is healthy, properly and fortunately so.

4. Competition with the patient. Some competitive therapists deliberately misunderstand their patients because they do not want them to get better. They like them sick because they like them weak and passive. One therapist revealed this motivation by lamenting that "all my patients are doing better than I am."

5. Narcissism. Some narcissistic therapists can only judge another's plight by the "myself dimension," by projective identification. Such therapists compare others' reactions to their own, using the criterion of what their reactions would be under similar circumstances—narcissistic empathy, not an accurate measuring yardstick.

One therapist said, "I understand your loss" but really meant, "I would feel the same way under the same circumstances." Though he congratulated himself for "sensing, empathizing, caring, feeling, and suffering along," his diagnosis was a self-diagnosis and his therapy was directed to what he might like to have if he were in his patient's position.

6. Simplistic thinking. Some therapists who think concretely oversimplify on that account. They may appreciate only one level of an event, though the event is meaningful on many levels. For any one incident, they do not determine what level gives the difficulty. An automobile accident is assumed to be purely a physical trauma, when it in fact stands for helplessness, for the fragility of the human condition, for the perversity of fate, or for the malignancy of the person who caused the crash.

Often their attention is drawn to insignificant matters. Many therapists focus on issues of quantity, such as how big a stressful mortgage, but overlook issues of quality, such as the difference between an expected or unexpected disaster. (Many depressives find a small, unexpected disaster harder to adjust to than a large, expected one.)

7. Limitations of time. An overconcern with patient suffering and how to relieve it may cause a therapist to take on too many patients. Eager to cure, he

now has neither the time nor the interest to explain things psychoanalytically, cognitively, or behaviorally. For such a therapist, theory is in the way of treatment.

8. Need for money. For a therapist in need of money, simplistic theories of depression are particularly seductive because they uphold reputations and fill practices. Patients like to be cured by simple, effortless means, and tell others how easily and quickly it was done.

SPECIFIC EXTERNAL FACTORS

Stress

Stress is included here with the external factors by convention, even though it is better conceptualized along the lines of a feedback loop, like the one heard when a microphone is placed near a loudspeaker. In this (admittedly imperfect) analogy, the microphone represents external provocation and the loudspeaker the individual personality/pathology. As with the microphone and the loudspeaker, little happens until a patient meets his stress. Then when he does there is a reaction that continues and crescendos, unless and until the two are separated. Continuing with this analogy, depression is the squeal of the feedback loop, the cry of pain that persists and grows until the stress is removed from the patient, or the other way around.

Stress therapists and stress management programs should study the "depressive squeal." They should be careful not to emphasize the contribution of the microphone over that of the loudspeaker, the provocation over the person provoked, downplaying both the idiosyncratic response to provocation and the feedback loop itself—the vicious cycling between external and internal events. In allowing external provocation to become everything, personal readiness and contribution nothing, therapists/programs join the depressive to become part of the problem instead of part of the solution.

One truculent, demanding passive-aggressive patient assaulted his family in subtle ways, cleverly hiding his interpersonal attacks in the guise of Freudian slips. For example, he "meant" to ask his wife about her biopsy report, but instead asked her about the results of her postmortem. His family hated him; he became withdrawn; this further antagonized and angered them; and so on. His therapist pronounced him an innocent victim under stress, allowed him to overlook his role as a guilty provocateur, and reduced to one the multiple interacting vectors in the depressogenic vicious cycle: to an arrow directed from out to in, as the patient himself was so fond of saying, "piercing my heart."

A researcher studying the effects of stress on the immune system observed the results of a parent's Alzheimer's disease on her daughter's immune system. But he overlooked the daughter's self-awarded masochistic martyrdom and its equally important effect on her immune system. Just as valid as the stressologist's formulation, "Taking care of your mother is compromising your immune system," was the formulation, "Both your com-

promised immune system and your self-destructive overcaring for your mother express your masochistic need to eat yourself up alive."

One errant stress manager grouped all workers together, even though some suffered from compensated psychoses, some from borderline conditions, and some from neuroses; that is, they had different levels of anxiety, defensive capacity, and capacity to test reality. When he formed an employee group to treat those stressed by not being promoted, he treated all the group members alike, oblivious to the fact that the realists were reacting appropriately, the masochists as if they deserved it, and the paranoids as if they were singled out and persecuted.

A pet-bereavement counselor assumed that all children reacted to the stress of the death of a pet with guilt over having been its cause. But only some of the children reacted this way, at least consciously. Others blamed bad luck, a malignant world, or the pet's misbehavior. As an example of the latter, one blamed "that stupid dog for not knowing better than to run out on thin ice after a duck." Others showed little interest in assigning blame, while an unfortunate few were happy or actually jubilant about the death.

The same event has different effects when it happens to different people. Therapists who overlook this may do so because they intend to be reassuring. They recognize correctly that equating people is comforting, because it gives the message that shared responses are on that account alone not neurotic responses. But this easy reassurance is false and dangerous, because it glosses over the plight at hand, risking complications later.

A patient was reassured that his reluctance to purchase property was normal because "taking out a mortgage is worth thus and so many stress points to everybody." But for him the mortgage made sense. Since he could afford it there should not have been any fear, and no stress. For him stress was not normal but inappropriate, based on an idiosyncratic and irrational concern about becoming depleted. Untreated, his fears continued to plague him in new and different ways. For example, after he bought the house he worried constantly that it would be repossessed, a feeling fed daily by newspaper articles at that time about the worsening real estate climate. And in an example of the consequences of letting problems go unsolved, his fear spread, so that he experienced feelings of jealousy when his wife so much as looked at another man. This was also because he felt depleted, as he said, "because I don't have her exclusive affection."

Another example of how easy reassurance and support, along the lines of "everyone feels this way," divert from timely remedial action is the interpretation proudly given to support the man with the faucet compulsion described in Chapter 9. (He watched the drops as he counted to a hundred and if there were even a single drop had to repeat the hundred count until there were none.) He was reassured that he could safely keep his faucet compulsion, because though it was time consuming it hardly mattered, since his work did not require him to maintain a fixed schedule. But the compulsion he was "allowed" to keep spread and took a new form: agoraphobic-like symptoms due to a fear of getting head lice from body contact in the subway. Now this mattered, because he was trapped at home and could not work at all. And it happened for three reasons: radical intervention was deemed unnecessary, so definitive help was withheld; he was given permission to do something of which he was ashamed (the original compulsion

had a sexual meaning), so he developed more guilt, more obsessionalism, and more depression; and he became more depressed because he felt, "My therapist doesn't think I'm important enough to try to cure me."

Stress therapists in the public eye should be particularly careful to avoid patronizing people with one-size-fits-all approaches that deliberately overlook the role of normal idiosyncrasy-individual pathology, sacrificing depth for a wide applicability suitable for mass consumption. The audience will respond to being patronized either with embarrassment or, if they are sensitive, intelligent cynics, by damning the therapist as a fool.

A psychiatrist told his audience to treat their Christmas loneliness and depression by busying themselves doing something they were good at doing. He said whittling or making tollhouse cookies was ideal because it would undo helplessness with feelings of being in control, undo feelings of being useless with feelings of mastery, and for good measure, counteract low self-esteem when they received admiration for their good work. Not only did this not have the desired effect, but his audience, perceiving the psychiatrist as patronizing, wrote in to say that they were even angrier and more depressed than before.

Transference creates much of what is called external stress by manufacturing a real and present danger from a past anxiety. External stress is part of the problem, not its cause. When stress is transferential, environmental manipulation and crisis intervention will have little effect, since the environment is an internal one and the crisis merely the result of viewing what is in fact a safe, accepting world as a dangerous, rejecting place. The following case illustrates how transference actively creates stress that the patient believes is experienced passively:

A patient provoked her husband the same way she had provoked her sister when they were both children—and for the same reasons. For one thing, she saw legitimate wishes and expectations as demands to be resisted. For example, she offered to take her husband out to dinner and asked him if there was any one other person he would like her to invite along. In reply he picked his best friend. She predictably saw his request as a command. So, instead of calling this person, she "inadvertently" called the next number in her address book, not one of his friends, but one of hers. As she told the story, she became flustered when her friend answered, and "just to have something to say," gave the friend the coveted dinner invitation. Though this naturally angered her husband, her reaction to his anger indicated an unawareness of her own contribution: "I would have less stress if my husband were more understanding."

The same thing happened with her therapist: when he requested her permission to raise the fee to cover inflation, though she could well afford it she felt he was being demanding. Feeling out of control she became anxious and angry, missed her next session, then blamed her resultant depression on the stress of her therapist's acting just like her father.

Loss

Like stress, losses are here included under external depressogenesis, even though as often the true significance of a loss is in the eye of the beholder.

The Nature of the Loss

Some theorists postulate that all depressed people are orally fixated and that depression follows an "oral" loss, for example the loss of an actual caretaker or of a person who symbolizes a caretaker. But nonoral losses also cause depression. One patient was depressed by his "anal" loss—the loss of his controlling partner. Another was depressed by his "phallic" loss—the loss of a homosexual partner whose youth and good looks were for him an ancillary phallus.

Reactive depressions may merely seem to follow "oral" losses, first because any loss is a deprivation and all deprivation has oral implications, and second because the depression-prone individual, or the individual once depressed for any reason, regresses, and a regressed person predictably complains about the oral implication of even a nonoral loss.

One man with depressive tendencies was abandoned by his paramour. Before she left he enjoyed the relationship for the "good sex and because I can control and influence her." Dependency was not an issue, at least overtly. But after she left he made dependency the only issue, complaining, "Now I have no one to take care of me."

In conclusion, while it seems paradoxical to advise depressed people to look for other reasons to suffer, nevertheless, making only oral complaints when there is so much more to complain about diverts them from rational assessment of the damage and so from making the proper repairs.

The Role of Preexisting Personality/Pathology

We are all familiar with systems that score losses on scales from one to ten. It is true that one loss can be inherently more severe than another. As an example, the loss of a child by a parent is almost always more difficult for the survivor than the loss of a parent by a child. Two of the many reasons why the first loss is more devastating than the second are (1) the absolute and relative youth of the child and (2) disorder in the orderly, anticipated succession of losses.

However, one really cannot create a table of losses of increasing/decreasing significance, for the reasons cited throughout the text, of which three are further elaborated here:

1. The personal value of losses. We have seen that many depressives do not become depressed from real stress from real loss, real stress they can handle. It is only symbolic stress from overelaborated loss that creates depression; *that* they cannot handle. This leaves many depressives in a peculiar position—that the worse the stress and the worse the loss, the less the depression, and vice versa.

A patient's beautiful apartment was his ammunition in his rivalry with his brother. On that account he overreacted to a minor fire in his apartment that did but a small amount of smoke damage to his possessions.

A patient who had developed migratory joint pains and a swollen and painful foot learned that he might be developing a collagen disease. Because the damage to his body stood for itself, he could handle it without becoming depressed. When, however, the maid dropped a decorative bottle on a glass coffee table and broke the bottle and chipped the coffee table, the damage, though itself insignificant, reminded him of the perfidy of others and the unpredictability of fate. As a consequence he became extremely depressed.

2. The defensive structure in dealing with losses. An example is the individual's capacity for denial, illustrated by the patient who used denial to relieve his anxiety during the months that it took to rule out an acoustic neuroma.

3. The individual's pathology. Given the same provocation, preexisting pathology influences the reaction to loss.

Paranoids find losses particularly depressing because they view them as personal attacks that confirm that they have been singled out by fate. (Treating paranoid depressions with antidepressants can cause decompensation into frank paranoia.)

Narcissists find losses particularly depressing because they are unable to accept any disappointment or failure as part of life, and thinking they should feel good all the time, they cannot tolerate any degree of depression. (Overtreating depression in narcissists accedes to their demand to feel completely good all of the time, and as such is the psychiatric equivalent of unnecessary surgery.)

Obsessives find loss particularly depressing because their guilt leads them to blame themselves for having caused losses that are in fact completely beyond their control.

One patient viewed getting married as an abandonment of her father. She believed she was responsible for the stroke he had shortly after her marriage, even though as a nurse she knew his stroke was due to a preexisting arteriosclerosis.

Sometimes obsessives blame themselves completely for losses for which they were only partly responsible, and sometimes they imagine losses to blame themselves for.

A patient believed he had destroyed his raincoat by leaving it too close to the heat from a light bulb.

Another patient, a computer operator, was tortured after closing down for the day by an unrealistic fear that he had inadvertently demagnetized his backup disks by carrying them too close to a television set.

Also, while narcissists overreact to losses because they view them as interrupting a pleasurable steady state to which they feel entitled, obsessive-compulsive patients overreact to losses because they view them as the significant

flaw that makes the diamond worthless—the imperfection that ruins their whole life.

Existential Losses

Existential losses are more symbolic than real, and the response more philosophical than rational.

For one patient the only significant losses were those that meant mortality. For another the only significant losses were those that referred to man's insignificance in the universe. The losses provoked not overt sadness, grief, or depression, but a fear of nothingness or disintegration.

Existential preoccupations are both causative of and consequential to depression. For it is depressing to be so preoccupied, and being so preoccupied is a symptom of depression.

In an example of causality, a veteran shattered by his army experience devoted all his energy to discovering the meaning of war, and none to repairing his life. By giving priority to existential over real concerns and letting his real problems go unrecognized and unsolved, he neglected himself and allowed his depression to get worse.

However, considering the trivial nature of even seemingly important preoccupations (in this regard one patient cited the restaurant critic who was positively elated by her perfectly prepared cow's ear stuffed with truffles), people who are preoccupied with philosophical matters may be right to get more depressed when something is amiss in the transcendental than when something is amiss in the real world.

This is an extreme view, but some clinicians have speculated that because depression is an *inappropriate* flight or fight response, it rarely or never appears in a true emergency, when reality is overwhelmingly unfavorable, so that all depressions are existential depressions. At least therapists must not fail to recognize existential precipitants by finding anything short of a complete disaster too insignificant to be worthy of their attention.

One patient whose depression was due to existential/philosophical loss of faith in his country was told, "With all the trouble in the world, how can you worry about such a minor matter?" Another was told, "I don't understand it; you are more upset about your suit getting wet in the rain than the possibility that you might have cancer."

Existential concerns should be considered when advising all patients, not just those believed to belong to a certain elite.

One assembly-line worker complained incessantly about his routine job and was advised, "If you hate it so much, then retire and find something more inspiring to do." But the advice was wrong, because even more than he hated his job he feared the loss of a sense

of purpose and involvement. When he retired he became depressed, and his depression was labeled "chronic and incurable, resistant to drugs and shock." In fact, a simple, effective, inexpensive remedy would have been to tell him to make up his mind that he was stuck with his job, continue to do it, and to stop both his endless and fruitless complaining and his search for a better position. He should have been told to recognize that work is a place where most people have to tolerate conditions, otherwise intolerable, for the money. Work is hard and unpleasant, and that is why they pay you.

In conclusion, a therapist should not say to his patient, "Your worries are unimportant in the infinite scheme of things." Even when he intends not to criticize but to calmly reassure the patient that things are not as bad as he makes them out to be, telling a patient that things could be worse is not only a way to misunderstand the patient's plight but a way to belittle the patient and reproach him for his preoccupation with trivia.

Sadness, Grief, and Depression as a Reaction to Loss

Sadness, grief, and depression are distinct emotions and distinct existential displays, but also overlapping ways to react to loss. Unconvincing are attempts to distinguish mourning from depression by such simple dichotomies as the presence or absence of low self-esteem or, what is sometimes the same thing, self-hate due to self-blame. For example, though some clinicians consider self-hate due to self-blame necessary and sufficient for depression, it is in fact minimal or absent in the manipulative depressions, in many biochemical depressions, and in the retarded, regressive depressions that result from life-endangering deprivation (sometimes called the "marasmic depressions").

The following case illustrates the usual state of things: an intermingling of sadness, grief, and depression:

A man lost his cat. The loss was real, for he loved the cat, and symbolic, for it stood for the perfidy of fate and the lack of control over bad things happening. He was sad to see the cat go, mourned for his lost friend, and got depressed, thinking, "All is lost and the world is incomplete. It's as if there is a hole where it once was. My life is no longer worthwhile." Though he loved the cat he also hated it. He had hated it when it was alive, for missing the litter, and after it died, for abandoning him. He also hated the cat as a defense. His hatred was a way of saying, "I don't miss you because I despised you." His self-esteem fell because he internalized his anger, because he felt guilty, and because of a postmortem self-questioning about whether he was kind enough to the cat when it was alive and whether he had gotten it the best medical care available before it died.

When there is an emphasis of sadness, grief, or depression, one over the other, it can sometimes be accounted for by nothing more mysterious than secondary elaboration, the product of axis II pathology/secondary gain. Thus, given the same loss and the same reaction to it, the more hysterical individual might display sadness to impress, the more dependent individual display grief to elicit sympathy or care, and the more aggressive individual display depression to attack.

A notable characteristic of the sadness/grief/depression olio is pessimism, the feeling that the sadness, grief, and depression will be chronic. This feeling is unrealistic, because no matter how severe the loss, no matter how shattering, patients usually adjust, although in many cases a part of them remains forever subject to encapsulated reminiscences associated with depressive affect.

Trauma

Depression resembles post-traumatic stress disorder when the current trauma involves a loss and/or relights an earlier trauma that involved a loss.

The patient who was held hostage in a store reacted with depression because the shootings reminded her of the time when she was 8 years old, when her mother's brother committed suicide by shooting himself in the head while she watched.

Anniversary Reaction

In an anniversary reaction, an early trauma is reexperienced some time later on the date when the trauma first occurred.

Holiday Depression

In holiday depression a holiday acts as the trauma. The strains of a holiday season push a normal person, or one with preexisting pathology, over the brink into an overt depression. Special holidays have their special traumatic content. Easter revives death and rebirth; Christmas revives fulfillment and depletion (around the gift symbolism); Thanksgiving revives zero-sum guilt (the more I get the less you have); and Independence Day revives guilty fears over hostile assertion and over fantasies of murder and revenge.

There is another explanation for a holiday depression. It is possible that instead of the holiday creating the depression it is the other way around—the depression creates the holiday. By the depression creating the holiday is meant that one can view the holiday itself as a shared display of shared depression. In this view depression appears in many people simultaneously at the same time of the year. Examples include fearful depression in fall, when the earth seems to be dying; resignation depression in winter, when the earth seems to be dead; or guilt over rebirth/life symbolism depression with the onset of spring. In this view the holiday is a symptom of the depression, not its cause. It is symptomatic as a hypomanic defense is symptomatic. The depression believed to be the result of a bad holiday would then actually be due to the holiday celebration's being inadequate to the task of relieving the depression.

Holiday depressions are not the trivial matters they are often presumed to be. They can be quite painful, and may not disappear after the holiday is over. Indeed, they may linger and even usher in a more serious depressive illness. People who have them simply cannot afford to place their emotional state in jeopardy. They cannot afford to visit family they do not get along with, get

upset, have an uproarious argument, then shrug the unpleasant experience off as "just one of those things—everybody has trouble at Christmas." They cannot afford to use such holidays as Christmas, New Year's, Easter, and Thanksgiving as scheduled uproarious sadomasochistic episodes not permitted at other times of the year.

One sadistic husband regularly insisted that he and his wife visit his mother for "the big ones." They sat in the mother's hotel room all day, upright, in hard-backed chairs, just talking. The mother devoted the time to evaluating whether or not they were behaving in a loving way toward her, putting them to a number of tests, all of which they failed. They were forbidden to go on walks or visit their friends in town, lest they take precious time from the mother. At Christmas the only activities were opening and admiring gifts, and the meals afterwards, which were scheduled, ritualistic affairs that began and ended on time with little room left for hunger or individual desire. When the wife complained, the husband unsympathetically blamed her for being uncooperative, and when the wife's brother suggested that the husband was a mama's boy he took his revenge by never speaking to him again.

Old Age

People who believe old age is only golden overlook the fact that old age is also a period of decline. It is better to accept this and work with and around it than to deny it and fool oneself long enough to be unprepared for a harsh but inevitable reality.

Senility

In early senility a secondary depression may be the result of an awareness of failing mental capacity. Or it may be due to the tendency for emotional problems to coalesce and intensify as a result of diminished defensive capacity, organically caused.

True senility must be differentiated from pseudosenility, which is a result, not a cause, of depression. In pseudosenility we see a delusion of senility, a depressive delusion where the patient elaborates such normal/expected memory deficit as a modest inability to find nouns into a delusional conviction that he is suffering from clinical Alzheimer's. Many obsessive depressives who enjoy torturing themselves convince themselves they have Alzheimer's by trying to find words they haven't used in years, never knew at all, and/or had trouble finding when they were young.

CHAPTER 11
Primarily External Depressogenesis: Depressogenic People

The following discussion of depressogenesis by depressogenic people goes beyond such generalities as "stressful relationships," "difficult marriages," or "interpersonal incompatibility," to detail some of the real ways real people make and keep other people depressed.

In the following discussion, depressogenic people are classified first according to their specific behavior and second according to their specific diagnosis.

CLASSIFIED ACCORDING TO BEHAVIOR

Double-binders

Double-binders issue their victims contrary messages/orders. The contrary messages/orders make the victims feel confused and helpless and put them in a no-win situation. Then they issue a stricture to keep the victim in the no-win situation. With escape impossible, the only way out is depression or, in less favorable cases, schizophrenia.

The railroad conductor who was mentioned in Chapter 10 of this book, after giving his passengers contrary messages to move to the front of the train and not to walk between cars, warned them (the stricture) that if they did not follow his orders they would be ejected from the train.

A sister ignored her brother on major holidays but called the day afterwards to say how much she loved and missed him. He could not reject her since he would lose even the tardy and mistimed attention, yet he could not accept her because he knew this meant setting himself up for another rejection the next holiday. For the stricture she used her position as his only family.

A patient caring for his elderly mother arranged for her medical care. His mother's internist would not fill out the mother's medicare forms. Indeed, the office lied on more than one occasion, saying the forms had been sent when they had not been. After some months of cajoling, begging, and pleading, he got a few forms, but not all. Requests for more brought the accusation that he was being a pest. His choice was between two equally undesirable alternatives: losing his money or losing his doctor. The stricture was that the doctor was the only one in town who made house calls.

Four types of double-bind are:

1. Duty without protection from adverse consequences. An example is the therapist's duty to report a patient's dangerousness without being give protection from breaching a patient's confidence.

One therapist was ordered to disclose confidential information about his patient by a law-enforcement agency and threatened by his patient with malpractice if he disclosed this information. In essence he was forced to choose between the lesser of two evils, even though the evils were essentially equal.

2. Assault with justified defense too costly. Frivolous lawsuits employ a version of this double-bind for their often purposefully depressogenic effect. The stricture in the frivolous lawsuit was well expressed by the victim's attorney when he asked his client, "How much justice can you afford?"

3. Assault where defense inspires further assault.

A patient's paranoid mother falsely accused him of stealing, perceived his denial as talking back to her, and condemned him for attacking her, then criticized him harshly for his cruelty to her, saying, "It is a helpless old lady you treat in this way."

An artist received a one-two punch from a critic who, after severely criticizing him in public, made matters worse when he tried to defend himself, and ask for mercy, by responding, "I don't see why you let a little criticism from me bother you so much."

4. "Damned if you do . . . "

One patient was victimized in his supermarket by a checkout clerk who criticized him whenever he came through her line—for miscounting the number of items he brought through the checkout line (he counted two potatoes as one item; she counted them as two), and for putting his money down in the wrong place ("not on the conveyer belt because it would be carried into the mechanism; not on the scale because it would ruin the scale's balance; not on the shelf because it is too far away for me to reach; not anywhere else because everywhere else is covered by parcels.") When he complained to the management about his mistreatment, either they ignored his complaints or he was effectively silenced by the threat of a slander suit. The stricture was that there were no other supermarkets in town and no other checkout lines open at the time he shopped.

Another patient, a musical comedy composer, retired because of frustration over his critics' saying his popular works were too classical and his classical works too popular. (In the section on criticism below there is the speculation that such unregulated sadistic

"collective critical behavior" may be responsible, more than such other factors as inspirational failure and economic problems, for the current absence of written-in-America musical comedy hits.)

Those Who Ignore a Person's Legitimate Needs

There are three (overlapping) subtypes of people who ignore the legitimate needs of others:

1. The generally self-serving.

An example of a patient who only thought of herself was a patient with introital spasm who proclaimed to her husband, "I don't care if we never have sex again." Omitted: Maybe you care.

2. Those who ignore another's legitimate needs mainly when they conflict with their own legitimate or illegitimate needs.

A dental technologist asked a psychologist to comment on her pressing emotional problems while he was having his teeth cleaned. He felt helpless and angry at her disregard for his status as the identified patient.

3. Those who burden others with a depression of their own when their victim is himself depressed.

The above-mentioned psychologist told his periodontist's secretary how he became depressed after periodontal surgery (a common occurrence). She replied, "What do you have to be depressed about? My husband just died; now there's a real reason to be upset."

Those Who Willfully or Carelessly Encourage Excessive Grief and Depression

People who encourage grief and depression may be generally sadistic and/or may specifically prefer to have others grieving or depressed because they like passive, malleable, cooperative, needy, compliant not stubborn, and contrite people. Such people remind others of how much they have lost, how it can never be regained, and encourage mourning for their own purposes—the longer, the more intense, the better. They often wax positive about prolonging grief on moral grounds, while discouraging improvement on the same grounds. Samples: "How can you enjoy yourself so soon after your wife died?" or "Aren't you something—twelve months after your husband dies here you are, taking a pleasure cruise."

Those Who Provoke Others to Have a Depression so that They May Avoid One in Themselves

A patient's mother increased her self-esteem by criticizing her daughter for failures that were imagined, real though understandable, or unimportant. She also avoided compli-

menting her daughter for her real successes, though substantial. By putting her daughter down, the mother was able to compensate for her own low self-esteem, the result of her feeling comparatively inferior to her daughter.

Mother-in-Law/Father-in-Law Depression

Mother-in-law and father-in-law depression is a distinctive enough entity to warrant special consideration. (Though only mother-in-law depression is discussed below, with minor variations the discussion is applicable to the wife's relationship with the husband's father.)

A mother-in-law dealt with her own depressive low self-esteem by putting down her daughter's husband. The mother-in-law reasoned, "If my daughter can be convinced she has a defective husband, that will knock her down a peg or two and I will look good in comparison." Also, she reasoned, "If I can get my daughter to recognize how her marriage was a mistake, I might be able to convince her to return home to live with me."

The only person to protect the husband from such acting out is the wife. Conversely, the husband will become very depressed should the wife side with the mother-in-law, out of anger of her own towards her husband or out of misplaced fidelity to the mother that is given precedence over fidelity to the husband. Warning sign: the husband's protestations and pleas for love to his wife not only have the reverse effect but increase the wife's defense of her mother. If the wife sides with the mother, the mother's attacks will in turn intensify because she senses the divisiveness and uses it to drive a wedge further between the husband and wife.

As for the remedy, the husband must first stop any pathological behavior of his that is grist for the mill. Then he must insist that his wife both identify the wife's mother as the common enemy and join forces with him against her. The wife must join him in telling her mother in no uncertain terms that the wife is on the husband's side, 105 percent, and that the mother must either accept this and find a way around it, or leave. Both must insist that the wife's mother, if she cannot like the husband, at least stop criticizing him. Both must warn her that if she does not, then it will be she who will be excluded. Failing this, the husband should either plan to be depressed the rest of his life, and accept this, or file for a divorce and accept that.

Bad Bosses

Different types of bad bosses cause despair and depression in different ways: As a group bad bosses can be divided into (1) nonpsychopathic and (2) psychopathic/antisocial (exploitative).

Nonpsychopathic

This category of bad boss may be further subdivided into the bumbling, the neurotic, and the angry and/or mean bad boss. The bumbling bad boss might

cause despair by eliminating employee incentive through not distinguishing a good from a bad employee. The employee's depressive cry is, "Why bother?" On the other hand, the neurotic bad boss inflicts pain to reduce his own anxiety or improve his own self-esteem. Because of this, others become depressed, because it is their self-esteem that falls.

Arnold, the head of an upper school, liked people who were dependent, who said "please" and "may I," who virtually "talked baby talk" and, instead of knowing how to do things on their own, asked him in a childlike way for his advice and guidance. In contrast, he disliked people who were mature, forceful, and independent, especially teachers such as Jane, an independent person who knew what to do, preferred to speak her mind, and was so competent that she did not really require his advice or guidance. Indeed, she could have given him some!

Under other circumstances the admirable Jane would have been considered an excellent teacher. Arnold, however, considered her pushy—really because she was viewed as a threat to his masculinity. The professional evaluations he gave Jane were bad because they were based not on her teaching but on Arnold's oedipal fixation, in this case a need to soften the impact of his own childhood oedipal rejection by seeing all women as defective. An example of how hard Arnold had to look to find reasons to give Jane the bad recommendations he had already determined she should have: "She doesn't get along with the parents because her poor handwriting angers them." (Historically the criticism seemed more appropriate to a problem Arnold had with his *own* parents than to one Jane had with the parents of her students.)

The angry/mean bad boss rejects by refusing to love his employees and/or humiliates them by attacking them covertly or openly. Rejection and humiliation is especially hard on people who are already hypersensitive because of prior personal/professional experience or subclinical depression.

The headmaster at the school cited above told his teachers not to display coffee or any other drink in their classroom because "it sends the message to the students that the teacher is more interested in drinking than in teaching." He continued, "If you do have a drink, at least you are to hide the cup before the students come to class." The same headmaster gave a teacher a good recommendation, as it turned out, to get rid of her. When she thanked him he came clean. "I lie creatively, don't I?"

In one company a passive-aggressive boss devastated the entire company by attacking his staff indirectly—by never giving them a compliment. The low morale caused talented people to leave, and because of the boss's reputation, only inferior replacements could be obtained. The company's standards and reputation suffered, and the company went bankrupt.

Psychopathic

The psychopathic bad boss knows what he is doing. Often he hurts others for personal gain.

One such boss made an employee depressed by concocting an impersonal/legal motive to hide a personal/illegal one. He wished to get rid of the employee so that he might hire

a friend. What he said to the employee was, "I'm getting rid of you because your work is bad." By making an impersonal action into a personal one, the boss added a personal rejection, and an existential shudder about the perfidy of authority, to the real loss of being fired. The employee's not unexpected response was the defense fantasy, "I'm not a bad person; you are my persecutor." The result: a reactive paranoid disorder, with assassination contemplated.

Victims of bad bosses often make things worse for themselves in one of several ways. They may justify the boss's bad behavior by investing him with the expertise and authority their parents once had. They may personalize the relationship, assuming that the boss withholds love because they deserve to have it withheld and because they are unlovable. They may identify with a psychopathic boss out of admiration, then believe psychopathic behavior is a way to get ahead in the world, forgetting that miscalculation and self-disgust sooner or later cause even the psychopath to go too far for his own good. They may stay on a job because they delude themselves into thinking the people at work are like family. Assuming he cannot change his circumstances, and he has alternatives available, the victim of a bad boss should make up his mind either to stay and tolerate the working conditions as they are, or leave. But he should not stay and complain, because this is merely one way to work oneself into a depression.

Critics

Unconstructive criticism (defined below and contrasted with constructive criticism) stresses everybody, no matter how psychologically healthy and strong. Though such factors as sensitivity due to preexisting problems, low self-esteem, an identity dependent on what others think, and masochism that makes it difficult for the individual to avoid his critics and/or dismiss them in a timely and effective fashion can lead a person to contribute to his own distress at the hands of his critics—for example by taking even minor negative feedback too much to heart. The effects of unconstructive criticism are largely independent of internal factors, and for most people even mildly destructive criticism can be traumatic enough to leave its victim shattered.

Differential Diagnosis of Critics

While there is a differential diagnosis of critics whose criticism is emotionally based (given below), perhaps the most common scenario is that the critic is himself depressed, and his criticism a self-humiliation externalized to become a humiliation of others, a way to defend against his own low self-esteem.

One depressed political critic criticized liberals for being slothful, a criticism originating in his own life-long guilty desire to be cared for, and criticized conservatives for their heartlessness towards those in need, a criticism originating in his own fear that should he become helpless, the people he depended on would reject him, as he believed his mother had once rejected him.

In other scenarios the paranoid critic criticizes others as a projection of something he dislikes about himself; the narcissistic critic criticizes others as a by-product of his belief that he (not others) is the chosen one; the hysterical critic criticizes others to live out oedipal envy and competition; the obsessive critic criticizes others as part of his own excessive perfectionism; and the psychopathic critic criticizes others as part of a plot to get something for himself.

A hysterical music critic suffered from low self-esteem originating both in identification with a father perceived as "weak, ignorant, and disgusting" and in hopeless competition with the same father, paradoxically perceived as "powerful, smart, and admirable." In later life his guiding principles were "I have to be number one" and "If I'm impotent, then everybody else should be impotent too."

When insightful, he compared himself to the sadist who went to the opera hoping not to hear good singing but poor intonation and miscues. But when he was uninsightful, which was most of the time, he was motivated to increase his own self-esteem by creating low self-esteem in others. So he saved his most scathing criticism not for bad, but for good, composing.

He attained a powerful official position, as he said, "by manipulating my way to the top through a sea of depressive masochists who permitted me to do so without fighting back." During the period when he held sway, he was responsible not only for aborting the careers of many talented individuals but also for creating mass depression in the musical arts. He excused himself by concluding, "Great musicians have a compulsion to compose and will do so no matter how much interference they get from me." And, with supreme gall, he averred, "Being brutally honest is the most important part of my job."

Another critic, this time a perfectionistic obsessive with skewed priorities, in his professional life, criticized others for insignificant grammatical errors as in his home life he criticized his wife for being sloppy, and on that account alone filed for divorce. He admitted that her sloppiness was confined to her habit of putting her feet on the sofa and that if the money were the only consideration, getting new sofas was cheaper than paying alimony.

A psychopathic medical student hoping to get the best grades in his class criticized grinds and teacher's pets and told everyone he did not study so that they would identify with him and also not study. Then he turned off the lights at night in his dormitory room so no one could see him "burning the midnight oil" and "crammed" until morning—by flashlight.

One can profitably speculate both on the diagnosis and other behavior of the "outspoken critics" who place the bumper sticker on their car that says, "If It Ain't Country, It Ain't Music."

Constructive versus Destructive Criticism

Constructive, or altruistic, criticism is criticism that is meant to be helpful. It emphasizes the self-fulfilling reasons for change. For example, the individual should change so that his vulnerability no longer gives enemies, critics, and other ill-wishers the advantage. It is a cooperative venture, with its object a response to another's request and need. It is an assessment, not an attack. Its goal is to revise, not to wound. It is directed to real defects, not to imagined

defects or nondefects. It is directed to correctable defects, not such things beyond the individual's control as innate, genetically determined changes in appearance, uncontrollable urges, or bad luck. Where there is a mixture of bad luck and fate-tempting, it affixes blame where appropriate and gives absolution where indicated.

A pet owner became depressed when his veterinarian made him personally responsible for letting his animals suffer the effects of flea infestation, though the pet owner lived on Fire Island and had two long-haired cats and a dog, with the dog bringing fleas back home whenever she went out, and had already tried all the usual preparations with little success. A less sadistic veterinarian would have supported the pet owner by telling him he had already done everything he could, allowing him to admit defeat, and urging him to be patient, awaiting the first frost.

Destructive criticism does all the same things as constructive criticism, but in reverse. It is consciously meant to be harmful, or consciously meant to be helpful but unconsciously meant to be harmful. It is selfish, not altruistic, a response to the needs of the critic, not to the needs of the object. It is unsolicited, forced upon an unwilling victim. It is often a symptom of the critic's emotional disorder, originating in an infantile fixation manifest as a persistent, irrational, one-sided quality of criticism in a setting of a transferential relationship with the victim. This one-sided quality reflects the persistent, irrational hold the personal, unresolvable, conflict has on the critic.

Destructive Criticism

Emotional-dyslogical destructive criticism is criticism inspired by the need to criticize. A target tempts to be shot down not because of any inherent quality belonging to the target but because the critic needs to do some shooting. The need to do some shooting may be due to irrational prejudice, like distaste for a book one has not read because one already knows what is in it, and/or rational overreaction, as happens when one hears words or phrases that become rallying cries by being taken out of context. Dyslogic is employed both to fit the criticism to the emotion and to make it seem as if it is the other way around. The dyslogic is typically a part-to-whole dyslogic along the lines of, "If it's not all good than it's no good at all."

To completely condemn the liberal for his self-sacrificial attitude, the above-mentioned political critic had to overlook the liberals' admirable altruism, while to completely condemn the conservatives for their selfishness and disregard for the plight of the meek, he had to overlook their admirable views on self-actualization, such as, "You reap what you sow."

Three characteristics are often (but not always) present in emotional-dyslogical criticism. Group loyalties are affirmed; the criticism is expressed less in idea

than in exclamation point; and though impervious to logic, the criticism often yields to a simple personal manipulation, like an invitation to dinner.

One editor-critic illustrated both group loyalty and the use of the exclamation point when she wrote on a manuscript: "No! You may want to rethink your position, consulting an article by *X*!" with *X* a student of the critic's former husband. This critic, deaf to logical refutation, could be soothed by a note submissively thanking her for her useful suggestions.

One mechanism of destructive criticism is to injure by withholding love or by withdrawing love already given. Another is to employ a knowledge of the victim's weak points; the critic suppresses self-defense by using his special position vis à vis the patient, whether this be lover, parent, expert, helper, purveyor of the right of free speech, protector of society's right to know, and/or possessor of a safe perch.

A familiar example of criticism from the position of the safe perch is the practice of some homophobics of hurling antigay obscenities at pedestrians—from a moving car.

When destructive critics are good at what they do, the only survivors will be the masochistic, the divinely inspired, the megalomaniac, the otherwise insensitive, and the individual whose personality structure is such that he intensifies his creative efforts to prove himself to himself or to get revenge against the world by making it ashamed of what it did to him.

Mass devastation may be caused by destructive critics. To the commonly held belief that affective disorder is rife among an artistic population might be added that affective disorder is an occupational hazard for artists. Artists, to paraphrase Harry S. Truman, can neither stand the heat nor get out of the kitchen. Yet sometimes society forces them to withstand the heat and leaves it up to their own devices as to how to do so. And they must even tolerate infantile, paranoid, self-serving, self-aggrandizing, and sadistic critics' conscious or unconscious efforts to effectively retaliate in kind for what the critics feel to be the world's rejection of them for their own personal and creative lack.

Clever and powerful critics can adversely affect a large number of individuals, thrust many into despair, and produce mass demoralization/depression leading to a company's fiscal collapse, a country's economic and structural collapse, or an age's artistic famine. The reasons for their power are as follows:

1. While a psychotic break is easily identified as "him, not us," the chronic "mild" disorders of most critics, such as manipulative paranoia and psychopathy, are mostly identified as "us, not him."

2. The mild, low-key, vengeful, simmering sadomasochistic vendettas of some critics, while modest, are so pervasive, clear in direction, and unalterably motivated to go forward that they make up in devotion to purpose what they lack by virtue of being dilute, derivative, and in terms of psychopathology, refined.

3. Many critics are not interpersonally related enough or are too grandiose to

show interest in a vendetta against an individual. They want to influence not another individual but an entire group.

4. Fight is impossible. Though one cure for a depression due to criticism lies in fight, most depressives are too anergic to do so, and even the fighting depressions, such as the agitated depressions, are ineffective fights, for three reasons. First, effective fight depends on an open and direct expression of anger, too difficult for most depressed patients. Second, fight is aggressive, and aggressive behavior is likely to worsen guilt. Third, attempts to get a well-defended critic to back down are usually counterproductive, inspiring not retreat and apology, but further attack.

5. Flight is unsatisfactory. Flight not only means abandoning one's art but also giving up and abdicating to the critic, giving him what he wants. Particularly unacceptable are two forms of flight: passive compliance, a ready excuse along the lines of, "It's easier to give in than to fight the battle and lose the war," and masochistic compliance, which attempts to punish the critic by making him feel guilty, ultimately a personal loss if only because it means an ongoing relationship with a critic who by now has probably completely lost interest.

In a possible conclusion, society must protect artists from critics, who can compromise or destroy an entire generation of artists, giving us an Age of Depression instead of an Age of Gold. Perhaps, as a public health method of prevention and treatment of depression, society should even consider putting a degree of restraint on critics, even if the restraint is incompatible with their freedom of speech.

Nature of Depression Resulting from Criticism

Work-related disabilities are a prominent aspect of the depressions due to criticism. These are writer's cramp and the worm.

1. Writer's cramp. Writer's cramp may be either motoric or ideational. In the motoric form we might see an inability to move one or both hands while typing or writing. One subtype is pseudocarpal tunnel syndrome, incorrectly attributed to overuse of the computer keyboard. Another subtype is pianist's cramp: hand pain and stiffness and/or paresis of the hands while playing the piano.

One patient who equated success with murder of the father developed a paresis of his dominant hand. Explaining why his pianist's cramp affected his dominant hand, he said, "Pianistic success means taking a hand to my father: I spare my left hand, the less dangerous, weaker sister, allowing 'her' [sic] to live." In this tragic case, unnecessary mutilating surgery was performed on his hand in the belief that the disorder was of neuromuscular, not psychological, origin.

We can speculate that Ravel's "mysterious neurological ailment," an inability to hold a pen in hand to compose, falls into this category.

A third subtype is an inability to sing because of "hoarseness." A fourth takes in some cases of stage fright.

In the ideational form of writer's cramp we may see writer's block: the inability to think of things to say or, if thought of, the inability to persevere in a thought or the compulsion to take it back. In unfavorable cases this may lead to creative paralysis or psychotic undoing: a tearing up one's work because it is delusionally believed to be unsatisfactory.

We can speculate that Samuel Barber might have fallen ill with an obsessive depression as a result of a critic's dismissal of his opera *Anthony and Cleopatra* with a fey comment along the lines of there being more happening in between than during the acts. Possibly as an obsessive-compulsive repetitively washes his hands, for the last years of his life instead of writing all new music, he revised and rerevised the opera, possibly to meet the critic's expectations and/or to undo the humiliation dealt him. It might have helped if Mr. Barber had had the support of someone like Haydn's Esterhazys, or Tchaikovsky's patroness to see him through. Other composers, such as Sibelius, Berlin, Rossini, and Copland may have met similar fates, and Rachmaninoff certainly narrowly escaped this destiny early in his career.

One can further speculate that Barber's depression may have been partly responsible for his final illness, one from the group of immune disorders.

In some cases of writer's block we may see compulsive and paralytic life search regarding the writer's profession.

One writer spent the day not writing but wistfully thinking, "I wish I had written for the movies, not the *University Review*." In him the compulsive life search often took the form of concern about money, a concern whose apparently practical nature was in fact a displacement from feeling rejected by his critics, along the lines of "getting money equals being loved."

This life search may be lived out in impractical, unrealistic, and unnecessary job changes with a conscious intent that seems self-fulfilling but with an unconscious intent that is in fact a figurative self-mutilation.

Dynamically speaking, for either type of writer's cramp to appear, two conditions may have to be met. The first is a devastating present reality; for example there is criticism from the hostile, depressed, envious, anticompetitive critic. The second is a childhood terror that is relighted by this devastating present reality.

A typical relit terror for artists is an oedipal one. This was illustrated by an artist who had a modestly talented father with whom he competed—successfully, but not without guilty regret. A critic who in essence chastised the artist for being too successful revived oedipal guilt, cramping the artist. The cramping effect was the equivalent of a hysterical paralysis, appearing here in a creative function.

In summary, in motoric writer's cramp, creativity is intact but performance is impaired. In ideational writer's cramp, creativity is impaired and there is no performance.

2. The worm. In this phenomenon, related to writer's cramp, the defect appears not as an inability to create but as a defect in the creation itself. The creations appear, but are flawed by a contaminant that crawls into the production and, like a computer worm, or "virus," spoils or destroys it from within.

Shostakovich's music may reveal the presence of a "musical writer's virus" in the form of an uncertainty of identity or of purpose manifest by a shifting from one to another style or point of view, from inspired musicality to a soon-to-be-tiresome joke, from shouts of genius to stretches of aridity.

Ernest Jones discusses the appearance of a similar virus, or worm (of course, without identifying it as such) in the music of Gustav Mahler, who confessed to Freud that in essence he had a compulsion to contaminate his heights of inspiration with something banal.[1]

Tchaikovsky's complaint along the lines of not being able to patch ideas together without the seams showing may have referred to his awareness of a worm or virus-like "stylistic spoilage" in his music.

Leonard Bernstein's sometimes disconcerting shifts between popular and classical styles in the same work may also belong in this category.

Finally, cramps and worms occur not only in artists and in the arts, but in all creative people and in all creativity, in the everyday, on-the-job creativity that flourishes when the worker is loved and given strength and courage by the boss or professor but withers when the boss or professor demeans, criticizes, and/or threatens to fire.

Non-work-related disabilities from the depressive spectrum also result from destructive criticism. These include:

1. Depressive physical equivalents. Sometimes the effects of criticism appear as depressive physical equivalents like ulcers, asthma, and headaches. In particular, if a critical hysterical partner compares his mate to another using sexual performance as a standard, he throws water in his mate's face and elicits sexual symptoms such as inability to be aroused sexually, generally alubricatory joylessness, erectile impotence, ejaculatio tarda, and the inability to have or feel orgasm.

2. Depressive acting-out. This may be manifest in such covert suicide attempts as sports injuries or in such overt suicide attempts as purposeful auto accidents.

3. Miscellaneous depressive symptoms. Included here are loss of interest, inability to enjoy oneself, especially when doing one's favorite things, and/or a general depressive anhedonia manifest as an inability to laugh and play, often associated with an envy of others who can.

Non-work-related nondepressive symptoms/syndromes are found as well. Included here is schizophrenic-like anhedonia from being kept in a double-bind over time, as happened in the patient whose mother alternately encouraged her to meet a man and get married then told her that she was too good for any man she met. Also included are the manic denial syndromes; the borderline-like

devaluing of friends and lovers originating in an identification with the critical aggressor (one way in which child abuse is passed from generation to generation); obsessive-compulsive paralysis in consequence of a successophobia; and hysterical frigidity due to sexual guilt.

CLASSIFIED ACCORDING TO SPECIFIC DIAGNOSTIC CATEGORY

Paranoids

Paranoids are depressogenic because

1. They are hypocritical. They hold others to standards loftier than the ones they apply to themselves, criticize others while not allowing themselves to be criticized, and see the very flaws in others that they overlook in themselves.

2. They are rigid. There is no arguing with someone who knows it is so because he knows it is so, hears no counterarguments and brooks no disagreement, or becomes more aggressive and menacing in the face of contradiction.

3. They are vengeful. As they see it, vengeance is never a first strike, always a counterstrike.

4. They put people down. They do this to render their imagined enemies powerless and to enhance a self-esteem dependent on being better than the next person. In one put-down characteristic for paranoids they treat another's assets as liabilities:

One individual identified a woman's child-bearing capacities as inferior to the load-bearing capacities of men by claiming that producing a child was an inherently less worthy activity than raising a roof.

5. They are demanding in their dependency. They create and nourish adversarial situations to make themselves appear helpless and in need of rescue.

6. They refuse responsibility and displace blame onto others. Their decreased guilt is in some ways the opposite of a depressive's increased guilt.

One obese individual, to avoid taking responsibility for her overeating and need to diet, complained that others mistreated her. "They tell me to stop eating fattening foods. Don't they know I would if I could? Their ordering me around makes things worse for me. It upsets me and causes me to overeat. What I need is sympathy, not criticism. This is the kind of thing that caused me to get fat in the first place."

In addition to displacing blame, they dissociate themselves from blame. The dissociation appears as a not-me attitude epitomized by "it's not me, it's my voices" or "it's not the good me but the bad me."

7. They are prejudiced. Prejudice and paranoia overlap. Both involve an external attribution—a labeling of others as defective based on a self-dislike and

a scapegoating of others as a way to lift one's own low self-esteem. Paranoid prejudice, like all prejudice, may be overt, as it is in homophobics who bash homosexuals to disavow their own forbidden homosexuality, or subtle, as in irrational critical distaste.

One critic condemned as dilettantes all people with multiple interests, ranging from Albert Schweitzer to Leonard Bernstein. Two factors were operative: (1) extrojection of the hated amateurish self, and (2) forgetting (really overlooking) the fact that amateurism can be, as it was in former times, a mark of stature, a sign of the Renaissance man.

The victim of prejudice, especially if he already has depressive tendencies, becomes depressed, or more depressed, first because he feels excluded and attacked, second because he feels the exclusion and attack are deserved, third because the exclusion and attack humiliate him and his self-esteem falls, and fourth because, as often happens, he accepts the subordinate, inferior role in the hope that if he is passive and compliant enough he may eventually reverse the prejudice and earn the love he desires.

8. They are intelligent and clever. This is true even when it is a question of pseudointelligence due to hyperabstractness and persuasive paranoid dyslogic. Their intelligence and cleverness in turn makes them good at being depressogenic.

Understanding paranoia is one of the depressive's best defenses. Helpful is this conversion of an adage: Listen carefully, the paranoid is talking about himself. Another good defense is the good offense: use the same techniques the paranoid uses, in order to aggravate the paranoid's own paranoia to drive him away.

Grandiose Hostile Manics

Grandiose hostile manics depress others by proclaiming, "I am better than you: I am right where you are wrong; I am smart but you are a fool." They choose victims who offer no counterargument because they are passive-compliant and authority dependent. Should the victims surprise by arguing back, they are not refuted logically but bullied into submission, as one patient put it, "abused by being disabused."

One psychiatrist reclassified all schizophrenia as affective disorder, as he later admitted, just to throw his weight around. When others disagreed he responded not with evidence and proof, but with the ad hominem argument, "You are behind the times."

Borderlines

Borderlines afraid of merging and losing their identity devalue others to avoid getting close.

One borderline psychiatrist was unable to learn because for him learning meant losing his individuality. To maintain his individuality he challenged and humiliated his professors until they had to expel him in order to relieve their own depression. He himself became depressed when he recognized that his sense of self was intact but his career was in a shambles.

Dependents

Dependents want to abdicate the responsibility for their own lives by foisting it on others. When the other does not want the power of life and death over a dependent, the dependent becomes an unwanted responsibility, a burden. Dependents also depress their rivals-in-dependency, obliterating them so that they can maintain a desired one-to-one relationship. This they do using all the means at their disposal, ranging from backbiting to Iago-inspired self-serving lies. Other exasperating depressogenic behaviors are dependent testing, to see if abandonment is imminent, and using dependency to manipulate, to demand things without paying for them, and/or to get things without having to give anything back.

Passive-Aggressives

Passive-aggressives are not frank and do not come clean, so they may use roundabout hostility to provoke by getting under a victim's skin and inflaming wounds in a way that they can later deny.

A man deliberately walked his dog without a leash in order to provoke and frustrate his neighbor. He knew that by the time the neighbor called the police and the police arrived, the dog would be safely back in the house.

People respond to passive-aggressives with a double take and a slow burn, recognizing the hostility only after the fact, when it is too late to discuss it, resolve it, and/or retaliate. Depression appears, because by the time the victim catches on, the opportunity for response/revenge is lost.

Sadists

Sadists combine the paranoid attitude that others are natural adversaries, the grandiose attitude that others are natural fools, the passive-aggressive attitude that others are natural victims of torture, and the psychopathic attitude that others are natural pushovers. Part of their depressive effect on others is their ability to disappoint those who believe people have sufficient character, sufficient dislike of being aggressive, and/or sufficient humanity not to go so far.

Masochists

Masochists provoke others' guilty sadistic impulses by their pleas for punishment associated with the secret hope for leniency.

Narcissists

Narcissistic people depress others by humiliating them. It helps the depressive to remember that while in some cases narcissistic behavior to enhance self-esteem is other-directed, in other cases it is simply a by-product of smugness. While the narcissist who says, "My clothes are the most beautiful in the world" may be putting another's clothes down, just as likely he is merely expressing self-congratulations, with no involvement with the other either implied or intended.

Obsessives

Obsessives make others depressed with the following (overlapping) behaviors:

1. Perfectionistic behaviors. They may criticize others for the way they handle money. One patient hated people who did not use grocery store coupons, calling them, with typical perfectionistic excess, revolting spendthrifts. They may also hate others for their presumed lack of neatness and cleanliness. One patient made his day's interest "searching and destroying," looking for and finding men who were otherwise well dressed but had badly shined shoes. Or they may hate others for mishandling time. One patient left his wife for nothing more than dawdling every time they headed out the door.

A wealthy real estate broker with better things to do stood guard for hours at a dumpster rented for a construction project of a building in which he lived, vilifying passersby who put their personal garbage in it. He feared they would "contaminate it" and hurt him financially by increasing its weight, and so his share of the building's expense of hauling it away. When advised that he was spending too much time on an unimportant matter, he responded, "Yes, but someone has to stand up for what is right."

A team member of a mental health service team paralyzed the team by insisting at the beginning of each meeting that they decide whether now and future meetings should or should not begin with the creation of an agenda for the meeting to come.

Perfectionists like to humiliate others by catching them in minor errors.

A patient who delighted in discovering minor errors of grammar was positively exhilarated when he found a spelling error on his ophthalmologist's eye chart. Two words found on the eye chart, "mountain side," should, in fact, have been run together as one.

A patient joyfully pounced on others caught unawares in contradictions with, "On the one hand you said, but on the other hand you also said. . . ." Two examples of contradictions that inspired him were: "Priests get closer to God by renouncing sexuality though sexuality is a God-given desire," and, "Doctors, sworn to save lives, perform euthanasia to end them."

Those who like to catch others in contradictions are often themselves inconsistent, even taking opposite positions, leaving others not knowing where they stand or how they should behave.

One patient condemned people now for being too altruistic, now for being too selfish, now for being in between (he disliked their lack of profile and inability to take a stand).

Another condemned "dirty" television shows, couching his condemnation in language more foul than any he heard.

A third issued contradictory orders along the line of contrasting messages from his superego—the double standard. For example, he condemned his wife for looking at other men while retaining his own right to look at other women, which he called "the man's prerogative."

The wealthy broker referred to above, in an act seemingly inconsistent with his behavior at the dumpster, told a fellow tenant who wanted to sell his apartment that he would act as broker, but only if he reduced the price of his apartment considerably below what it was worth so that he, the broker, could get a quick commission.

It is a short step from perfectionism to the superiority and grandiosity of, as one patient put it, "The I-only-read-Classic-Comics" type.

A patient's husband awarded himself the ability to decide right and wrong, good and bad, inferior and superior. For example, he proclaimed that listening to news programs on radio was inherently superior to watching television mystery programs.

2. Controlling behaviors. An obsessive's need for others to participate in his rituals makes others anxious, wastes their time, and disrupts their everyday life.

A man made his family leave the house each time he used the bathroom to have a bowel movement.

A patient returned his psychiatrist's bills for the smallest error. Crossing out and erasures were not permitted, using the flimsy excuse that they would not pass muster with the IRS.

3. Hostile behaviors. In the obsessional, hostile behaviors often take the form of obsessive worry.

One patient's worry that his lover might get into an automobile accident was a roundabout way of saying, "I hope you die in a fiery crash."

Another patient's worry that he might be contaminated by shaking hands was a roundabout way of telling others they were dirty.

One patient stated his own intention of quitting treatment by worrying that his psychiatrist had canceled his appointments without telling him.

A patient, angered at how much his elderly mother's attendant charged, called the attendant up repeatedly to worry aloud that he had dropped a loose staple on the floor and to express the fear that the dog would eat it and die. When this stopped he developed a new worry: that his 90-year-old mother's summons for jury duty required an urgent reply. With this in mind he ordered the attendant to make a thorough and immediate search of the house for papers that would prove the mother ineligible because of her age. The attendant

became depressed because, though she felt like screaming at him, she knew that her continuing employment depended on his continuing favor, so she had to remain silent.

A hypochondriac's worries about his health were deliberately structured so that he was unable to be reassured. He had learned that the way to structure worries for this purpose was to fail to distinguish the possible (anyone can get cancer) from the likely (probably you do not have it).

In responding to a hypochondriac, the therapist must distinguish between the obsessional hypochondriac, who has nothing to worry about, and the hysterical hypochondriac, who fixes on a real worry which he overelaborates. An example of the former: A man's persistent worries that he might have Lou Gehrig's disease expressing not realistic fears about his health but unrealistic castration anxiety, to be treated by clarification. An example of the latter: A patient had an early breast cancer removed, then constantly worried that she would have a recurrence. This kind of patient should be treated with sympathy, education, and, where possible, reassurance.

Where hostile behaviors take a paranoid form, the "worries" may have dangerous consequences for the clinician.

One patient's growing conviction that the hearing test the doctor gave him had created a ringing in his ear promised to become the basis for a malpractice suit.

4. Repetitive behaviors. Compulsive obsessives depress others by harping on things of no manifest importance (there is a symbolic importance for the patient, but this is of no interest to the listener-victim). Another manifestation of their covert hostility is that asking them to stop only increases the frequency/intensity of the behavior.

Hysterics

Depressogenic hysterics devote their lives to defeating successful and powerful people. Their perfect victim is the "current idol," strong but vulnerable. An example is a current president of the United States, elected but impeachable. Some hysterics castrate directly; others, like the boss who promotes defective underlings over effective superiors, manipulate others to do their castrating for them. Among depressogenic hysterics we find the matter of the castrative put-down.

One patient waited for what his psychiatrist clearly thought were his most brilliant formulations, to put him down by telling him, "I am smarter than you" in every way he could. He admitted that he was like his own father, who always allowed that he knew more than his son. For example, whichever route the son chose to drive, the father would say, from the back seat, "I know a smarter way to go."

Depressogenic hysterics tend to make life into a competitive enterprise, lining up and comparing things that can just as easily stand or fall on their own.

A hysterical critic's feeling of inferiority to his own father appeared in a depressing tendency to judge popular music as inferior to classical, joyful music as inferior to sad, diatonic music as inferior to twelve-tone music, violence in movies as more reprehensible than sex in movies, and women writers as inferior to men.

Competitive hysterics are drawn to zero-sum triangular relationships in which there is only one prize and one person's loss is per se another person's gain.

Psychopaths

Psychopaths deliberately depress others by lying and devaluing, the motivation for which is having their own way with as little effort and expense as possible. For example, a patient accuses a doctor of being money hungry to avoid paying the fee, or a boss accuses his employees of being defective so that he can justify refusing them a raise. The victim of a psychopath has a depression that typically consists of an admixture of feeling depleted, a déjà vu feeling that "I am letting them get away with it again," a self-attack for permitting oneself to be victimized, a weak and ineffective passive-aggressive counterattack on the victimizer, and a masochistic plea for kindness and restitution.

NOTE

1. Ernest Jones. *The Life and Work of Sigmund Freud*, 3 vols. New York: Basic Books, 1953–57.

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Part III

PREVENTION

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CHAPTER 12
Prevention of Depression

Preventing depression requires

1. Early detection. Self-monitoring and regular mental health checkups for depression are as helpful as self-examination and regular physical checkups for physical disease.

2. Avoiding bringing a depression on oneself by emotional means. A depression-prone individual should avoid relationships that deplete him, arouse intolerable feelings, or create problems for him in the real world. He should avoid the buildup of internal tension from long-suffering, simmering anger. He should also avoid unnecessary brooding and worry, and he should not deliberately expose himself to trauma in the hope that this time he can handle it or this time the sadistic demon will at least be merciful.

3. Avoiding bringing a depression on oneself by physical means. A depression-prone individual should watch his diet, get adequate exercise, and not try to function with too little sleep.

4. Seeking help in a timely way. People who feel depressed should not avoid asking for help because they worry about what the doctor might find, are too guilty to be good to themselves, are afraid of becoming dependent on the doctor, are ashamed they have a body, or assume they cannot afford it when they can.

5. Avoiding becoming overreliant on authority. Patients should be informed consumers, questioning things they read in advertisements and brochures and not entrusting their lives to others without first checking and evaluating their credentials.

6. Facing the truth. Depressives deny aging and death until it is too late to plan for them. A number of conceits serve denial's purpose. One is calling old age the "time of one's life" or the "golden age," even though old age is at best a golden alloy. It does contain the precious metal of experience, refinement

of sentiments, peace with oneself, and increased self-esteem from work well done. However, the precious metal is contaminated by the base metals of cumulative losses; an off-putting rigidity of personality manifest in bad habits like repetitiveness, miserliness, complaining about physical illness and memory deficit, and living in the past; and physical deficit. A bleak but honest view is that life is a saving of the worst for the last. In the long run this at first depressing view solves more problems than it raises, because it allows what prompt and effective repairs can be made to be made and/or allows the individual to prepare to pass his wealth to a spouse, a child, a homosexual lifetime companion, or a charity.

7. Making adequate financial preparations. The older person should not suddenly decide to become a junior entrepreneur and lose all his money in an ill-conceived, covertly self-punitive get-rich-quick scheme. Having money and spending it on others is one of the better solutions for the problems associated with aging, and some older patients achieve a degree of peace only after accepting that to have friends and lovers they have to bribe them with money.

8. Avoiding pathological grief. We should all be nice to people now so that there will be fewer regrets later when they die.

9. Making and keeping friends. The individual should avoid wasting his time with people who have a history of chaotic relationships or who are chronic isolates. He should develop a storehouse of friends, family, and lovers, likable now and useful later in hard times and/or in an emergency. He should do favors now so that later he can ask for favors in return. He should suppress his hostility over minor matters and recognize that what is gained by a cleansing bout of anger is usually more than lost by antagonizing others. He should be positive and uplifting. He should look good, be as interesting as possible, and act as if old age is a reality but not a problem. Constantly calling others' attention to one's advanced age and/or infirmities is like referring to a stain on one's clothing, which might otherwise go unnoticed. Worries, like worry about disease and death, are private matters especially not to be shared with younger people who want to deny the possibility of infirmity and death for as long as they can.

10. Avoiding specific misbehaviors, such as the following:

- Age-inappropriate behavior. To be avoided is competing with younger people instead of developing age-appropriate personal interests and style.
- Suspicious behaviors. Older people should be neither too sentimental about nor too suspicious regarding money. It is wise to develop a paranoid shell but not a paranoid core, enough to protect one's finances but not so much as to be isolating. A living trust is a private way to keep people from stealing without making fear of one's money being stolen too much of an issue.
- Controlling behaviors. Others are separate individuals whose views should be heard and respected. There are better ways to guard against feeling passive and weak than by knowing it all and ordering others about.

- Pettiness. Patients should not antagonize friends by fanatical preoccupations, as with whether or not one has received proper and timely thank-you notes.
- Prejudice. A large chunk of perfectly good humanity is eliminated when people are despised on the basis of their age, sexual orientation, and/or ethnic group, particularly when this attitude is accompanied by such changes in appearance as the bigot's rigid, clenched jaw, tight lips, and hate-filled glare.
- Manipulation. The individual should not use people as transitional objects to treat his low self-esteem, collecting people as trophies or relating to them not because he likes them but because he wants to be identified with their good looks and strength.
- Constant dissatisfaction. Constant dissatisfaction is often the last straw, as it was for the husband whose wife could do no better than complain about how he filled her laundry basket several times a day by using a clean towel every time he washed. She had to decide: an empty laundry basket or her husband.

11. Working hard. The individual should work more, not less, as he grows older. He should work harder because this is one of the things he can still do as well, or better, than he could when he was younger. While everyone is retiring he might even consider beginning a new career.

In a positive denial of aging and death (to be contrasted with the negative one described in category number 6, above), one individual thought, "If I begin a new career when I am 50, then I will have to live into my 80s to complete my work."

Obsessionals should take special care to stay active as they grow older. Obsessive depressives whose work was an arena for a defensive obsessionalism will find that without work they become anxious, restless, agitated, and severely depressed.

12. Avoiding entering a nursing home, when possible. Much of the time, home health care is a less expensive and even superior alternative. After consulting with his own attorney, the patient should check the surprisingly liberal Medicaid laws. Wherever possible the treatment for Alzheimer's should be a nurse-companion in the home, if only because the patient who moves becomes personally confused and, what is often as disruptive, confuses the people on whom he depends by interrupting ingrained habit patterns. While nursing homes are often advertised attractively, even seductively, and some really are attractive and seductive, they are never a panacea. For example, they do not seem to have solved the problem of companions, since the illness of the other inmates often prevents them from serving as adequate substitutes for old friends and family.

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Part IV

TREATMENT

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CHAPTER 13
Handling Internal Depressogenesis

FORMS OF TREATMENT

Treatment Based on an Eclectic Orientation

Because the multiple facets of a single depression both require and respond to different treatment approaches, the treatment sections that follow have an eclectic orientation along the lines of "all roads leading to Rome"—some being shorter, quicker, more scenic, less arduous, better paved, and so on.

In a single case of depression, depressive thinking yielded best to cognitive therapy; depressive defenses, to psychoanalysis; primitive (oral) regression, to support and environmental manipulation; the primary mood disorder, to pharmacotherapy; and the interpersonal withdrawal secondary to the mood disorder, to education and deconditioning.

In another case the depression originated in fear of failure and guilt over success. The fear of failure was treated by reassuring the patient that he was less of a failure than he imagined, while his guilt over success required a behavioral, total-push approach, where the patient was first asked to accomplish something positive, then asked to bring the resultant anxiety back into therapy for discussion and analysis.

Also, every depression is created and sustained by vicious cycles. One depressive's anger drove nonmasochistic people away. He felt lonely and abandoned, he was angry over being abandoned, and his anger drove more people away.

Vicious cycles can be interrupted in different ways, according to the following three additive principles:

1. The vicious cycle or cycles that cause and sustain depression can be completely disabled by disabling any one of their legs.

2. In any vicious cycle there are different legs to disable.
3. For any one leg there are different ways to disable it.

As an example of different legs to disable and different ways to disable each leg, the angry leg in the case cited above can be disabled with, among other things, abreaction, drugs, or shock (not necessarily recommended); and/or the abandonment leg can be disabled with, among other things, socialization groups or interpersonal analysis. In each case the results can be the same: no anger, no loneliness, no depression.

A good eclectic therapist not only combines treatment approaches but varies each according to a specific need. He might use a combination of antidepressants and psychotherapy for both reactive and endogenous depression. This obvious statement must be made, because some clinicians rigidly believe that one should use psychotherapy for the first, drugs for the second. In the reactive depression, the therapist might give the antidepressant in a lower dose, to promote relaxation and sleep and in psychotherapy emphasize understanding, while in the endogenous depression he might give the antidepressant in a higher dose, to elevate mood and in psychotherapy emphasize support.

Treatment Based on Reactivity Profiles

The treatment approach and goals of treatment should be derived from an understanding of depressogenesis. Clearly, a loss depression like grief has to be treated in a different way from an existential depression due to dissatisfaction with the quality of life. Especially with internal depressogenesis, the therapist must consider the patient's dynamics when structuring interpretations. A depression brought on by a success, such as a promotion, will require an entirely different interpretive approach from one brought on by a failure, such as being fired. If there is fear of success, that has to be resolved first; otherwise the patient will have a negative therapeutic reaction—the better he gets the worse he gets—and/or a masochistic triumph, where the patient proves that no matter how hard the therapist tries, he cannot help the patient get better. Hint: Transference behavior is a good indicator of the nature of reactivity. For example the patient who complains that anything short of a complete and rapid cure is inadequate is likely to be a spoiled complainer who creates the hard luck he complains about.

HANDLING SPECIFIC TYPES OF INTERNAL DEPRESSOGENESIS

Guilt

Excessive/Inappropriate Guilt

The following are some of the ways one therapist reduced excessive/inappropriate guilt.

1. Externalization of guilt, though paranoid. A therapist told his excessively guilty patients to blame others instead of themselves, to think, "I suffer, not because I am bad, but because of prejudice against me."

2. Avoiding people who make guilt worse. He told his patients to visit their guilt-creating relatives as little as possible. He suggested they pick friends who were not excessively self-punitive and keep these relationships going, because if they gave them up a resurgent harsh superego would only demand an even greater atonement and revenge.

One patient became aware that his senile mother was showing strangers her pearls and bragging to them that they were worth a large amount. He thought about insuring the pearls in case of loss or theft but recognized that should there be a claim for a loss or theft the insurance company would probably cancel the entire homeowner's policy. He was also concerned about the real danger to the mother from robbers. So he took the pearls from her, gently explaining that he would keep them for her because she was not feeling well enough to have them. When she complained that he was stealing her jewels, taking away something she had had for her entire life, he felt self-critical and guilty. A friend came to the rescue by pointing out that in his opinion he was doing the right thing. In fact, the friend went even further, saying, "What does she need them for? Since you are her heir, sell the pearls and use the money for her benefit now, and eventually for yours." The burden of guilt lifted and with it the nagging "I'm a bad person" depression that had been plaguing him.

3. Giving the patient permission to do forbidden but healthy things. An example is expressing appropriate anger or getting appropriate revenge.

As for revenge, the therapist pronounced it as understandable and permissible as self-protection and counterattack by an animal under attack. He gave his opinion that there was a continuum between mindless, sadistic, undeserved punishment; appropriate, creative retaliation, in essence a form of self-expression; and passive compliance and servility.

The therapist recommended the in-between posture of creative retaliation. He made it clear that he was not advocating an eye-for-an-eye philosophy, was not telling his patient to become the forest predator or the avenging punisher, was not advocating physical punishment, and was not suggesting an entire philosophy of life but a treatment for depression. He quoted Ralph Greenson's aphorism, "A death-wish a day keeps the analyst away."[1] He told the patient not to spend much time at vengeance and not to make it his life's work, but he reminded him that, as far as he was concerned, one of the most important principles in treating depression was, "If it's a choice between your depression and the other fellow's, then let it be his." He warned the patient to temper justice with pity (e.g., he advised him not to retaliate against his parents when they are elderly and helpless for the abuse he had received from them as a child). He told the patient to make absolutely certain that the other fellow could tolerate the revenge about as well as the patient could tolerate the insult. "Then," he said, "if all these criteria are met, go ahead and get your fill."

One of his patients was a man who had paid a high price for his property only to have his neighbor, a hate-filled bigot, curse him and threaten him physically for his religious and sexual preferences. There was no mechanism for handling bias crimes in the state.

The patient became even more depressed when the neighbor began to park a large, battered truck in front of his house, an ever-present, oppressive, larger-than-life eyesore emblazoned with the neighbor's detested name, visible through the patient's windows. The truck began to preoccupy his mind, and he became even more depressed when he discovered that parking the truck there was legal because it was within the weight allowed by the local zoning laws.

He wanted to hire a lawyer but believed that by doing so he would be only hurting himself financially and provoking the neighbor further. His attempted solution: to become excessively kind and understanding, to think, "This man has six children, needs his truck for his business, and if I complain I will be hurting him. Better I should suffer an eyesore than they go needy."

The therapist suggested the patient might feel less depressed if he were more active, more in control, and not handling his wish for revenge by turning the other cheek and becoming excessively kind to the enemy. So he recommended exacting retaliative, compensatory pain. He worked out the following plan with the patient: "Your yard abuts on his. Put up a clothesline and hang your laundry in front of his windows whenever he parks his truck in front of your house."

When the patient followed this advice, the man got the point and stopped parking the truck there. The patient felt better, and the man himself, in time, actually told the patient he was pleased that he had not been, once again, "permitted to get away with murder."

4. Leading by example. The therapist discussed his own philosophy, attitudes, and insights from his own treatment, and otherwise shared experiences in the hope of remaking the patient in the therapist's own more benign, more sensible, less guilt-ridden image.

Helpful/Appropriate/Inadequate Guilt

Most psychotherapists focus too narrowly on excessive guilt and ways to reduce it. But some depressives need excessive/inappropriate guilt to maintain self-control.

Other depressives are not excessively guilty. Because they have been bad, they are appropriately guilty, or not guilty enough. When this is the case it makes little sense to reduce guilt. Instead it makes more sense to increase it—at least until the patient mends his guilt-producing ways. In other words, the patient who mistreats others should keep his guilt until he learns to treat them better. For such people the treatment is not guilt reduction but education, reassurance, and support. The patient might be told, "Anyone can make a mistake," but should also be told, "Don't make another," and "Make amends whenever possible."

A demanding patient was told not to make too many demands on others lest he wear out his welcome, and was told to think about the other person every once in a while, not just about himself. Then, in a corrective emotional experience, an interpersonal reedu-

cation, the therapist reacted to transference manifestations of his cruelty by saying, with mock horror, "I hate it when you do that." This not only set limits but showed the patient how others, not so understanding as the therapist, might be reacting. The therapist, in forbidding the patient to do unacceptable things, was careful not to be critical or controlling but to appeal to the patient's moral sense. (In depressives who are also psychopathic, the therapist will instead have to appeal to the patient's fear of retaliation.)

Finally, all people have to handle guilt in their own way. The therapist's way is not necessarily the patient's way, and it is unfair and sadistic for a therapist to order a patient to handle guilt the way the therapist thinks he should—in ways that work for the therapist but not for the patient. Especially to be avoided is forcing patients against their will into such positive sublimations as "be religious," "work harder," or "be kinder to others who depend on you."

Anger

Most depressives are both inappropriately and excessively angry. The excessive/inappropriate anger may be overintense instinctual "hormonal anger." Or it may result from a relative or absolute inability to repress an ordinary amount of anger. Or it might originate with the ego-ideal, where anger is idealized, as in the patient who believed that an angry man is a real man. Finally, some patients inadvertently or purposefully stir up excessive anger in themselves when, out of guilt or excessive loyalty, they start and maintain relationships better avoided or abandoned.

A patient became depressed each time he visited his dental hygienist. Once she scolded him for fogging up her mirror by breathing through his mouth. She criticized his designer clothes, said he was too fat, and told him the plaque on his teeth was the most disgusting thing she had ever seen in her life. When asked why he kept going back, he replied—with transparent rationalizations inspired by guilt about making a change and near-delusional belief—that he wanted to keep a valuable friendship.

In depressives the excessive anger is often kept inside. Guilt is the usual reason cited, but the anger might also be stifled and introjected because the object is someone needed; someone who has already suffered too much, as with someone physically ill or dying; or someone with a good excuse, as with someone mentally ill. Again, the anger might be stifled because, as with natural disasters, there is no one, except perhaps God, who can be held responsible, and getting angry with fate or God is too nebulous and too unfocused to seem appropriate or helpful, or because, as with just wars, there is no one who can be blamed.

Patients who are excessively/inappropriately angry should first take steps to reduce their anger, such as removal. If that cannot be done they might consider expressing the anger, but in modified form, following the principle that when it comes to expressing anger, refined is better than raw. Some good ways of refining anger are positive sublimation, deflection, reaction formation, and intellectual-

ization. Positive sublimation might create useful/effective social behavior from instinct, or it might change sadistic anger into anger for another's benefit; for example, sadistic anger might be refined into pity. Deflection might shift the object of the anger from a loved one to a stranger or to a thing, while still making its point, albeit indirectly. Reaction formation might change sadistic anger into "tough love." Intellectualization might express the idea, often palatable, without the feeling, often abrasive.

One patient positively sublimated his anger into philanthropic causes. He continued to express it, only now at those who were not as charitable as he thought they should be.

Another patient deflected his anger with his wife by instead scapegoating a stranger whom the whole family could despise—while still managing to make his point about what he did not like about his wife.

Another patient developed a reaction formation to his anger with a child who refused to study by "pitying him, because if he failed in school he might be drafted and killed."

Finally, another patient, an obsessional, used intellectualization by isolation of affect, so that he might continue to think and say the most dreadful things, permissible, he correctly believed, because they were bleached clean of an open expression of raw feelings.

The following patient was taught to express enough anger to keep her from getting depressed, while submerging enough to maintain a positive relationship with her son:

A mother was angry with her teenage son because he refused to give up companions of whom she did not approve. She believed the companions, by being from a lower socio-economic class, diminished her standing in the eyes of her own friends. She was unable to ventilate her feelings because she feared losing control, because she feared antagonizing her son and driving him away, and because she knew she was wrong to feel so strongly about a matter that was essentially none of her business. She was so full of anger that she was in danger of becoming suicidal.

The therapist used the following emergency technique. He suggested that she ventilate her anger not openly but passive-aggressively (i.e., obliquely), by asking questions such as, "Don't you feel you are hanging around with others inferior to you?" or "Are you doing this to hurt me?—Don't get mad, it's only a question." (Of course, the son's therapist then had to deal with the problem the mother's passive-aggression presented for the son.)

If modified expression seems inadequate to provide relief and/or does not have the desired effect, then the patient might be told to have a temper tantrum and get it over with. But he can only have one when the following conditions are all met: (1) it is safe, constructive, and creative to do so; (2) the anger is justified; (3) the anger is directed to the source of the anger, not to an innocent substitute; (4) the original purpose of the anger remains the focus of the anger throughout; (5) the target can defend himself without becoming unduly anxious and depressed;

and (6) the target's basic feelings will not change from positive to negative in a way that eventually proves detrimental to the patient.

Because it is impossible to know in advance how much anger is too much, ideally the patient should judge the effect of the anger while he is expressing it and adjust the level of his expression accordingly. For this reason, in the beginning he should always leave a margin of error that allows him to back off, if at some point he recognizes he has gone too far.

Finally, for some depressives one might suggest the unthinkable—suppressing excessive/inappropriate anger. This can be helpful on two accounts. First, triumph over one's "weaknesses" is an achievement on its own. Second, depressed people need relationships even more than they need a good cleansing bout of anger, and depressives who are seething, nasty, obstreperous, or brutally offensive lose friends—put simply, for these depressives, expressing anger, while good for the soul, is bad for the reputation.

Changes in Sex Drive

Depression results from both decreased and increased sex drive:

Decreased Sex Drive

When there is a low-level sex drive, or an actual sexual anhedonia, there may be less motivation to relate to others, resulting in a kind of predepressive isolation. Also, with diminishing sex drive, work inhibitions can appear in those patients for whom hard work functioned as a sexual sublimation.

Increased Sex Drive

Depression can result from anxiety about being flooded sexually, or from internally or externally inspired guilt. Indeed, pleasure in general and sexual pleasure in specific seems to elicit guilt in many normal individuals. An example of external guilt is guilt that arises from the social cognitive error that proclaims forbidden thoughts to be exactly the same thing as forbidden deeds.

Another example is the sadist's use of religion to double-bind the patient. One uncredentialed preacher alternately stimulated his congregation with guilt-relieving permissiveness, accompanied by promise of salvation, then deflated them with guilt-inducing threats of punishment and warnings of the dire consequences of failing to heed what he said in his sermons.

NOTE

1. Ralph Greenson. Broadcast speech, c. 1960–61, San Francisco.

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CHAPTER 14
Handling External Depressogenesis: Depressogenic Situations

PLIGHTS

Mid-life

A characteristic of mid-life depression is becoming old before one's time. Some people become old before their time by saving all their money for their old age, depleting themselves now to avoid being depleted later. Others become old before their time by bringing about old age actively, to avoid letting it happen to them passively.

One woman did this by having purposeful accidents. For example, she fell and broke her hip because she would not stop taking prescribed benzodiazepines even though they made her dizzy. Though her stated reason for continuing to take them was that the doctor would not prescribe them if they were dangerous, her real reason was to injure herself so that she could enter a nursing home now, to avoid worrying about being put in one later.

Poor Health

Patients neglect their physical health by not having preventive checkups, often because they are terrified of what the doctor might find. Because delaying makes it more likely that their fears will be justified, the longer they wait the harder it is to go. The therapist should advise the patient to become a slave to regular checkups. A patient who starts when he is young can go yearly, reassured that if anything is seriously wrong it will probably be caught early.

Bad Medical Care

Though even competent doctors err, not all practitioners of medicine are equally competent. Patients should be advised not to overrely on doctors just because they have the imprimatur of authority. Patients should pick a doctor not on the basis of proximity and fee but on the basis of experience, credentials, and reputation, first researching the doctor in the Directory of Medical Specialists.

Some doctors do unnecessary procedures. While few of them operate unnecessarily, some do essentially unnecessary semi-invasive procedures like intravenous pyelography or magnetic resonance imaging, perhaps in the belief that everyone benefits. Where possible the patient should get a second opinion before he agrees to even a semi-invasive procedure. This avoids unnecessary expense and physical discomfort or pain. It also avoids what can be worse, the emotional pain from waiting in dread to see if the medical report indicates a serious or fatal illness—unnecessary suffering over a procedure that was not indicated in the first place.

A second opinion should be obtained from a doctor who will not merely give one that is a mirror image of the first, as can happen when the second doctor is recommended by the first and/or because the two have to live with each other in the same small town and/or are on the same hospital staff. Sometimes the best second opinions are those obtained in a mecca for medicine like Boston. Though many people will say it is too much trouble, after all it is not hard to get on a train or a plane to see a doctor in another town—certainly no harder than a trip to a resort or a spa, and probably worth much more.

One sensible physician, presented with a frightening, life-threatening diagnosis of his own illness, promptly arose from his hospital bed in New York, signed out against medical advice, boarded the shuttle plane to Boston, and presented himself in the emergency room of a major Boston teaching hospital for a reevaluation of his physical condition.

The Tragedy of Success

As one patient discussing his tragedy of success put it, "A change for the better is being worked against me." For him success was forbidden because it had oedipal/incestuous meaning. Being successful meant murdering an oedipal rival. For others, as happens with abused children, success is avoided because any involvement has historically been associated with brutalization. Still others avoid success to keep from being disappointed. This is especially true of people whose expectations are so high that no matter how great the success it is still perceived as a failure.

Patients wrecked by success who are in therapy can be expected to respond negatively to treatment gains. For such patients the therapist might try a roundabout approach. Instead of directly encouraging success, the therapist can encourage success indirectly, by telling the patient he should find himself a "power behind the throne" or identify with someone not failure oriented (including the

therapist himself). Because the patient has a chronic problem, he is like the diabetic who needs insulin daily. He cannot give up the encouraging relationship(s), lest the problem return. In particular, the patient should be advised to avoid letting the relationship itself become a casualty of the need for failure, breaking it off just because it is going well and serving the very purpose for which it was created.

LOSSES

Broadly speaking, the term "loss" refers to any condition in which once there was more and now there is less. We have seen that losses cannot be effectively graded on a severity scale of one to ten because the same loss has different meaning for different people. The reader is reminded here of several reasons for the idiosyncratic meaning of loss:

1. The symbolic meaning of the loss makes every loss at least partly in the eye of the beholder. The therapist must determine what aspect of the loss gives his patient difficulty. For a divorce it might be the sense of finality, the loss of companionship, or even the loss of a persecuting critic who formerly saw to it that the patient did not do forbidden things.

One patient complained that he could not get over his father's death though he hated his father. What he could not get over was the absence of control and regulation that the father had provided, and what troubled him most was his new freedom to do what he wanted.

2. The perception of a nonloss as a loss is a special problem for people who are already mildly depressed, because anything that has a negative tone becomes a personal rejection. This includes constructive criticism, reasonable refusal, necessary discipline, or another's self-protective behavior, such as demanding payment of an overdue bill.

3. The overreaction to minor loss is also characteristic of people who are already mildly depressed. A partial loss becomes a total loss, and a total loss becomes "all is lost." (This is a factor in the anxious component of some depressions.)

4. Some depressives minimize or trivialize their losses in order to appear strong to themselves and others.

A physician frustrated his grief by returning to work the day his father died. He not unexpectedly felt all day as if his head were flying off. Delayed recovery, with grief lingering and intensifying instead of improving with time, was the predictable result for him, as it is for most patients who try to deny their grief.

5. Masochists welcome losses, because losses create desirable suffering. Nonmasochists provoke them as a way to remove themselves actively before they

occur passively or as part of anticipatory grief (planning in advance for a loss expected in the future).

The idiosyncratic meaning of loss makes it essential for the therapist to reality-test all losses as if they were delusions. Was it actually a loss? How significant was it? Is it temporary or permanent? Is it partial or complete? Is it real or symbolic? Is it maximized because of a general tendency to be anxious, or minimized because of a fear of being weak? In other words, the therapist should order losses not on the usual severity scale but on a reality scale: fantasied to real. Otherwise the therapist risks dealing only with the symbolic aspect of a loss, which in turn risks overlooking the distinction between a psychosis and a reactive depression.

A patient complained of the loss of the use of her dwelling and her peace of mind from distant trains, which she believed were shaking the earth beneath her bed. The loss should have been treated as a psychosis, with supportive psychotherapy and/or phenothiazines. Instead the therapist treated the reality. He recommended an engineering firm, which made the patient an expensive but ultimately useless mechanism geared to counter bed vibrations "from the trains" with vibrations of its own, equal in force but opposite in direction.

Different schools/approaches contribute to effective therapy of depression resulting from loss. These will be the subject of the remainder of this chapter.

Analytic Approach

The therapist might identify the infantile components that make a tolerable into an intolerable loss.

Cognitive Approach

The therapist might correct the cognitive errors that make a molehill loss into a mountain loss.

Educative Approach

Handling Being Alone Following a Loss

A patient who learns the difference between normal and neurotic loneliness and resolves the neurotic loneliness will only have to handle "ordinary" loneliness. With this in mind, the therapist should reality-test the distortions that make being lonely more difficult than it has to be. For example, when appropriate the therapist could say that it is bad enough to be lonely without seeing being lonely as a punishment. In treating those who are overreacting to being alone, the therapist should avoid platitudes and false reassurances. For example, he

should not gleefully distinguish between being alone and being lonely for those who feel that the distinction is mainly semantic, nor should he recommend solitary splendor to those who prefer group living.

Allowing Time to Heal

The therapist might tell the patient who has suffered a loss that he has to pass through a post-loss stage. Denying it or covering it up, say with alcohol or drugs (prescribed or otherwise), postpones resolution. He should reassure the patient that except in those unusual cases where there is a progression to chronicity, patience will be rewarded because grief subsides spontaneously. Indeed, grievers who lament, "I won't ever be able to live without him" and feel that their grief will never end, may only need reassurance that grief is time-limited.

Because the griever can better tolerate an illness that he knows will be gone in six months to a year, the therapist should reassure the griever that improvement will take place gradually, but steadily, even without help (though possibly faster and better with it). In time the patient will integrate the loss, detach feelings from the lost person, as an amoeba detaches pseudopodia, and gradually miss the person less and less (though never entirely) and be able to live without him.

The therapist should also reassure the griever that in time he will, if he likes, replace the loss. In, say, two years time, if he wants it, he will again have what he had before. However, the therapist should not try to argue with the griever who insists otherwise; for him the pessimistic attitude may not be the innocent matter that its name implies, but a tenacious delusion not influenced by the reality of counterargument. Instead, the therapist might test pessimistic reality, following Frieda Fromm-Reichmann's principle for handling delusions. First, state the disagreement gently but firmly, for example saying, "You and I don't agree about the reality." Then describe and offer to explore the differences between the patient's and the therapist's view.[1]

A positive side benefit of this approach, even more desirable because it is insidious, is the reassurance that comes from the therapist's implying that things are not as bad as the patient thinks they are. Most patients register and acknowledge such reassurance without admitting it. When reality-testing seems more acceptable from peers than from superiors, the pessimistic patient might ask a friend or a family member to reality-test with him. The patient should only collect opinions from those able to both disagree and remain supportive. This approach might be called consensual invalidation, to distinguish it from consensual validation, where the individual wishes to prove, not disprove, one of his contentions.

Using Caution in Making Replacements

Because judgment is surprisingly bad during grief, the grieving patient should defer/postpone irrevocable financial and personal decisions involving replacing losses.

A psychiatrist was evicted from his office by a landlord-colleague whom he formerly liked and trusted. He purchased a condominium office that he could ill afford, just to feel whole again.

The therapist can calm the patient by reassuring him that there is plenty of time to replace losses. The patient, even if he is older, may move more quickly or have more time left than he thinks, and there is the parable of the tortoise and the hare. Instead of making new, irrevocable personal or financial commitments on the rebound, the patient should wait until at least six months have passed. This avoids personal choices that are compulsive/driven in one of two ways: either as an exact replacement for the loss or as the exact opposite of the person or thing lost. Either way, the replacement is chosen, not by the patient, but by emotional forces over which he has little control. When this happens any quick relief obtained will be undone by slow, leisurely repentance.

A patient abandoned by his lover selected the lover's best friend for his new lover, as a way of continuing the relationship and getting revenge.

To be recommended are temporary safe substitutes, in place of permanent dangerous duplicates. Ideal for this purpose are transitional objects. Too often therapists condemn relationships with transitional objects even though under the circumstances they are actually ideal. They not only serve the purpose well but, easier to find, can provide the gratification of instant success. Examples of safe substitutes might be a therapist in place of a lover, a peer in a group therapy session in place of a friend, a teacher in place of a parent, or a needy person or a needy group in place of oneself. However, the patient should not look up all the transitional objects he has not seen in years. Old relationships are dead for a reason. If he tries to revive them, he will only find his friends using his vulnerability for a new opportunity to be critical of his former behavior. Besides, these friends will know they are being used and, expecting him to leave again, remain aloof, this time to spare their own feelings.

Giving Guidance in Making Replacements

When he is ready and if need be, the patient can be guided in his search for satisfactory replacements (i.e., told what he has to do to improve his luck).

One therapist advised his patient to try harder, look some more, and most of all, emit an internal glow that makes others want to come to him: a core beauty, a radiance that suggests self-satisfaction and inner peace.

Recommending Helpful Defenses

There are helpful defenses the therapist can recommend for a patient who has suffered a loss, in the categories of identification, denial, and structure.

1. Identification. The griever may become like the lost object, to dilute,

diminish, and/or postpone the impact of his loss. The object, resurrected within, keeps the griever company while he works through his feelings about, and grows accustomed to, the loss.

One therapist gave his patient the following illustration of identification at work: "I had a patient who began using the same expressions as the person he had lost. This person, his lover, would touch his nose with his forefinger and say, 'beep.' After the breakup my patient would go about uttering 'beeps' to himself."

2. Denial. Denial may be of the loss itself or of the importance/meaning of the loss. Healthy denial is like two boards over a hole being repaired—in more psychological terms a superficial functioning during a deep healing. This kind of denial is to be distinguished from unhealthy or pathological denial, which overlooks reality and forces things to be whole prematurely.

A worker after being fired wrote to his former boss, "We cannot continue a profitable association if you maintain your self-imposed silence."

A patient worked himself into hypomania by forcing things with an insistent, "I don't care," "I am doing well," "I am unharmed," and "I have repaired myself."

A patient handled the loss of his lover with frantic late-night, late-age disco dancing and by buying a house in a chic country resort, less because he wanted it than to reassure himself that "all is well and I am important, because I am where the action is."

The therapist should support healthy over unhealthy denial.

A therapist, believing "denial by resurrection" was more helpful than harmful, supported his patient's harmless involvement in seances, an attempt to bring back his dead wife.

Unhealthy denial must be discouraged as rapidly as possible.

For the patient who minimized problems on a job so that he could "stay with the coworkers, who are like my family," the therapist, after making sure that the patient did not want to fire himself actively to handle the fear that he would be fired passively, suggested he quit and get it over with.

Sensitivity was needed in dealing with denial in the patient mentioned earlier, in Part II, Chapter 10, whose husband was denying of cancer.

Her husband's doctors told her that her husband's chemotherapy for what was in fact terminal cancer had kept the tumor from growing and said that, unable to grow, it would wither and die. This only postponed an inevitable depression following his death, so the therapist suggested, "Ask yourself: Are you denying, and is your denial keeping you from planning for the future and setting the stage for greater disappointment later?

3. Structure. An aspect of loss is boredom. The patient who loses a job or a relationship has lost a time-filling activity, and having too much free time is

depressing for anyone. The most helpful activities are those that are regular and productive, bring the patient into contact with others, organize him, and give the appealing (though temporary and false) illusion of a real relationship. Such activities range anywhere from massage therapy (rolfing, with the sense of touch and contact, especially useful for borderlines who cannot otherwise make contact) to regular visits to the dental hygienist, to visits to the gym, to formal psychotherapy. Regular exercise has the additional benefit of improving the patient's health and physical appearance. A patient who improves his body feels better about himself and looks better to others, and is better positioned to find a replacement for his loss.

Maladaptive Defenses to Be Avoided/Treated

1. Regression. Depressives regress by yielding to alluring infantilism. The depressive tempted to regress must force himself to continue as before, even though it is painful. He should not permit himself to take a vacation, switch to an easier job, or refuse a promotion when these are primarily regressive behaviors. Also to be avoided are regressive bad habits like overdrinking and overeating, and regressive abdication to enemies, by which he becomes a "don't make trouble depressive" who gives the hated them what they want to maintain the peace even at the expense of his own self-esteem.

2. Suicide. Because appealing to the patient not to commit suicide often has the reverse effect, a therapist might confine himself to stating his opinion that suicide is inadvisable, giving reasons why this is so, and hoping aloud that the patient will stay alive.

One therapist told his suicidal patients that it was his honest belief that even when people were under extreme duress, in pain, resources depleted, and family life shattered, they should not kill themselves because the decision to do so is mainly an emotional, not a realistic one, infantile and transferential, full of excessive self-pity and blind, inappropriate revenge against fate.

Some therapists handle suicide by using a manipulation.

One therapist confused his patients with prolonged and complex philosophical discussions about suicide. He dwelled endlessly on the pros and cons of suicide, and how suicide as a way to enter one's afterlife now and/or follow a loved one to it was illusionary. His goal: to make the patient into a confused, paralyzed obsessional, unable to effectively act on his impulses.

3. Perfectionism. Perfectionism, which attempts to make whole symbolically, instead creates neurotic loneliness because the patient isolates himself, believing that nobody is good enough, and drives everyone away with his fussiness and apparent conviction of manifest superiority.

One patient "proved" to his doctor that there was no place to go for a weekend for people who lived in New York. One town was too lonely for singles; another was not

accessible by public transportation other than bus, which he hated; a third had too few activities; a fourth was too far away; a fifth too expensive; and so on. This patient finally admitted that he was being overly perfectionistic in "wanting a beach resort in the mountains far from the teeming city, with a convenient subway stop at the door."

One therapist treated a perfectionist as follows: He told his patient not to ask whether others are perfect, but to ask, "Does good prevail over bad, or the other way around?" He was also to ask, "What makes me such an expert?" and, "Who am I to be handing out judgments?" He used as an example one patient who profitably asked himself, in a transport of insight too soon abandoned, "Who died and left me king?"

This patient was also under the spell of advice books that advocated a self-destructive perfectionism, in essence suggesting he leave his new girlfriend at the first hint that sex might be less than ideal. The therapist noted the cognitive error: "If there is something wrong with the sex, it means there is something wrong with the relationship"—a part-to-whole syllogism.

Then the therapist analyzed the factors that contributed to the patient's perfectionistic demands of others: his longing for an ideal parent; the way associating with others with flaws made the patient feel imperfect by extension, along the lines of, "If you are the best I can do then I can't be any good myself"; and his excessive narcissism, which led him to judge (and condemn) others using the same excessively lofty standards he used in judging himself.

Throughout, the therapist used the patient's transference resistances as illustrations. The patient could not expect the therapist to be perfect. He would have to stop playing Eric Berne's game of, "Why don't you, yes but," in which the patient asked for advice, then discounted each of his doctor's "imperfect" suggestions just to enjoy the high-esteem that came from defeating the imperfect expert.[2] The therapist noted that competing with the therapist was silly because he had hired the therapist to help him.

The therapist also discussed the patient's excessive grandiosity, which made it difficult for him to acknowledge that someone could know more than he.

Finally, instead of making the patient more stubborn and rivalrous by giving him more and more advice that he could misperceive as imperfect, the therapist put the ball in the patient's court, then stepped aside. He gave helpful advice, but just for the record, and listed the potential consequences of not following through, not as warnings but also just for the record.

Finally, the therapist told his patient that if he persisted in his excessive perfectionism, his too ready criticism of others, and his grandiose self-opinionatedness, there was little the therapist could do about it, and the patient should plan to be alone and make the best of it.

Supportive Approach

Sharing Experiences

One therapist told his patient how he himself was able to compensate for losses he at first had believed to be devastating and permanent.

Reducing Guilt in Grief

Guilt in grief comes from at least three sources:

1. Griever's amnesia. The following cases illustrate griever's amnesia:

One patient after his father's death blamed himself for abandoning the father just before he died. To sustain the guilt he had to overlook the way his father cherished his independence, neither wanted nor permitted help, and even became argumentative when it was offered.

Another patient after his mother's death blamed himself for keeping her alive though she was suffering. To sustain the guilt he had to overlook the fact that he had had no choice whatsoever in the matter.

Another patient after his lover died blamed himself for being impatient with the lover during his final illness. To sustain his guilt he had to overlook the fact that the lover, himself depressed because he was ill, ignored his caretaker's good efforts and saw only his flaws.

2. Survivor guilt. Survivor guilt appears not only in concentration camp victims, but in anyone who is involved in a tragedy but himself spared, including those who stay alive after a relative or friend has died.

3. Guilt over how good a griever one is. Silent grievers are often guiltier than grievers who grieve aloud, because society rewards the griever who grieves aloud and in public but not the one who grieves quietly by himself. The silent griever needs reassurance that he is just as good, just as honest, and perhaps less hypocritical than the dramatic griever, certainly than the one who displays his grief just to prove his sincerity or to attack others with his suffering.

The therapist should tell the guilty griever that it is always possible to have done more. He should counter a griever's self-criticism by reminding him of his positive thoughts and actions and by suggesting self-congratulations as well as, or instead of, self-recrimination.

Helping the Griever Defend Himself

Depressogenics use the griever's vulnerability to abuse him, or to abuse him further. Categories of people who do this (admittedly overlapping) are as follows:

1. Those who attack now because they recognize it is safer for them to do so. Often they have been saving up their revenge for the right time. A patient's cousin, disappointed at the bar mitzvah gift he gave her son, later got revenge by snubbing him at his father's funeral.

2. Those who control now when they find it is possible for them to do so. A typical behavior: instead of visiting, they give the griever lists of suggestions on the phone, at their convenience, with a minimum of effort.

3. Those who handle their own guilt by making another feel guilty. There are those who do this by hurling accusations. They believe no one can die without someone being responsible, and make the griever partly or entirely to blame. They might say, "Don't you think you should have taken him to the hospital a

little sooner—I was only asking a simple question, that's all, now don't get mad." They often employ attack by the viable alternative or debatable point. The person allowed to die at home should have been hospitalized for the medical care, while the person hospitalized should have been allowed to die at home for the comfort and security.

4. Those who handle their own guilt for having done nothing before a death by making themselves feel useful after it. They might harass or order the patient to do things, sometimes things he could not do before—emotional things like "don't worry," or practical things like "have him move in with you."

The relatives of one patient appeared, as he said, "From cracks in the wall" to demand he stay with his mother after his father died because "now she is alone." They did so even though they knew he could not stay with his mother before, when the father was alive.

5. Those who understand their own grief but not the other person's. They might say, "Yes, but my father was a young man when he died, and your father had lived his life."

The therapist should either advise the patient to associate as little as possible with such a person, at least until grief is over, or advise him to abandon the relationship on the grounds that maintaining ambivalent relationships (where because of the hostility one cannot get all the way in and where because the relationship is seductive one cannot get all the way out) creates a chronic discomfort and dissatisfaction that is a precursor of depression.

Because a griever with many relatives all calling up with lists of suggestions will predictably feel confused and overwhelmed, the therapist should replace democracy by relatives with dictatorship by therapist—so that someone is in charge—at least until the patient is better able to take control on his own.

Supporting Homosexual Grievers

Some homosexuals are special people with special needs at times of loss. For reasons unknown, some homosexuals who have lost a lover seem to need more than the usual amount of reassurance that they will get over their loss in time. They also respond unusually well to this reassurance. For example, one patient's depression lifted after he read a newspaper column that assured him that all who want to can find another lover in two years' time. (It is doubtful that the author knew how much good he did.) Homosexuals after a loss who feel, "There isn't anyone else in the world for me," and "I'll never find another person to love me like he/she did," may be at special risk for suicide. Also requiring special attention are those homosexuals who, like some heterosexuals, have had a relationship they believe to have been a love affair but was actually more like a brief psychotic episode. The psychosis continues into the grief, intensifying it and giving it a psychotic hue, manifest in wild lamentations and the manic excesses of late hours, compulsive cruising, and excessive drug use.

In some homosexuals grief is very intense because of minority-group low self-esteem, caused by a lifetime of taunts, criticisms, slights, and overt/covert prejudice. Some homosexuals are especially lonely at times of grief. One put it this way: "My gay friends are too busy having a good time, and my straight friends, no matter how understanding, can't really believe I'm grieving over another man."

A therapist supported one grieving homosexual as follows:

Because the patient was overcompensating for a feeling of shame, the therapist made homosexuality the nonissue he felt it should be, nothing to get depressed over. He forbade the patient to become hypomanic, to try to replace his loss too soon, before he was ready. He did not permit the patient to set foot in a gay bar during grief or even to make a special effort to go where gay people are, avoiding packaged tours and gay resorts. He told the patient that not only is there plenty to be afraid of out there to put him in real danger, but that such things as gay bars bring out narcissistic tendencies in people, who stand and stare in a feast of mutual admiration and/or reject others to increase their self-esteem, and in this way would decrease his. Late night hours, drinking, and drugs might disorganize him, make it difficult for him to work and relate to friends and family, and so reduce good sources of satisfaction.

He told the patient to improve his attitudes toward other people, especially to check his own critical tendencies and need to elevate such superficialities as looks, money, and social status over other, more substantial personality traits like stability and fidelity. When the patient countered that his looks were holding him back, the therapist replied that people fall in love with others who like them, support them, and give them positive feedback more than those who look handsome or wear fine clothes or have a good body, and that beautiful people are those who give warmth, comfort and love, not those with the right shape of nose or amount of muscle mass. But he allowed that because good looks were still important, he should improve his body by going to the gym, dressing attractively, and replacing frantic hustle by business as usual with a smile on the face, a self-sufficient look, and an aura of radiant self-love.

These things done, the therapist said, others will do the work of trying to meet you, instead of the other way around.

Pharmacotherapeutic Approach

Drugs such as antidepressants cannot relieve the pain of a loss completely but can, in selected cases, as Dr. Richard Wagman put it, "move the person from here to there," helping him feel better so he can better integrate his loss and deal with his loneliness.[3]

Behavioral Approach

Behavioral modification is not as useful for handling losses as one might wish, because behavioral modification tends by its nature to be more suited to treating presences, like a fear of bridges, than absences, like an empty, isolated feeling.

NOTES

1. Frieda Fromm-Reichmann. *Principles of Intensive Psychotherapy*. Chicago: University of Chicago Press, 1960.
2. Eric Berne. *Games People Play*. New York: Grove Press, 1964.
3. Richard Wagman, Personal Communication, 1990.

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CHAPTER 15
Treatment of Specific Symptoms

ALTERATION IN LEVEL OF ACTIVITY

Loss of Interest

1. Total-push therapy. Total-push techniques are often used to mobilize an underactive depressive. Gentle total-push urges the patient on, while radical total-push orders the patient about. On the positive side, total-push techniques convey a sense of caring and help the patient to release a portion of the energy bound in his depression, energy he can then use to mobilize himself further, on his own. On the negative side, the independent and stubborn ambivalent patient can respond negatively to total-push.

One therapist who told his anhedonic patient to keep busy was told in turn that this was like telling a paralyzed patient to walk.

Another patient "let my therapist do all the cheerleading as I sat back refusing to play."

One patient, a reporter, wanted to quit his job and do free-lance work. But even though he was independently wealthy, he feared that being out on his own would mean financial disaster. He fired his first therapist for pushing him to quit his job, saying self-fulfillment came at too great a potential cost. He fired his second therapist for encouraging him to make the most of a job he already had, because he should have known the job was stifling him. And he fired his third therapist for leaving the decision up to him, because "this therapist doesn't care enough about me to tell me what to do."

Negativity and other resistances may be handled by explaining what the therapist hopes to accomplish, by being honest about the limitations of the approach, and by informing the patient about such potential complications as increased anxiety and the temptation to rebel.

2. Insight-oriented therapy. Insight-oriented approaches recognize that most depressives would keep busy on their own if only they could and explore the reasons for their inactivity. For example, some are phobics who are afraid of what success symbolizes, and some are obsessives who undo every success with an equal and opposite failure.

Agitation

1. Insight-oriented therapy. Insight-oriented approaches can be used to uncover such underlying causes of agitation as anger and guilt.
2. Supportive therapy. Reassurance that everything will be all right may be effectively based on a contrast between the therapist's and the patient's view of the patient's reality.

One fearful pessimistic patient, though very wealthy, became agitated whenever interest rates fell because he thought his income would be inadequate to support him in his declining years. In reply the therapist not only showed the patient how his present fears originated to a great extent in an early relationship with a nonnurturing mother, but also contrasted his own more optimistic financial analysis with the patient's gloomy predictions for the future.

3. Diversion. The therapist might tell the patient to take a vacation from the problems that make him agitated. This method is useful only as long as there is something besides oneself to take a vacation from.
4. Calming. Among the useful techniques for calming are biofeedback, massage, and/or pharmacotherapy.
5. Setting limits. This helps prevent/interrupt the vicious cycle of agitation that breeds agitation. The therapist recognizes that being too nice to, too permissive with, and too easy on the patient often increases the agitation by increasing the patient's fear of loss of control. (Secret resentment for the limit setting might in the long run increase the agitation, however.)
6. Organizing. Structure, such as scheduling the day in occupational therapy, is useful for counteracting the disorganization that is both a cause and a consequence of the agitation.

DEPRESSIVE-EQUIVALENT BEHAVIORS AND SYMPTOMS

Gambling and Kleptomania

Depressed gamblers and kleptomaniacs, who gamble and steal to get something for nothing in order to undo a lifetime of real or imagined deprivation, may improve in group therapy, both with insight and because the group provides them with real companionship and love.

There are three caveats: (1) Some gamblers and kleptomaniacs are not basically

depressed. (2) Others are depressed but only secondarily—from being broke or getting caught. And (3) for gamblers and kleptomaniacs who are primarily depressed, it can be dangerous to treat a depression that controls pathological behavior.

One depressed man stopped stealing and gambling because they were too pleasurable for him to bear, only to resume stealing and gambling when his depression was successfully treated with antidepressants.

Addictions

A true addiction can originate in a depression.

An example of an addiction originating in a depression is heavy drinking and benzodiazepine addiction in a lonely homosexual. The loneliness of this particular patient was the inevitable product of problems with getting close, expressed as a need to seduce remote strangers into loving him—the more remote and unavailable the better—and as a parallel need to simultaneously criticize, demean, hold at a distance, and reject anyone available to him. When he learned that both his behavior and his addiction originated in a latter-day repetition of an infantile need to win over a remote, self-preoccupied, unforgiving mother, he was able to value and accept love from those who were available to him and able to love him back. Now the depression improved and the addiction stopped.

Not all addicts are depressed, however. There are as many significant differences between addiction and depression as there are similarities. For example, some addicts like to hallucinate, but many depressives with obsessive features become anxious with even the slightest loss of their grasp on reality.

True addictions should be differentiated from pseudoaddictions, like compulsive television watching. Many pseudoaddictions are depressive in origin. For example, some compulsive television watching is a self-induced nondrug hypnotic stupor used to relieve depressive anguish.

Depressed alcoholics may use alcohol (sometimes in combination with benzodiazepines) to treat their depression. This is ineffective treatment for a number of reasons, of which two are cited here. First, alcohol releases anger. Released anger can create guilt, and guilt can lead to sadomasochistic destructive behavior, as happened with an alcoholic who got drunk hoping to drive his car off a cliff or into a group of strangers, to hurt himself and them at the same time. Second, alcohol can remove sexual inhibitions at the same time that it diminishes good judgment. This can lead to self-defeating and ultimately dangerous sexual acting up.

For the depressed and the nondepressed alcoholic alike, complete abstinence is the only remedy. Not only does abstinence eliminate the negative intrapsychic consequences of alcohol, but also the abstinent alcoholic has more money to spend, feels better physically, looks better to himself and others, and experiences the pride of sobriety.

Infidelity

Not all infidelity is depressive. Nondepressive infidelity may be due to simple boredom, paranoia (when the infidelity is a retaliation in kind for a spouse's presumed infidelity), or thoughtless, narcissistic-psychopathic self-gratification.

Infidelity that is depressive often originates in conscious or unconscious spousal depressogenesis.

In a typical scenario a spouse said, "I discovered he was unfaithful to me; I can't forgive him; I am humiliated and defeated; I hate him; I want a divorce." But the real sequence of events was, "I always hated him; I could never forgive him; I have always wanted a divorce; and I suspect he knew this, which was why he was unfaithful to me." Her hatred took the form of lack of interest and lack of excitement in the relationship, lack of support for him, and sometimes overt humiliation and castration. This was not part of a conscious plot. Instead she was unaware of her behavior because it was an unconscious transferential repetition of her childhood problems with her father.

The next case not only illustrates the role of spousal depressogenesis in infidelity, but also shows how the little things can be the most damaging. A patient went to the opera and the theater alone because her husband had to get up early the next day to go to work. Her husband appealed to her to stay home with him on weeknights, but she refused on the pretext that "opera and theater are the important things in my life." Soon he began to test her to determine whether she was abandoning him. For example, he asked her to pick up a grapefruit for him on her way home. She refused, saying, "It's too late at night for me to be shopping." He saw the refusal as a rejection and thought, "Something is wrong with my marriage; this is so depressing." First, to be able to perform sexually while having sex with her, he thought of new partners who would be more attentive to him. Second, he began to be unfaithful to her in reality.

PHYSICAL SYMPTOMS

Pseudofatigue That Is Really Depletion

Depressive fatigue is a pseudofatigue. As such it is not only different from physical fatigue (how they differ was described in Part I, Chapter 4), but requires different treatment. While physical fatigue should be treated with rest, depressive fatigue should be treated with increased, perhaps forced, activity.

Bowel Problems

Many depressives suffer from a bowel syndrome marked by a combination of tense constipation and anxious diarrhea. One consequence is anal pain due to fissures from straining at stool. In treating depressive bowel syndrome, laxatives, enemas, and disimpactions are to be discouraged. The patient might be told to try air-fluffed popcorn for the constipation, for the diarrhea secondary to the constipation, and for the fissures, but only after consulting an internist and

asking him if there are contraindications. (The popcorn expands the stool, which emerges quickly and easily, in this way sparing the anal and rectal tissues from trauma.)

Hypochondriasis

Depressives who want to punish themselves or focus diffuse worries into a single worry may use the science sections of newspapers and magazines to stimulate their hypochondriacal concerns/activities. Such people should be prohibited from reading medical articles until they learn how to use the information the articles contain for purposes other than to depress themselves.

Because hypochondriacs are very suggestible and impressionable, they should also be cautioned against submitting to trendy unproven treatments.

Depression as a Side Effect of Medication

Depressive symptoms may be a side effect of medication taken for another psychological disorder or for a medical disorder. Among the most familiar are the depression-resembling side effects of the major tranquilizers and some antihypertensive drugs. But even seemingly innocuous over-the-counter medications taken in prescribed doses can cause depression. For example, one patient seemed depressed from the benadryl in her cough syrup.

The side effects of medication can begin a truly vicious cycle, as illustrated by the following case:

A depressed patient suffered from labile high blood pressure due to anxiety and anger. The doctor prescribed antihypertensive medication, the side effects of which made the patient more depressed. As a result his blood pressure rose, and the dose of antihypertensives was increased. His antihypertensive side-effect depression worsened, so the doctor prescribed an antidepressant. The antidepressant caused urinary retention, misdiagnosed as prostatic hypertrophy and treated by prostatectomy.

The patient was not told in advance of the effect the prostatectomy might have on his sex life. It was only after surgery that he was to discover that he could not ejaculate as before. His doctor thought, "What does such an old man have to ejaculate for, anyway?" but the patient thought instead, "Now that I can't ejaculate I really feel old."

The patient's depression worsened, and his anger with his doctor increased. When he expressed this anger, albeit mildly, the doctor called him an antagonistic paranoid and recommended haloperidol. (Making the diagnosis of paranoia helped the doctor reassure himself that it was the patient, not the doctor, who was to blame.)

The numbing effects of the haloperidol worsened the patient's depression, and so on. It would have been preferable to at least attempt to treat the high blood pressure by a trial of psychotherapy, diet, and exercise.

In conclusion, all somatizing depressives should be advised not to use their bodies as a mode of expression. They should be told that if they have something

to say, they should say it with words. Do not refuse with a headache; say no. Do not attack with a chest pain; say, "Go to hell." Do not withhold with an abdominal cramp; say, "I won't." Also they should be advised to express themselves, to themselves, in words. They should be advised not to punish themselves, in their relationship with themselves, with somatic symptoms derived from hypochondriacal worries, a complex meant to be self-punitive or to create painful anxiety. Also, they should be advised not to use the delusional conviction that they are ill as an irrational fear meant to protect them from an otherwise intolerable self-perception, or as a dereistic assessment of an internal world, meant to obscure what needs to be changed in the external world. Finally, they should be advised not to use factitious (self-made) symptoms, ranging from obesity from overeating to self-induced ulcer-like skin excoriations, to provide them the excuse they are looking for to withdraw and regress.

CHARACTEROLOGICAL MANIFESTATIONS

General Aspects

Ambivalence

An ambivalent patient is unable to choose and/or compromise and then commit himself to his choice and/or compromise. He can neither decide between alternatives, nor merge and blend them, nor stay with his selection or synthesis. Instead he is uncertain, indecisive, and changeable. In this he frustrates himself and others, and in the worst cases he becomes paralyzed. The choices/compromises especially difficult for him are the following:

1. Is it to be me or you? The depressive who cannot decide whether he is going to please himself, others, or both, will please either himself or others, and when he is pleasing himself will think, "I should be pleasing others," and when he is pleasing others will think, "I should be pleasing myself."
2. Is it to be now or later? The depressive who cannot decide whether he will live for the present or live for the future, or do a little of both, will either spend or save his money, and when he is spending money think, "I should be saving it," and when he is saving it think, "I should be spending it."
3. Is it to be spiritual or mundane? The depressive who cannot decide whether to be Spartan or hedonistic, or both, will alternately renounce pleasure and pain, and when renouncing pleasure think, "I should be having fun," and when having fun think, "I should be more serious about life" or "It's bad to enjoy myself so much."

In the transference, the ambivalent patient's contrariness turns treatment into an adversarial relationship.

A patient complained that his doctor's advice to take vacations ran counter to his need to save money for his old age, and that his doctor's advice to save money for his old age ran counter to his need to take vacations—the attack by viable alternative.

A perpetual patient summed up a lifetime of experience with treatment this way: The pharmacotherapist who gave me drugs did not help me to understand myself; the analyst who gave me insight did not help me to solve my problems of everyday living; and the behaviorist who helped me conquer my fears manipulated me without understanding the "me" behind my symptoms.

Ambivalence about being a patient can be acted out in passive-aggressive noncompliance. The patient might forget a dose of medication, or forget to renew his prescription. Noncompliance is one of the main factors in the emotional toll treating ambivalent patients takes on the doctor. This emotional toll is often expressed as, "I hate treating depressed patients," when what is really meant is, "I hate treating ambivalent patients." A proper approach for a therapist treating a patient ambivalent about therapy is to decide what the treatment is to be; then adopt a take-it-or-leave-it attitude.

A homosexual in an ambivalent relationship with a lover turned therapy into a no-win situation for the therapist. When the therapist took the patient's side, the patient accused him of breaking up the relationship by siding with a sick person (the patient). When the therapist took the lover's side and suggested that the patient assess his own contribution to the problem, the patient accused the therapist of being nonsupportive of him in his war with his lover. In a final hostile action, the patient threatened to quit to find a therapist who would agree with him.

This clearly had to stop. The therapist told him, "I have decided that we must limit our work to an exploration of your contribution to your own problems. Naturally you are not the only one to blame, because it takes two. But for therapeutic purposes we will be arbitrary about it and limit our study to how provocative you can be. At the very least this will give you a tool for self-analysis for the future."

The patient responded by terminating both his relationship with his lover and his therapy. This seemed an unfortunate outcome. But, in a testimony to the importance of the long-term view and the necessity of adequate follow-ups, the patient recognized, some ten years later, that he could make a new relationship work by taking some of the blame for the problems that arose and by taking some of the responsibility for resolving them.

Envy and Jealousy

Both envious and jealous depressives need to learn self-direction, but for different reasons. The envious depressive should learn the self-direction of not wanting something just because someone else has it. The jealous depressive, however, should learn the self-direction of accepting jealousy, which is normal when it is the expression of a legitimate wish to have an exclusive relationship with a loved-one. The patient who does not want to share a partner should follow his impulse to tell the partner so. Otherwise he might permit more freedom of movement than he intends, appear rejecting, and encourage the very infidelity he fears. If the partner feels smothered he can always say so. But more often than not the sentiment is first appreciated and second reciprocated.

Lack of Assertiveness

Lack of assertiveness in the depressive may be the result of a need to hide angry thoughts, feelings, and/or desires. In a typical manifestation the patient becomes progressively more passive to deal with mounting anger. A valid approach is combined assertiveness training and exploration of the reasons for the unassertiveness. Also helpful are encouragement of identification with the more assertive therapist, and pharmacotherapy when anger is excessive and/or there is marked anxiety about even minimal assertiveness.

Low Self-Esteem

Low self-esteem is not invariably depressive. It is paranoid when the result of imagined persecution; hysterical when the result of an internalization of oedipally castrative/humiliating parents and/or contains significant oedipal-comparative aspects along the lines of "I'm not as good as the other guy"; and masochistic when it represents a submission to the tyranny of others, perhaps in order to buy their love. In contrast to paranoid, hysterical, and masochistic low self-esteem, which involves others, depressive low self-esteem appears at least superficially to arise as a self-assessment. It is less a question of "you hate me," or "I compete with you," or "I sacrifice myself to get you to like me" than a matter between me and me, as "in my opinion I don't have what it takes."

The therapist treating depressive low self-esteem first identifies it as symptomatic. This would be an obvious statement were it not for the way the typical depressive, and his therapist, tend to view his low self-esteem as appropriate. Low self-esteem should be flushed from such hiding places as the following:

1. Compulsive life-search. "If only I had taken this turn in the road, not that one."
2. Pseudoaccomplishment. Instead of getting a promotion, writing a book, composing a symphony, or making money, the patient rises to a challenge just to do so. He does a certain number of sit-ups a day beyond what is required, has an expensive stereo that produces sound beyond perception, or collects complete sets of things without intrinsic value, like swizzle sticks from different lands.
3. Hypochondriasis. The patient says not "I am defective" but "I have a defective body."

Effective therapy for heightening self-esteem requires extensive knowledge of the reasons for the low self-esteem. Some of these follow.

1. Not meeting one's ego-ideal.

A patient who disliked his aggressiveness because he basically believed that a good person is a passive person was told to be less assertive, not more, and helped to sublimate his assertiveness/aggressiveness into socially useful activities.

In contrast, a patient who disliked himself for his failure to be assertive enough was helped to be more assertive. As an illustration of what he disliked about himself, he related the story of entering the voting booth to vote for a currently unpopular candidate

of whom however he approved. Guilty for casting his vote for this man and fearful of social disapprobation, he pulled the booth's curtains closed and then, without voting, impulsively opened them again, to find to his horror that he had lost his vote.

2. Comparing oneself unfavorably to others.

A patient who felt he was the homeliest man in the world learned on his own to increase his self-esteem by putting others down in his fantasies. He viewed them now as a tube from mouth to anus, now in compromising sexual positions, now as anatomically similar to a frog propped up on its hind legs.

3. Inability to see one's own good points.

One author of obscure sociology textbooks compared himself unfavorably to a successful fiction writer, particularly regarding the accoutrements of commercial success. "I live in a small house in a poor town, while he lives lavishly in Hollywood. I know other professors. He knows movie stars."

The therapist pointed out that the comparison failed in several respects. Chiefly, it depended less on what the patient knew than on what he had to forget: the value of his own work and the friend's dark side, which was the product of the same personality traits that were at least partly responsible for the friend's success. An example of this was his friend's shabby treatment of his wife, such as staying away overnight, cheating on her with the starlets in his movies.

A psychiatrist complained he was no good because he had no private practice. It was determined that he had no private practice because he refused to give benzodiazepines to all comers regardless of medical indication. The therapist, instead of agreeing with the label of no good, commended the psychiatrist for his caution and sense.

4. Not having altered one's bad points. Many depressives are in fact difficult people who have to change. They do not stop with picking on themselves, but pick on others, devalue them, point out their flaws, and overlook their virtues. When brought up short they excuse themselves, lamely, but often effectively, with "I can't help it, I'm depressed."

A patient picked on others, then became depressed when he got what he had coming to him. He was alone and deserved it, because the others did not want to be treated the way he treated them. The patient was told to cease and desist and make amends before it was too late. Only afterward was he analyzed and shown how his picking on others was an expression of his guilt: guilty about his sexual impulses, he called others wanton; guilty about his hostile impulses, he called others uncaring; guilty about his heterosexuality, he called others whores; and guilty about his homosexuality, he called others queers.

Though tempting, it is counterproductive to be too harsh with these patients, because they are already as harsh with themselves as they are with others. The therapist should tell them what to do instead of criticizing what they already

did. Or he should at least let them off the hook a little by telling them he understands that they cannot always help themselves.

5. Real-life failure. Patients who base their self-esteem on their accomplishments become depressed when they feel they have too little or have not accomplished enough. A version of a cliché, "Nothing succeeds therapeutically like success," is applicable for these people.

6. Illusion/delusion of failure. A common source of the illusion of failure in depressives is a confusion between being different and being worse.

One patient failed to recognize that a husband and wife, secretary and boss, supervisor and student, and mother and child are different from, not superior or inferior to, each other. In particular he confused an appropriate division of labor in which different partners played different roles and he was the more submissive partner, with being the "low man on the totem pole."

Another common source of the illusion/delusion of failure is contamination of the here and now with the there and then.

One patient was unable to give himself a vote of confidence because he brought to current situations his long history of negative feedback from his father, a negative attitude the patient believed he deserved. As an example, he cited how his father did not approve of his considerable academic achievements, reserving approval only for such of his unimpressive sports accomplishments as his being able to swim a quarter of a mile without resting. Later in life this patient viewed anything less than unconditional approval as a statement of his personal worthlessness.

A third source of illusion/delusion of failure comes from the disappointed need to be in complete control at all times.

A patient's lover's mother called only when she had a problem, at other times ignoring the couple. While the lover could accept this arrangement, the patient could not, because he had a father who was, like her, concerned more with his own problems than with his son's well-being. For example, when the patient was a child the father had annoyed the son all night with obsessive fears that the son was developing a fever, regularly waking him up by coming into the room to kiss him on the forehead to take his temperature. At the time the patient had blamed not his father but himself, for being too small and weak to be able to stop his father.

This was also the case now; he blamed himself for being a weakling, because he could neither influence his lover nor stop his lover's mother. His self-blame took the form of uncontrollable sobbing and temper tantrums over how he could not make the lover speak up to the mother, followed by even more self-blame for being unable to control himself.

7. Being a voice in the wilderness. The person who is right when everyone else is wrong is isolated and defensive and soon comes to question himself.

One patient's taking two unpopular positions in his cooperative apartment complex left him a man shunned and criticized for being unforgiving. First, he criticized a co-tenant

for giving a cocktail party and inviting the sponsor of the cooperative, though the sponsor, having left the building incomplete, was the common enemy. Second, he criticized the board for accepting as one of its members a tenant who was suing the board for $1 million, knowingly without justification.

8. Others' unjustified negative opinions. On occasion the therapist must deal with low self-esteem, not by analyzing his patient, but by analyzing the motives of the patient's critics, such as why his friends and family assign him the one-down role. Also helpful to such a patient is a contrasting positive opinion.

One therapist helped a composer patient complete a commission by telling him how good his music was. Another told his patient, depressed about being 47 years old, "In my opinion, 47 isn't such a bad age to be."

Crestfallen depressives can also get help from identifying with people who like and respect them. When a friend, or therapist, says, "I don't believe there is reason for your low self-esteem," the friend or therapist not only gives positive feedback but becomes an identification model: an individual who thinks positively about others and, by implication, about himself.

The therapist should not tell the patient to ignore his critics and not care what they think. Because most depressives cannot help caring, the patient, not being able to follow his therapist's advice, will think he is a bad person for being unable to accept help. Removal is a better plan.

One therapist suggested, "I understand that you can't handle visits with your mother, at least for now, because she makes you feel as if you are a terrible person. I see that telling you what a great person you are and advising you not to care what she thinks also doesn't help. So tell your mother you won't bother with her until she is less critical and more supportive. What do you need this for? Better to be alone than to go back and have her ruin what self-esteem you have left."

The therapist should tell the patient who tries to increase self-esteem by going back again and again, in an attempt to reverse negative opinion, that he will only be hated again, his self-esteem will fall further, and the frustration will make him agitated. Arguing and explaining oneself is as useless and unwise as begging for love. If any attempt to repair the relationships is effective, it will come from a position of strength—not a plea, but a demand. However, one should not give up before being certain that he has gotten the other's attention.

In the above-described case of the lover and the lover's mother, the patient harangued the lover until she protected him from the irritating mother. However, this worked not because the lover changed her attitude, but because she did not listen the first time, and when she listened it took time to sink in, and she was the sort of person who did not think anything important if it was not worth repeating.

9. Life's imperfections. Narcissistic patients see having to take the good with the bad as a personal blow.

One idealistic patient wanted to be an artist if only that were not so impractical, or a doctor if only that were not so unartistic. His therapist told him of the exchange involved: an artist may get depressed later in life because he has no money for his old age, while an internist may get depressed early in life because he has no art for his young age.

10. Internalized anger. Internalized anger often boomerangs as low self-esteem. In such cases the patient might be advised to reassign the anger to the individual provoking it. When this is not possible, simple abreaction might suffice, at least temporarily.

One therapist advocated singing along with an opera in which the hero kills the evil mother and father, watching a murder mystery and identifying with the villain, or punching a punching bag with the enemy in mind.

Not advocated is spilling anger out on others who do not deserve it or, if they do deserve it, are too weak to tolerate it and too helpless to defend themselves.

A therapist should also address the consequences of living out low self-esteem.

One therapist said, "Just because you feel down on yourself doesn't mean you have to act in a self-destructive fashion. It's better to stay with the feelings for a while. Don't do anything, and bring the feelings to therapy instead of living them out." This statement was also an attempt to increase ego strength via delaying discharge of impulse, in this case of self-destructive impulse.

Manipulation is often effective.

A therapist manipulated his suicidal patient by telling him that the therapist would suffer no harm if the patient committed suicide, and that if he killed himself the therapy would be over. These were statements of fact, intended to dissociate the therapist personally from the patient's fate, deemed necessary because the therapist believed the patient intended to commit suicide just to harm the therapist.

That manipulations are a double-edged sword and can backfire is illustrated by the patient's response. The patient, disappointed to discover that his well-being was of no interest to the person who mattered most to him, attempted suicide just on that account.

Following are some miscellaneous inspired approaches to low self-esteem from other therapists. Dr. Malvina Stock's approach to low self-esteem was to ask the patient, "Why can't you give yourself a vote of confidence?"[1] Dr. Alma Tamir's rather similar approach was to tell the patient, "Feed yourself a little confidence."[2] Dr. Ferrucio di Cori's approach was to manifest self-love with which the patient could identify.

Once a patient criticized the doctor for having a messy office (actually full of lovely books in random piles). With self-love, Dr. di Cori replied, "My office is agitated, not messy."

Also, Dr. di Cori, by deflecting personal attack, by proclaiming his humanity, and by indicating the real advantages of his behavior, showed the patient how his self-esteem remained intact no matter what others thought of him.[3]

Specific Syndromes

Paranoia

For the depressed person paranoia can add a level of offensiveness to others that makes the patient even more undesirable to what few friends he may have left.

The lonely, depressed patient who decided to sue his ear doctor for putting a buzz in his ear with an audiology test was told, "That's all you need. You have nobody but your doctors. Keep this up and even your doctors will be increasingly reluctant to see you."

Therapists might tell their paranoid patients to talk not to a sympathetic friend but to one who is unsympathetic. An unsympathetic friend can better give the patient his comeuppance for his suspicious attitude, hopefully slowing his self-destructive paranoid elaborations.

Borderline States

Depressive borderlines who overvalue and devalue may become even more depressed simply as a result of exhaustion with themselves. For this reason the depressive with borderline tendencies must not overvalue by falling in love at first sight. He must be suspicious of any new acquaintance. He must reserve his positive emotions for people who are appropriate and deserving. He must avoid devaluing, being overly critical, shattering others often over such a minor matter as the state in which they were born, as in the familiar, "I can't stand people who come from." He should make and stick with a distance decision early in a relationship. An inability to decide whether he wants to be alone, have a keep-your-distance relationship, or be symbiotic may create havoc with every one of his relationships.

Narcissism

Depressives are simultaneously too narcissistic and not narcissistic enough.

1. Excessive narcissism. Some of the terms appropriately applied to many of these patients are "selfish," "demanding," "self-preoccupied," "self-centered," "malcontented," "unreasonable," "egocentric," "without humility," and "ungratifiable." Descriptions of narcissistic depressives often refer to "anger-proneness," manifest as temper tantrums when they are crossed,

thwarted, or denied often in the slightest degree. There is a proneness for taking impersonal slights personally, one manifestation of the narcissist's relative or complete unawareness of their essential unimportance in the infinite scheme of things.

An example of self-centeredness is the patient who became angry because she had to change trains to get to her psychiatrist's new office. She felt that if her psychiatrist cared, he would have chosen an office both closer to her home and on a single train line. She herself recognized that her self-centeredness was really a way of saying, "The hell with you."

An example of self-importance is found in a wealthy patient with a six-figure income who was able to consider himself poor only after comparing himself to titans of industry, used as models of comparison on the questionable grounds of their belonging to the same athletic club.

An example of self-interest is found in a patient's father whom he described as, "both the wealthiest and cheapest man in the world." To illustrate his father's cheapness, he told how at a formal dinner party the father had moved about the room handing out expensive cigars, only to pull them away as soon as someone tried to take one. The father's behavior had prompted this remark from one of the guests: "He's not handing them out; he's showing them off."

While narcissism can be rewarded even for a lifetime, most narcissists are at risk for depression because eventually they cannot have something they want. Often it is advancing age that lessens their appeal and compromises their bargaining position. The resultant depression consists simultaneously of reaction to loss, like feeling helpless, and a prolonged temper tantrum about being so deprived.

2. Insufficient narcissism. Even otherwise narcissistic depressives have difficulty giving themselves a vote of confidence, have minimal self-expectations, feel unentitled, and condemn even their reasonable needs as excessive.

Patients who were overgratified early in life feel entitled now, as they always have been. Patients who were deprived feel entitled now, as they never were. Patients who were unpredictably both overgratified and deprived are insatiable now, because a gratification recalls or threatens a deprivation.

The treatment approach to narcissism may employ the following methods:

1. Total-push. This is indicated for the luxuriant, unemployed, lazy narcissist who, overgratified early in life, is now accustomed to getting something for nothing. However, narcissists who have been undergratified early in life and are luxuriantly unemployed and lazy because their prior experience makes them despair of making a living by working should be encouraged and reassured, not pushed.

2. Education. The patient should be told of the negative consequences of his narcissism. Clearly a certain delicacy of approach is required, especially softening criticism by interpreting from the side of the fear, not the wish. An example

of an interpretation from the side of the fear is, "You must be uncomfortable with how demanding you can be."

Useful is a bland, intellectual approach that avoids both personal involvement and intent to criticize.

A therapist dispassionately described the virtues and flaws of both excessive and inadequate narcissism. For example, he suggested, "A reason against self-love is that it isolates people from others who also wish to be loved."

Another technique is to ask leading questions so that any negative assessment appears not to come from the therapist but from the patient.

One therapist asked a patient to himself seek answers to such questions as, Do I expect too much? Is that why I'm always disappointed? Am I selfish? Should I expect less? Do I pay too little attention to the needs and rights of others? Is my behavior reasonable and adult or unreasonable and childish?

3. Inspirational-identificatory. The therapist encourages identification with someone admirable.

A patient whose narcissism originated in an identification with an imperial mother was treated by encouraging new, healthy identifications to replace the old, unhealthy ones. This patient condemned others, just as his mother did. As his mother fired maids and doctors on minor pretexts, he left a favorite restaurant because he deemed the maitre d's greeting insufficiently friendly. He treated the therapist like an underling—picking desired topics for therapy as if he were ordering food from a menu, then paying the fee promptly only when he deemed the therapeutic service adequate.

The therapist countered neither with criticism nor with analysis, but by telling the patient how differently he, the therapist, would behave if he were in the patient's shoes. For example, the therapist allowed that in the restaurant he would leave room for the maitre d's moodiness, and if he were in therapy he would delight in having a therapist who picked interesting topics for discussion.

4. Limit setting. Limits should be set on narcissistic behavior, not only because it has negative effects on others and because excessive narcissism virtually assures excessive disappointment, but because many narcissists are more guilty about their narcissism than they let on.

One patient hoped to schedule four weeks' vacation during an ongoing psychoanalysis, leaving the analyst unable to fill the hours. The analyst pointed out, "When you do that, I suffer a loss. So if you go, you will have to pay for the sessions." The patient realized, "I am guilty of always thinking about myself. I didn't even ask you if it was okay. Perhaps that is why nobody likes me and I am depressed all the time."

5. Transference clarification. Reducing narcissistic transference expectations reduces the possibility that the patient will provoke his therapist's negative countertransference.

The patient who demanded that the air conditioning in restaurants be adjusted to please him angered his therapist by demanding that the therapist open or close the window as the patient saw fit. Finally, unable to contain his anger, the therapist expressed it and got it over with. He said, "Not only do you try my patience and waste my time and yours, but you are driving me away just as you drive others away outside of treatment." The therapist assured the patient that his basic feelings remained positive and that he was only criticizing the patient's character flaws, not the patient himself. The patient became flustered and silent, then responded, "Boy, I guess you told me," thanked the doctor for pointing out one of his bad habits, and asked for a list of his other bad habits. (Some patients seem grateful at the time, but quit treatment later because resentment builds.)

6. Encouraging helpful narcissism. The therapist should encourage, not discourage narcissistic relationships when they are all the patient has and/or they are the best the patient can do.

One patient's relationships were limited to paid flatterers—heavily tipped barbers and waitresses. When the therapist pointed out, "These aren't your real friends," an important source of gratification was removed and the patient became overtly depressed.

Anxiety and Obsessiveness

Depression may be a way to relieve senseless panic/worry.

Whenever a patient left his doctor's office, he worried about whether the secretary had put the hyphens in the number on his Medicare form, and whenever he left a restaurant he worried that he might have dropped valued items from his pants pockets. The worries persisted until he was able to think that "life is an exercise in futility and nothing matters anyway."

Because obsessive-compulsive disorder is a chronic problem difficult to treat, the therapist's goal might be the limited one of getting the patient to give up his public obsessions, for example in the restaurant, while still retaining his private obsessions, when at home alone or at home with his family.

NOTES

1. Malvina Stock. Personal Communication.
2. Alma Tamir. Personal Communication.
3. Ferruccio di Cori. Personal Communication.

CHAPTER 16
Specific Treatment Techniques: General Considerations

WHY DIFFERENT APPROACHES CAN WORK EQUALLY WELL

The hidden agendas common to different therapies can account for the positive effects of disparate treatment approaches. Examples of hidden agendas, with the reasons, stated or implied, for their positive impact on the patient, are as follows:

1. Encouragement. The eager therapist urges the patient on to health.
2. Expectation. The expectant therapist wants the patient to get better, and the patient gives the therapist what he wants.
3. Exhortation. The therapist successfully pleads with the patient to "snap out of it."
4. Benign neglect. The therapist avoids making matters worse while presiding over spontaneous healing. One example of making matters worse is psychoanalyzing sensitive paranoid depressives who view tracing the relationship between past and present as an accusation that they have brought their problems on themselves.
5. Reassurance. The therapist calms the patient by telling him that in the therapist's opinion everything will be all right.
6. Positive feedback. The therapist tells the patient he likes him. This increases the patient's self-esteem. In fact, the therapist who likes, respects, and wants to help his patient can on this account alone have a better result than the therapist with immaculate technique who is cold, self-preoccupied, remote, extremely perfectionistic, and critical.
7. Establishment of a real (professional, not personal) sustaining relationship. The therapist gives the patient the feeling that he has at least one friend.

8. Establishment of a regular schedule. The therapist organizes and stabilizes the patient's life by recommending regularly scheduled activities, whether this be quiet time, exercise, sitz baths, or the therapy sessions themselves.

One patient being followed for breast cancer revealed how supportive regular sessions are, over and above their content, when she became depressed because her surgeon pronounced her cured and cut her follow-up sessions down from every four months to once a year.

9. Telling the person what he has to know to survive. All good therapists manage to advise, either directly or in passing. As an example of advising in passing, an analyst told a patient why he should cut out a certain behavior by asking him to enumerate the behavior's neurotic components.

10. Corrective emotional experience. The therapist shows the patient a new type of human relationship. For example, by acquiescing where others have stood their ground the therapist may make the patient feel more worthwhile and more in control.

11. Magic. The therapist wittingly or unwittingly encourages that combination of wish-fulfillment and denial called the placebo effect. The placebo effect is a large element in what is in turn called a transference cure.

12. Deserved, constructive criticism. Depressives criticized for acting lazy, demanding, cheap, belligerent, or hate filled can improve as long as the ultimate purpose is to understand, not to accuse, and to warn before the patient goes too far and injures himself permanently.

GOALS IN TREATING DEPRESSION

The therapist usually attempts to reduce the duration, intensity and frequently of depressive episodes. Sometimes, when there is poor judgment manifest in impulsiveness, self-destructiveness, and abusiveness to others, the therapist may instead increase depression to decrease acting out. This is also a goal when there is a chronic subclinical depression which is better to have and get over with.

HANDLING RESISTANCES

Therapists should not assume they have a cooperative, eager, passive, compliant, malleable patient when in fact they are treating a skeptic or nonbeliever, stubborn, oppositional, and hating to be controlled, acting out by forgetting to take medicine, yessing the therapist to death, or in one case even keeping his fingers crossed during an entire analysis so that it would not work.

Depressed patients resist because they want to keep their depression. For patients who feel alone in the present, depression maintains a nostalgic contact in fantasy and/or reality with the past. For lazy patients the depression is an

easy excuse for retaining old habits, learned behaviors, old protective fears, and familiar solutions for new problems. And it can be of immediate direct use.

One patient wallowed in delicious despair because he discovered that by complaining to present audiences about his past traumatic experiences at the hands of past tormentors, he could subtly complain about present company to their faces without their catching on.

When negative transference resistances are insurmountable in individual treatment, the therapist might refer the patient to group therapy with peers and/or self-help therapy, both to bypass negative transference to authority.

The Use of Suicide as a Resistance

Many depressed patients use suicide as a double-binding transference resistance. They say one suicidal thing and mean another. They leave it up to the doctor to distinguish between suicide threatened and suicide meant, and force him to decide which, though they have withheld the information he needs to make the decision (typically there is a good excuse, such as being too depressed to decide for themselves). Then when things go wrong, they blame him, or see to it that he is blamed by others.

This use of suicide is playing a dangerous game. Whether suicide is threatened though not intended, or the reverse, the patient who leaves it up to his therapist to guess what he is thinking is vulnerable on at least two levels:

1. The patient is dependent on the wisdom, good faith, and intent, malignant or otherwise, of strangers—in this case, the therapist.
2. The therapist can overlook real suicidal intent, especially in the patient who cries wolf.

For both these reasons the patient should be asked to become an active participant in solving his suicidal problem. First, the patient should be told that ultimately the only person who can distinguish between an intended suicidal action and a suicidal wish or threat, between being truly suicidal (wanting to kill oneself) and playing suicidal games (wanting to upset, attack, or double-bind others) is the patient himself. This is true because prediction of suicidal behavior is a pseudoscience, with hindsight invariably superior to foresight. Though the therapist knows that what patients say and what they mean are two different things, he can only guess at the exact relationship between what is said and what is meant, because they are two different things.

Second, the patient should be asked to decide what he wants to do and tell the doctor about it, clearly and concisely, after he has decided. He must make a rational, planned statement—not an emotional, impulsive one, eyes closed as to intent and blind as to consequences. After all, his freedom is at stake. If the therapist thinks he is highly suicidal, he may be hospitalized against his will. The patient is asked to choose among the following possibilities, which may be presented to him as a written multiple-choice test he can take and sign:

a. I don't want to commit suicide.

b. I don't know if I'm suicidal.

c. I do want to kill myself, but I don't plan to go through with it.

d. I do want to kill myself, and I do plan to go through with it.

He may be permitted a few lines of essay to elaborate upon his answers, an opportunity to qualify intent by softening it (e.g., "I want to, but my religion won't let me") or hardening it (e.g., "I can be rather impulsive, and even though I don't intend to do it now, I very well might try to do it tomorrow"). Before he takes the test he should be instructed to consider the effect his answers will have and factor the effect of the answers into the answers themselves. In other words, since what the patient says seals his fate, he must decide what fate he wants before he commits himself to it. However, the patient may request a retest at any time if he thinks he has had a change of heart.

Third, the patient should not in turn be double-binded by being asked to make his decision while the therapist keeps the factors in his own decision-making process hidden. For example, before the patient takes the test he should be told how the decision about hospitalization is made. Otherwise he will think of the therapeutic interaction as a nonadversary situation, which is not true. He should be told that the decision about hospitalization is made as follows: the therapist takes not necessarily the wisest but the most realistic course, which is almost always the most conservative one. A wise course may (or may not) be the philosophical one, whereby the clinician accepts that a life belongs to its owner and the owner can do with it what he wishes. But a realistic, conservative course will be, "I have no intention of letting this person kill himself." The possible result: the patient is hospitalized just so the therapist can abort both a tragedy and a malpractice suit. The therapist is rarely penalized for hospitalizing a patient who does not need hospitalization, but often penalized for not hospitalizing a patient who then goes on to take his own life. A person who plays suicidal games, even one who merely muses aloud about suicide, is likely to spend three weeks in the hospital, so that if there is a successful suicide the therapist can at least defend himself by saying, "I did everything I could." The patient should always be told whether his therapist holds the view that another should be permitted to take his life on the grounds that it belongs to him, or that committing suicide is one of the four freedoms (even if the therapist knows his patient's demands for civil rights are a product of his illness).

Fourth, the patient should be told that if he wants to set the doctor up so that he, the patient, can complain about mistreatment or file a malpractice suit, ultimately he can. A malpractice suit might even help him to temporarily feel less depressed. But what is waiting in the wings and what will be the cost? If there is a malpractice suit the therapist will suffer and his insurance company (remember, rarely the therapist himself) may have to pay. But the patient will suffer more as the suit drags on and on, soon to become a fresh source of stress.

One patient entered treatment just to get a psychiatrist on her side in a forthcoming malpractice suit. Soon she actually needed her therapy. The stress? The malpractice suit itself, which lasted for five years, during which her own attorneys were remote and uncaring and the attorneys on the other side were dragging personal, embarrassing, and unflattering material out of her past and present lives. The revenge was sweet, but costly. And with a little planned or accidental miscalculation, she could easily have been mutilated or dead.

Passivity

Patients use the resistance of passivity to frustrate their therapist. This resistance is used more effectively against authoritarian therapists, who find it agitating, than against passive therapists who simply meet the resistance by becoming more passive themselves.

A dangerous subtype of passive resistance is nonparticipation in the process of making the diagnosis. The patient follows the medical model, presenting his symptoms to a doctor for diagnosis instead of involving himself in a joint diagnostic effort.

Misusing the Position of Patient

The patient may manipulate the helper's real or countertransferential reactions to create a diversion, obtain compensation he does not deserve, or gain sadistic gratification. Sadistic patients know how to complain to which authorities to raise what desired responses and how to abuse a long-suffering therapist under the guise of abreaction, freedom of speech, or freedom of association, by using the injunction to say anything that comes to mind as their sword or simply by being provocative.

The following are examples of provocative behavior that is best stopped:

A patient went to the bathroom three to four times before his session, did not wash his hands (the therapist never heard the water running), then gave details of his cleaning ritual immediately afterwards—while shaking his therapist's hand in greeting. The therapist became depressed, feeling, "There must be a better way to make a living than this." He began to dread seeing the patient and found himself not listening to what the patient was saying. Moral: The ritualistic patient whose rituals have an angry interpersonal intent that is directed to his therapist, in this case the wish to soil and contaminate the therapist, should either abandon the rituals entirely or, recognizing that the therapist is one of the most important people in his life, at least try to leave his therapist out of them.

A patient came earlier and earlier for his appointments. Eventually he came 45 minutes early, early enough to meet the patient who had the previous session. He sat in the waiting room during her entire session, disconcerting her and the therapist. He suspected that he might be making the therapist anxious, but continued to come early because he feared being late. He feared that there might be a long wait for the train, that the bank where he banked before his session might have long lines, that the lunch counter where he

bought his lunch might not serve him promptly, and so on. The therapist was becoming more and more uncomfortable, and angrier and angrier. He began to snap at the patient without knowing why. The patient was told that he had to choose between coming very early and having an angry, depressed therapist, or coming no more than ten minutes early, being anxious about being late, but having a therapist pleased to see him and comfortable working with him.

Many patients get themselves in trouble by thinking their therapist is not human—so resilient that he can withstand all the mistreatment the patient can give—or by thinking they are dealing with a medical machine who is trained to handle everything that comes along and even likes a challenge, the harder the better.

These are the harsh realities:

1. The patient's fate depends on having a therapist who likes to work with him, does not find him annoying and depressing, and does not dread seeing him, but looks forward to it.

2. Not only are therapists not so personally equipped and well trained that they can handle whatever feelings they might have, as most patients think, but it is a mistake to count on the therapist complaining about the manipulative behavior, even if he recognizes it and knows that it bothers him. Instead of therapists being honest with their patients about how they feel and resolving their feelings in the same way that they suggest their patients resolve them, in reality it is more often a case of "do what I say, not what I do." The therapist may suffer in resentful silence because he believes, with his patients, that getting angry is bad; because he has a misguided fear of antagonizing the patient; or because he believes his reactions are unjustified (i.e., believes them to be countertransference) even though they are justified (i.e., provoked).

3. Eventually the therapist will act out, and he has a number of ways of doing so. He can give passive-aggressive hurtful interpretations, sadistically twisted to come from the side of the wish instead of sugar-coated to come from the side of the fear; he may give improper, unnecessary, or excessive medication out of a secret wish to poison the patient; he may use enforced hospitalization not to treat but to sentence; or he may terminate treatment, perhaps suddenly, often covering his real intent with such face-saving rationalization as "maximal improvement" or "need for drugs."

4. The patient, troubled though he may feel, must try to help his therapist by identifying transference provocations; detaching himself from the provocative behavior; and stopping it.

Resistances from Positive Transference

Self-congratulation may not be in order just because the patient's feelings about the therapist are predominantly positive. Even when the result of the positive feelings is a transference cure there are two reasons to remain cautious.

First, a transference cure is really part of a transference illness, and so, theoretically at least, is a symptom of disease, not a sign of health. Second, there is the comparative factor. A patient may be better off dependent on and infantilized by his therapist than in the hospital, but he would be still better off independent and mature. Before creating/being satisfied with long-term "healthy symbioses," therapists should be certain that this is the best the patient can do. In particular they should monitor how much dependency is helpful and how much is a resistance to cure.

Ignorance

Otherwise intelligent depressives may not know how to give a good history. They do not learn how to describe their symptoms precisely and accurately, suggesting possible depressive causes when they exist. In particular, they lead the doctor astray by overattributing or underattributing emotional symptoms to physical problems.

One patient, worried about becoming ill from a physical disease, said not, "I worry that I might die," but instead, "I feel like I am dying," which was naturally misinterpreted as a somatic (physical) rather than as a cognitive (mental) event. The result: unnecessary surgery.

With a little training most patients can learn to tell the difference between a physical and a mental event, to distinguish nondepressive phenomena like anhedonia from depressive phenomena like loss of interest, and to distinguish primary from secondary depression—for example, feeling weak because they are depressed, from feeling depressed because they are weak.

One patient with the possible diagnosis of Epstein-Barr versus depression was told first to check for "true blue" mood, which was defined. Next he was told to ask himself if he was blue because he was sick or sick because he was blue. He was asked *his* opinion on whether he felt depressed because he had a virus or felt viral because he was depressed. He was told to make this a daily preoccupation and report back in a few weeks, after he had had a chance to learn more about how he felt, and why.

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CHAPTER 17
Specific Treatment Techniques: Specific Modalities

SUPPORTIVE TREATMENT

Giving Advice

Giving advice looks easy to do; there is always plenty of good advice to give; depressives invariably seem to need all the good advice they can get; and many depressives seem to need to be told what to do to survive. They lack information on how to handle their enemies, how to be less self-destructive, and how to feed themselves a little pleasure. Nevertheless, there are probably more serious problems associated with the giving of advice than with any other form of therapy, and even when advice is well given, most depressed people ignore, resent, or refuse it. For example, the grandiose depressive who builds his self-esteem on being smarter than the rest of the world will hardly welcome good advice if its implementation makes the therapist look good; the obsessive depressive perceives even helpful hints as a form of control; and the paranoid depressive misuses advice to make things go wrong so that he can then blame his misfortune on the advice giver.

Advice on the Patient's Physical Condition

1. Exercise. Exercise relieves depression both physiologically and psychologically, the latter by increasing attractiveness to others and enhancing self-esteem. Nautilus three times a week is particularly useful for obsessive depressives, who tend to like structure and repetition.

2. Diet. Though specific foods probably do not cause or cure depression by themselves, an improved diet generally helps the depressive look and feel better, and dietary supplements should be considered for depressives who do not eat a balanced diet because they live alone in large cities.

One patient who ate out did not get enough vitamin A. His lack of vitamin A produced dry, cracking skin. This decreased his self-esteem and became an obsessive body preoccupation that diverted him from healthier interests. A vicious cycle was created by treating the resultant depression with antidepressant medication, which made the dry skin worse.

3. Weight. There is a variable relationship between depression and weight loss or weight gain. In some patients depression causes weight loss via decreased appetite. In others weight loss is the product of depressive cognitive disorder, as when a depressive delusion of obesity is responsible for anorexia nervosa. In others weight loss is the result of treatment with antidepressants that have amphetamine-like side effects. In some perfectionists, excessive weight loss is purposeful. Finally, in some the weight loss is not real but imagined, as occurs in depressive hypochondriacs who are afraid they have cancer.

In other patients depression causes weight gain, by increasing appetite. The weight gain may be the product of depressive cognitive disorder, as with one depressive who overate and gained weight because he equated being thin with having AIDS. Weight gain may also result from treatment with antidepressants. In the more hypomanic, depressive overweight may be a personal aesthetic, well expressed by the descriptive phrase, "pleasantly plump." Finally, in some weight gain is not real but imagined, as occurs in depressed anorexia nervosa patients who believe any fat fold is a significant deformity.

Desirable weight gain after exercise may be the result of increased muscle mass. This should be distinguished from undesirable weight gain due to lack of exercise, the result of increased fat deposition.

4. Looks. Though problems with looks can be a reason for depression, it is common either to forget the role bad looks play in disposition or to obscure it by speaking euphemistically, for example of self-image. But bad-looking people despair on account of their appearance, perhaps because their appearance makes it difficult for them to attract others.

The therapist who treats a homely individual should ask him to assist in his therapy by giving the therapist permission to give brutally honest advice. The shock of such brutal honesty will wear off, but the good advice will last. Homely patients should be told to compensate with diversionary maneuvers, like a smile, an optimistic body posture, or a welcoming mien. The patient should aim for a look just on the fashionable side, without overcompensation that makes him look hysterically overdone or bizarrely schizotypal.

Good looks can also result in depression. For example, a depression can be a paradoxical response to being handsome/pretty, as in "everyone wants me just for my body." Some good-looking people are depressed because they would rather be plain/homely for defensive purposes or because they are masochists. Among this group we find those who ruin their looks to make a masochistic statement, perhaps by overcompliance with a sadistic or incompetent cosmetician. One cosmetician, advising a patient on the colors that "are you," recommended that she wear bright orange makeup.

When applicable the therapist should tell the depressive to avoid the pathological changes in appearance to which depressives are prone: the "schlemiel" look that say, "It's bad to be too ostentatious" (even being neat, interested in clothes, and clean is too ostentatious for some depressed people); the "I didn't buy it, I had it" look that says, "I am a boring, parsimonious person, not an exciting big spender"; the "I got it on sale" look that says, "I have an eye for a bargain, but not for a style"; the "sensible shoe look" that says, "function, not fashion"; and the "shopping bag" look, which, like the spotted look, proclaims disinterest or guilt by the fatal flaw—a worn shopping bag instead of a briefcase, stains on a tie, or badly scuffed shoes, spoiling the effect of an otherwise well done outfit.

Financial Advice

The therapist should differentiate preferential thriftiness from compulsive parsimoniousness, where the patient finds spurious reasons to save money or consider himself poor, and from delusions of poverty, where the patient is convinced he is impoverished, perhaps because he thinks that others are stealing his money.

A parsimonious patient, though he had a six-figure, tax-free income, avoided buying bottled water when he was thirsty on the spurious grounds that he was paying for something he was entitled to get free.

In treating parsimoniousness/delusions of poverty, the therapist might advise the patient not to save money for later that he should be spending now when he can enjoy it. In particular he should be warned against overdoing such possibly spurious motives as "I am poor because I don't have as much as the next person," "I am getting older and will need more in my old age because then I will have to buy love," "I will need the money because my family may not take care of me and I will only have myself to rely on," "I will be a victim of runaway inflation," "Circumstances will change and I will lose all my money," and/or "Someone will steal my money from me."

The therapist may argue that "you can't take it with you" and "you don't want to be the richest man in the cemetery." If this fails he may ask his patient at least not to act out his ideas of poverty in public—by dressing shabbily, leaving small tips, or not paying his fair share. Others expect him to maintain standards appropriate to his station in life and pay according to his ability to pay. They will not tolerate his cheapness, excuse it as a product of illness, and/or like him regardless.

Advice on What to Read

1. Self-help and how-to books. Depressives who are not too depressed to concentrate on their reading or too set in their depressive ways to be attentive to what they read can find self-help/how-to material inspiring, guilt reducing,

and organizing. But self-help material is not tailored to the individual, and it is the individual's uniqueness that can compromise the advice or render it entirely worthless. Also, the material often has a distortive organizing hook that is better for selling books than for treating illness, using questionable data and being subject to hysterical trend. Some of the classics of literature and psychiatry for example, some works of Freud, can be effectively used as self-help books.

2. Newspapers, books, and movies. These can harm by portraying the world as a bad place, by flooding with excessive repetition, by creating superheroes that give the ordinary person a sense of failure, by stirring up unmanageable violent or sexual impulses, or by reminding the individual of a personal trauma.

For one patient with excessive primal scene exposure, obscene material activated a pornographic fear of seeing/hearing something "dirty." It also activated an anxiety lest his partner be similarly exposed, an anxiety that took the form of pathological jealousy.

Advice on How to Function in Life

1. Formulating goals. The depressed person must be advised against formulating goals based solely on low self-esteem, envy of others, a masochistic wish to please everyone but himself, a consuming need for immediate gratification, or the narcissistic wish to have it all without having to make sacrifices.

One student was forbidden to choose a big-name school he disliked, just to impress his father.

A masochistic depressive was taught to be more calculating and self-protective.

An impulsive depressive was told to lose battles to win wars, for example not to sacrifice long-term career advancement for such short-term satisfaction as getting back at his boss.

A selfish, demanding depressive was told to give up something to get something: cherished independence in order to save a marriage and pride in order to save a job.

2. Making decisions. Depressed people have difficulty in making decisions and sticking to them. They obsess about decisions unproductively when it is a question of choosing between acceptable alternatives. Afterwards, if things do not go well they have regrets, blame themselves instead of recognizing that they did the best they could at the time, or blame others who tried to help them, criticizing them for telling them what to do. Such patients must be taught that life is a process of trial and error and that one failure does not necessarily impugn an overall plan.

3. Being patient. Depressives do not give things a chance. They feel passive when they have to wait for things to work. They push too hard just to feel active and in control.

4. Looking out for number one. Masochistic depressives increase their self-esteem by giving another's well-being priority over their own, with a conceit that makes for later resentment. For now it is a poor port in a real storm.

5. Making priorities. Depressives often allow meager values, such as thriftiness, to take precedence over important ones, such as love.

6. Using the geographical solution. In selected cases self-esteem increases in direct proportion with the distance between oneself and one's potential, or actual, torturers.

7. Respecting oneself. The depressive has to find his comfort, reassurance, and self-esteem from within as well as from without. Otherwise his self-esteem is too dependent on positive feedback from others, and he himself is unable to give himself a needed vote of confidence.

Advice on How to Get Along with Others

1. Starting off on the right foot. Depression is often long in the making, the result of interpersonal errors made early and compounded over time.

A boss made his own work-related depression by hiring workers not because they were challenging enough to inspire him and motivated, cooperative, and passive enough to do the job, but because they were in some trouble from which they needed rescuing. Then he complained that no one worked as hard as he and that good help was hard to find.

2. Meeting people. Depressed people feel lonely. They ask themselves, "What can I do to feel less lonely?" and try one thing after another. One woman year after year tried to vacation where there were many men; a gay man tried one trendy bar after another; and so on. The real question the depressive must ask himself is not "What else can I do that I haven't already done?" but "What am I doing to avoid doing what I should be doing?" or if doing it, "What am I doing to assure its failure?" or if successful by accident, "What am I doing to undo what I have already accomplished?"

A patient who referred to herself as the proverbial woman who cannot meet a man, selected men to be as unlike her father as possible because of her incest fears, then found them uninteresting because of her father fixation. Another source of her problem was grandiosity: she was looking for men of such high quality that it was unlikely they would find *her* suitable.

In a similar case, a man was looking for the perfect 25 year old even though he himself was a rather imperfect 65 year old. He excused his behavior with a smile, saying, "I guess I don't see myself as I really am, but see myself as young, as I once was." Then he dismissed his insight by failing to change either his self-image or his expectations.

Both of these people complained, "I can't meet anybody suitable" or "New York is no place to meet a man/woman" or "I have the worst luck." Both of them became hypomanic, even frantic, rushing about from place to place in an oral orgy of drinking and experimentation with drugs, keeping late hours in bars and discotheques. But in both cases their inability to meet others, and the resultant worsening of their already existing depression, was not due to their fate, not

due to their stars, but due to themselves—created by, not for them, not only what they feared, but also what they wanted.

Conclusion: if a patient is depressed because he cannot meet anybody, assume that it is entirely his fault and ask him to change his ways. Some of the behaviors many patients must change are (1) being demanding, (2) being overly perfectionistic, and (3) being so regressively attached to parents that one is, so to speak, unable to get them out of one's bedroom.

3. Not blaming others.

One husband blamed his inability to get an erection on his wife's mutilation from her mastectomy, when he was in fact an isolated, remote, withholding, unfeeling person whose humiliation of his wife was but another symptom of his emotional disorder.

4. Being direct and forceful. Depressives passively hope for the best instead of arranging for it to happen. They do this because they fear that being active means giving offense or otherwise being destructive. To make matters worse, they are afraid of speaking up, saying how they feel, and asking for what they want, in words. They are even phobic about it, fearing it as some people fear heights. They rationalize their passivity by making excuses for the people with whom they should have been active. For example, to avoid setting limits, such as, "Please stop this, it annoys me" or "I warn you this can't continue," they say, "He wouldn't do this if he weren't sick. He needs cure, not punishment."

5. Avoiding being manipulated. Depressives allow themselves to be manipulated out of a fear of making trouble. They should set limits, for manipulation is ultimately as undesirable for the manipulator, for whom it is an infantile, unrewarding behavior, as it is for his victim, for whom it is a form of unfair competition.

Manipulators who are particularly toxic to depressives are those who buy dependency by eliciting guilt.

A patient responded to his therapist's plan to retire by threatening suicide. The therapist felt guilty about leaving him and agreed to continue, though at considerable personal expense. But after self-analysis he realized that others could treat the patient, and it would be less of a hardship for the patient to find another therapist than for the therapist to continue to practice when he wanted to retire.

6. Avoiding being provocative. In the long run it is better not to provoke others than to have to handle the consequences.

One patient upset her obsessional husband, who liked to have things ready in advance, by going for a swim shortly before guests were to arrive for an important dinner party. When the husband became furious, she decided, at great personal expense, "not to let it bother me because getting angry only shortens your life." An easier way to avoid shortening both her life and the life of her marriage would have been by being less defiant in the first place.

Another patient provoked disdain by his soft, vulnerable-appearing walk and proclamations of defectiveness. For example, when his neighbor said of a fey summer resort, "The people there are a bunch of idiots," the patient replied, "Like me?"

One provocative, sadistic husband, though wealthy, would not let his wife turn on the air conditioner until after checking the weather report to see if the temperature/humidity index justified air conditioning. He claimed he was saving money, but he was really controlling her—figuratively, by making the rules, and literally as well as figuratively, by stifling her.

7. Avoiding regressive relationships. Some depressive friendships and love affairs are really symbiotic relationships. Symbiotic depressive relationships are marked by excessive jealousy of the partner, often with an inability to let the partner out of sight for more than a few hours, and rarely overnight.

8. Avoiding sadomasochistic relationships. Some depressive friendships/love affairs are really sadomasochistic relationships.

One patient married a girl 25 years his junior, then constantly abused her verbally and physically, rationalizing his behavior by saying, "All couples fight."

For some sadomasochists, "who is doing what to whom" becomes everything, and what counts is the pleasure of the sadistic or masochistic triumph.

A surviving rooftop jumper afterwards confessed that he deliberately provoked the crowd's sadism, wanting to make them yell, "jump!" so that after he did they would feel guilty.

A suicidal note-leaver, even willing to sacrifice his life to make others feel guilty, attacked others by reassuring them in the negative when he wrote, "I want you to know that you didn't cause me to do this to myself."

Patients should be told to stay out of sadomasochistic relationships. They should explain why to the other party, but only once:

An adolescent, depressed because he loved his sadistic parents more than they loved him, resorted to pleading and begging in the hope that they would treat him more kindly. Instead this only inspired them to further sadism. He was told they were not going to change without therapy. He was allowed to state once how disappointed he was, tell them once what he expected, then "put the ball in their court," keeping a safe distance until they changed, avoiding painful and nonproductive argument, with recriminations on both sides, until then.

The lover's mother who never called except to unburden herself of her problems was told, "We can get together over dinner and talk of pleasant or unpleasant things of mutual interest, but you can't use us as a sympathetic ear with no needs of our own. These are our terms. You decide when you are ready to accept them, and we will be there."

A patient's brother, who lived just down the road, wanted a phone-pal relationship—frequent phone calls but not dates. The patient, wanting either a face-to-face relationship or nothing, told his brother, "Every time you call me to say hello but don't make a date

to see me, it just reminds me of the way you ignore and reject me. For me the phone calls make things worse, not better. So I won't take any more calls unless they are to make a date to get together. My terms: either make dates, and see me, or stop calling. Which, is up to you."

9. Understanding how others operate. Taking things personally is often the result of failure to understand why others behave as they do. How this is a factor is illustrated by a discussion of some common reactions to one's children and to paranoids.

A child's criticism of a parent should not necessarily be taken as a positional statement of the child's basic feelings about the parent. As often it is a manifestation of normal oedipal rivalry: a way to castrate the parent to render him less frightening; a way to soften oedipal rejection along the model of sour grapes; and a way to make the parent less desirable, so that the child will find it easier to leave him when the child grows up. The parent who understands this will not vacillate between rage and guilt but will instead recognize the child's negative feelings as part of a developmental phase, virtually certain to give way to more positive feelings later on, in a "postadolescent" rapprochement. Realizing this the parent can say, "I am sorry you feel that way, but I don't agree that this is the way it is," and not take it personally. He can avoid both a sadomasochistic struggle and an endogenous-appearing "mid-life depression" that is in fact a reactive depression growing out of relationship problems with the child.

The victim of a paranoid attack should remember that behind every criticism of another is a self-criticism and that "it takes one to know one."

10. Being properly assertive. The depressive believes that assertiveness alienates others, partly because he believes that others' basic positive feelings change to negative easily and with little provocation. He seems unaware that others like assertive people, if for no other reason than that they know where they stand. Unassertive depressives do not speak up and say what they mean. If they do, they often speak in generalities to hide real intent.

When one depressive said, "I don't want to be a burden to you," he meant all of these things: "I prefer to be alone in my suffering; I would rather hurt myself than you because I love you; I do want to hurt you, but I don't want you to complain about it; I don't want merely to be a burden to you—in fact, I want to destroy you entirely; and please talk me out of my folly of not wanting to be a burden on you, because if you won't let me be a burden on you, what else will I do and who else can I be a burden on?"

The recipient of multiple covert messages is angry because he suspects dishonesty, senses deceit, and knows he cannot win, since no matter how he responds he will address the wrong side of the ambivalence and so say the wrong thing. The depressive would be better off stating his position, clearing the air, seeing how the other fellow responds, and where indicated, negotiating.

The above-mentioned depressive was told to say, not "I don't want to be a burden on you" when he really did want to be a burden, but "I like being dependent on you. How do you feel about being dependent on me?"

11. Being aggressive. Many therapists share the belief with their patients that while assertiveness is acceptable, aggressiveness is not. But on the contrary, aggressiveness, like anger, is a valid emotion. It clears the air, sets limits effectively, and when necessary, effectively neutralizes another's depressing aggressiveness.

A patient returned to his parked car only to find he had unknowingly parked it illegally in an unmarked parking lot of a fast food restaurant. He was assaulted from the flank by the restaurant manager, abusing him for parking illegally and warning him ominously that, "next time your car will be towed."

He could have responded with, "I'm sorry, sir." Then he would have respected and loved himself for being a nice person, but hated himself for being a passive, defective, and as he saw it, effeminate man. Instead he identified with the aggressor—a useful emergency defense that all patients can employ to avoid minidepressions. He said to himself, "I will treat you just as aggressively as you treat me, even though this is a version of a childish 'you are one, too' attitude."

He had learned in therapy that it is not a bad idea to use the techniques of children. He had been told that one of the reasons that many children do not get depressed is that they know how to defend themselves against a depression, only to lose the capacity later in life from a sense of guilt.

Accordingly, he responded with, "I don't park when it says No Parking. But you have no sign up, so how was I to know?" In effect, he replied, "I am not a bad person; you are a fool."

Then he asked, "What's your name?" He had learned that this question rarely fails to stop abuse from self-proclaimed authority. It shifts the premise of the interaction from "what I did wrong" to "whether or not I am going to report you and get you into trouble." The accuser now becomes paranoid, and more often than not uses the remainder of the interaction to assure himself that he will not be reported to his boss or to another feared authority. In the meantime, he forgets about attacking his intended victim.

12. Not being oversubmissive to authority. The therapist should show the depressive how like a child he is: how he grants expert status to anyone who has a forceful personality and/or an official position and/or any degree and/or who, for reasons of his own, often inadequate, believes himself superior in status, knowledge, or experience.

Advice on Handling One's Critics

Even the masochistic depressive who thrives on punishment should recognize that the harsh critic is his worst enemy. Following are seventeen steps the patient and therapist may follow in learning to deal with harsh critics:

1. The depressive must learn to identify his critics and their criticism. This is because unjustified criticism is often disguised as justified and because many

depressives are so accustomed to being abused that they fail to realize how abusive others are—instead they accept criticism as if it were background noise. As someone who constantly hears noise only realizes how lovely and contented silence is when he goes to the country, the depressive who is being criticized only realizes how bad being constantly criticized is after he meets someone who likes him, is supportive, and is kind.

2. The depressive should recognize that he is only human, that it is human to become depressed after criticism even when the criticism is justified and constructive, and that depression will intensify if he cannot defend himself, if he cannot rebel against the critic, or if when he rebels he finds that his rebellion is ineffective. If the therapist fails to recognize the demoralizing effects of criticism, the therapist becomes part of the problem, one of the critical "them." Instead of minimizing the negative effects of criticism on people with a tendency to become depressed, the therapist should recognize that potential depressives are sensitive to criticism. This is because (1) what their first critics—their parents—thought of them when they were children has become what they think of themselves now; (2) they tend to reinvest the critic with the quality of potency and wisdom that as a child they attributed to their parents; and (3) they tend to abdicate to critics by allowing them to decide their self-worth, or talk them out of a self-worth they already know they have. For all these reasons the therapist must never say to the patient, "Why do you let your critics bother you?" "Why do you care what others think?" "We all have to take a little criticism, so why should you be any different?" or "Don't be such a baby." This implies that the patient is behaving badly by being oversensitive, instead of behaving in a way that is understandable for a depressive.

3. The therapist must recognize the often serious, possibly emergent nature of the patient's response to criticism. Criticism can shell-shock when it reminds the patient of an earlier trauma, leaving the criticized depressive no better off than the soldier wounded in combat: needing to be removed, debriefed, abreacted, and supported.

4. The therapist should advise the patient to take prompt action against his critics. After identifying them, the patient should make handling them his first priority.

5. The depressive should be helped to squelch his critics. The therapist can show him how inexact a science criticism is. There are no fixed standards for excellence. Even the best criticism is only one person's opinion, no matter how expert the critic, no matter what his official status, no matter how impressive his credentials, no matter how high his manifest self-esteem. The worst criticism is emotional, arbitrary, one-sided, and prejudicial. The therapist might recommend one of the many books on critical presumption, prejudice, cognitive error, and gaffes. To illustrate cognitive error, Constant Lambert, in his book *Music Ho!*, compared the apples of a rhapsody with the oranges of a concerto when he condemned Gershwin's *Rhapsody in Blue* for being a bad concerto.[1]

6. The depressive should learn ways to outwit his critics. He might do this

passive-aggressively: love the critic the more he hates you, so that he becomes guilty; beat him over his head with your bloody body, also so that he becomes guilty; and live well, as the best revenge. A more purely aggressive approach is identifying with the critic, employing offense as the best defense, facing the critic down and countercriticizing, turning the passive role into an active approach/attack, and by turning the tables giving the critic the depression instead, getting even instead of getting mad. As for the timing, one might throw the critic off the trail by accepting the criticism, then counterattack when the time is right for you, instead of defending yourself when the time is right for him. Finally, the depressive might consider starting a nuisance lawsuit to be reimbursed for pain and suffering endured, or (this is advice not meant to improve character but to cure depression) just to be mean.

It often helps to practice one's repartee in advance of an anticipated attack by a critic.

A therapist taught his patient to reply to criticism for an artistic life lived at the expense of financial success using a store of simple but valid self-justifications, obtained from song lyrics, along the lines of fish needing to swim, or from familiar quotations, along the lines of "*Ars longa, vita brevis.*"

7. In this step, which supplements the sixth, the therapist helps the patient recognize pathology in the critic, pathology that makes critical perception an early casualty. An example is excessive competitiveness in overgrown oedipal children. Another is fault-finding originating in a critic's paranoia, where criticism of others is really externalized self-criticism. A third is a transference criticism, and a fourth is identification with the critic's parents.

One critic recognized that he was responding to an artist as if the artist were his parent, by complaining that the artist "doesn't give me what I hope to get."

Another critic who identified with his abusive parents abused artists as if they were bad children. "They are upstarts. They have no shame. They break all the rules."

Another's "carping criticism" of musicians was a way to relive his own parents' nagging at him when he was a child.

And another repeated his parent's preference for suffering over enjoyment in his irrational condemnation of joyful music as inferior to sad.

8. The therapist offers insight-oriented psychotherapy for those hurt by criticism. Though many artists, unable to work because of a critic-induced depression, can benefit from short-term or long-term insight-oriented psychotherapy, it is done less often than it should be because:

- There is a general unawareness of the possible connection between creative problems, depression, and critical abuse.

- There is a general tendency on the clinician's part to accord the problem of detracked artistic production less status than the more classical neurotic and psychotic symptoms.
- There is a general tendency for the depressed artist to believe that he does not deserve to be helped, to feel, even when he believes that he deserves help, too defeated to go for help or, going for help, too defeated to accept it when it is offered.

9. The therapist teaches the patient to avoid bringing criticism upon himself. Depressives may be guilty about success because it revives forbidden oedipal wishes or guilty about hostile or sexual feelings. Or they may need to suffer because pain is pleasurable for itself or because one pain is less painful than another. For these depressives it is second nature to leave themselves open to criticism; to ask for criticism by deserving it; to ask for criticism by selecting others who are malignant, then standing by them; and/or to deliberately tempt fate by putting their heads in the lion's mouth, hoping that this time they will not be bitten.

One patient told her oncologist of her worries about a recurrence of her cancer, even though she knew his response would be not reassurance that she was well and to forget about it, but criticism for not recognizing that she had a potentially fatal, potentially incurable, illness from which she could die.

Because critics will not change, it is best to keep silent and avoid the topic, if not the critic, altogether.

The above-mentioned patient learned to handle her follow-up visits with her oncologist-critic by entirely avoiding a discussion of her illness. Instead she used her time, even though she was paying for it, to talk with him about his family, hoping he would not change the topic and remind her once again that her cancer could recur and kill her.

10. The therapist tells the patient to avoid submitting to his critics. The person who criticizes requires a response—a scream of pain—to achieve pleasure. Silent strength, because it deprives him of the pleasure of the kill, is the most effective weapon. The therapist should advise his patient, "If you have been weeping, never let him see the red of your eyes."

11. The therapist advises the patient not to become like his critics. If a parent, he should be told not to use excessive criticism in the training of his children. Whenever possible he should reward instead of punish, encourage and support, not discourage and humiliate. Using criticism to train children can harm them in a number of ways. The children identify with the parent and become critical people themselves. After forging a depressive association between activity/achievement and being criticized, they may go on to become like the cat who, forbidden to jump on the table, jumps on it, but only when his master is not home—a psychopath concerned only with not getting caught who continues to do what he is not supposed to do, but now in secret. Finally, phobia can appear

in children and go on to become adult phobia when sensible warnings are issued harshly, perceived as criticism, and internalized.

A man perceived the exhortation "Stay off the New York subway, otherwise you will get killed" not as a helpful warning but as a criticism of his riding the subway. He continued to ride it, but now behind his critic's back—denying he took the subway, saying he took the bus instead. Like a little child doing something wrong, however, he was terrified all the way, feared being mugged even more than before, and eventually developed a subway claustrophobia with newly intensified fears of being trapped and murdered by roving gangs.

Patients should also avoid criticizing their parents. Parents can be as hurt by their children, as the other way around. Just as children see their parents' greater age as a badge of expertise, parents see their children's youth as a badge of strength. A certain amount of intergenerational rivalry is creative. Too much is sadistic and hurtful, and the patient may later regret it and have a prolonged sadness-grief-depression when the parent dies.

In such cases the reaction to the death is typically biphasic. The critical child first thinks, "I am glad he is dead," then after six months or so, misses the parent even more intensely, partly out of a sense of guilt. Then he wants the parent back so that he can make it up to him, which now of course, except for patients who believe in magic, is impossible.

The patient should also avoid criticizing all old people because they remind him of his parents, because they are examples of what he fears awaits him in later life, and/or because their helplessness has provoked the patient's sadism.

12. The patient is helped to focus on self-realization. He should not let interest other than self-interest prevail exclusively, as it did with the altruistic patient who tolerated an abusive, critical mother at his great expense because he believed the mother's need for him was greater than was his suffering at her hands. A dangerous variety of this behavior is spending one's life catering to a mean parent while waiting for an inheritance.

13. The patient who cannot avoid protracted/intense criticism learns how to handle his reaction to it. For example, he learns that excessive anger is not only bad for the soul but the body as well, and he avoids prolonged, slow burns because they hurt his vessels and heart.

14. In a step that is also useful when protracted criticism is unavoidable, the patient looks elsewhere for the antidote, which is positive feedback. Patients who receive positive feedback flourish. They feel supported, do better work, and generally avoid behaving in a way that encourages further criticism. When it comes to positive feedback, once is not enough. It has to be obtained, maintained, and repeated at least daily. Sources of positive feedback are books, friends, and support groups whose thinking is the same as the patient's and/or who disagree with the patient's critics. Friends and support groups can also help the patient abreact his response to criticism, reality-test by giving him a second

opinion, and become a model for identification. (One psychiatrist began to write fiction after receiving treatment from a group whose leader, a psychologist, was also a successful playwright.)

A patient contrasted two friends' responses to his expressed self-doubts. One responded to his search for support by snapping at him with another criticism for his self-doubts: "Again you are doing it—you know perfectly well that you are good, why do you always have to question yourself?" Another responded, much more supportively, "I don't care what you say about yourself; I think you are great."

Especially useful in this regard is the supportive transitional object. Such a person can be defined for our present purposes as an individual whose current status and/or needs make him willing to support a patient while he is dependent and needs the support, yet is able to lose interest in the patient as soon as he feels better and wants to become independent again. A good example is the male homosexual "sister" relationship, a close relationship but one where at least one of the parties, and usually both, plans to abandon the other as soon as one or both finds a lover. In finding adequate substitutes, when there is something about a critical person the patient likes, he might replace the critical person with a noncritical person who retains the valuable characteristics.

Pets (properly matched to the patient) make good permanent transitional objects, as do people who need the patient too much to be overly critical, such as helpless children and the elderly. (Of course, one cannot abandon pets, children, and the elderly when *they* are no longer needed.)

15. In a step that is useful in serious/emergent cases, the therapist may advocate complete retreat. If the patient is depressed and unable to work because besieged by his critics, he should, if he can, take a vacation from work. This is especially true if he is forcing the work or is cramping or paralyzed or has a creative virus (all described in the section on critics in Chapter 11). If he continues working he may produce an inferior product, and if so the resultant negative feedback will create even greater despair and prolong his illness. When possible he should not resume his former activities until he feels more positive about himself. He might want to use his retreat to find the friend or support group he needs to prepare for his re-creation.

16. If it is the therapist who is the harsh critic, the patient should fire that person and find one who is less critical. Too many depressives stay in treatment with a therapist who gives the message, "You are no good; here's what's wrong with you," making them depressed each time they hear it. They do not get better, not because they have an intractable illness but because they have an intractable therapist. While many therapeutic comments are by nature somewhat critical, it is the wise therapist who gives a positive, not negative, twist to his interpretations and clarifications. All depressed people need to be told not "this is what's wrong with you" and asked to change, but "this is what's right with you" and stimulated to improve because they are fundamentally good people

who owe themselves the improvement. In group therapies, the good group is one that gives interpretations this way to its depressive members. It avoids picking on them in the guise of being honest, sending them home defeated because the group members have been sadistic or sided with a cruel, punitive mate or individual therapist.

17. This step is perhaps the most important. Though it is hard to accept unflattering things about oneself, the healthiest and most mature patients can use whatever is constructive about criticism to improve.

Setting Limits

A therapist who is unable to set limits allows his patient's pathology to become ever more insistent and his patient to become even more agitated.

A patient in long-term treatment made it his practice to detect therapeutic inconsistencies and demand that his therapist reconcile them. The permissive therapist obliged. This inspired the patient further. Then the patient became depressed, believing he had an incompetent therapist. Eventually the therapist, partly in self-defense, replied, "In treating complex emotional problems over the years, inconsistencies inevitably appear, so lay off." Not only did the patient's behavior improve, but his depression cleared.

Another therapist permitted his patient to call him at home at night whenever the patient wanted to—usually, as it turned out, when the therapist was settling down for a relaxing evening. The therapist resented this, and it showed. But he gave in for months, yielding to the patient's pleas that "I have no one else, so I need you." But the more he gave in, the more the phone calls increased and the more bothersome and terrifying they became, culminating in wild lamentations and suicidal threats.

A better approach was to give the patient less time, not more. The therapist said, "Stop calling me. You are making me anxious and angry, and you are making me the captive of your neurosis, with my schedule determined by your illness. If you call me I will refuse to talk with you about your problem. I will only talk with you to the extent necessary to schedule an emergency appointment if you need it. But you will have to travel to my office, have your session there, and pay for it." (Like most therapists, this therapist did not charge for phone calls.) That way, the therapist continued, "any interruption in my life will be both minimal and reimbursed."

The patient stopped calling, thanked the doctor for "putting him on a leash," explained how out of control he had felt he was getting, and admitted that he had really been testing his doctor to see how much he could get away with, hoping that he would not be allowed to destroy the doctor, whom he loved.

There was an additional learning factor here. Because this patient's father was remote and distant and his mother uninvolved, he had never been taught good manners. So for him bad manners represented as much an absence of knowledge of how to behave as a neurotic presence. He in fact compared himself to a feral child never taught to walk, who quite logically assumed that crawling was as good a way as any to get from here to there. This patient not only needed to have his bad manners analyzed, he needed to be taught good ones.

The following are some harsh but often life saving limit-setting approaches to take with depressives whose acting-out is escalating. In the following discussion the advice is either stated or implied. Also it is usually possible and always desirable to simultaneously use the more kindly approaches discussed elsewhere.

1. Advice to chronic complainers.

One patient complained because she broke her leg instead of her hip. "If only it were my hip I could have been operated on and it would have been all over. There is no operation for this leg; I have to suffer while it heals on its own."

Instead of being given sympathy, she was told she was an abrasive pessimist who always saw the dark side of life. She was asked to put herself in her listener's place and think how she might feel if she heard herself complaining in this way.

2. Advice to those who are treating their depression by taking it out on others. A patient may make others depressed by being belligerent or otherwise abusing them, especially if he does this to those who cannot protect themselves, either because they are dependent on him or because they love him too much to retaliate. The therapist should tell this patient that although he will feel temporarily more powerful and important, and this will temporarily increase his self-esteem, in the long run he will not only feel guilty but he will be alone, because as soon as they are able the others will retaliate or remove themselves.

One wealthy homosexual took as a companion a destitute young man twenty years his junior. He felt, "Others don't respect and need me, but he will because he's dependent on me." However, instead of caring for the young man, he abused him, partly to deal with his depression over his companion's comparative youth. He humiliated the young man for keeping junk food in the refrigerator and acne medicine in the medicine cabinet, saying, "It's like teen-age fun land all over this damn joint." Though the patient had done the rejecting first, when the youth finally left he became seriously and chronically depressed, partly as a way to never forgive himself for his behavior.

A depressogenic mother attempted to cure her own depression by causing one in her daughter. The daughter was caught in the relationship both practically and emotionally. She was caught practically because the mother followed the daughter wherever she went. (Once, after the daughter moved, the mother sold her house and herself moved to be close to the daughter.) The daughter was caught emotionally because of a need for punishment; because of a sense of responsibility for the mother; because of the fantasy that "a daughter's role is being a peacemaker"; because the daughter's self-image/self-esteem depended on her being kind to the mother; because of the daughter's love for her father, who never left the mother's side; because the mother maintained the pathological interaction by inducing guilt; and because the mother cowed the daughter by her criticism of her. For example, the mother put her down by responding to her legitimate complaints with, "You are being ridiculous," or to her deep-felt emotions with, "You are acting like Sarah Bernhardt."

The patient took it out on her husband, who became depressed himself, considered divorce, and finally issued an ultimatum: "Either it's your mother or me." About his

wife he said, "She's not the woman I married."

Her children also became depressed. Their grades fell; they got into fights; they formed antisocial gangs (one gang was formed to throw over portable toilets on construction sites); and they acted in self-destructive ways, for example, surfing in inadequately protective wet suits or arranging to be caught cheating on a test.

When the mother left for two months' vacation, the daughter's depression cleared; she and her husband began to feel as if they were on a honeymoon again; and the children's grades improved and their self-destructive behavior stopped. When the patient saw this, she limited her contact with the mother to major holidays, whereupon the mother developed a serious depression of her own.

3. Advice to triumphal masochists. Triumphal masochism is cutting off of one's nose to spite *another's* face.

One patient punished the boss by quitting, not because he wanted to leave but because he hoped the boss would suffer the agony of not finding a good replacement. Naturally, making this important decision via the silent hardship of depression perpetuated rather than resolved the problem, missed an opportunity to fix what was wrong, and created another in a long series of lifetime enemies. The patient should have asked himself not "who shall be punished?" not "How do I get an eye for an eye?" but "What's best for me?" He should not have exchanged the momentary enjoyment of the triumph of the kill for the long-term suffering of the masochistic triumph. He did not really want to leave. This was not really a bad job. The other jobs that were available were not better. He acted in haste, only to repent at leisure over how he merely exchanged the short-term satisfaction of spiting the boss (which the boss would soon forget, since it did not affect him personally) for the long-term sorrow of unemployment (which the patient would long remember, since it affected him both personally and financially).

The therapist who suspects that his patient's motivation in quitting a job is to get back at the boss should tell the patient to wait until he has scheduled a meeting to air his grievances and has given the boss time to explain his side of things and make repairs.

Among triumphal masochists we find those who deliberately relive a trauma best forgotten to enable themselves to abuse others.

As an example, the reader is reminded of the little boy who absented himself from his apartment to play doctor with the little girl upstairs. The mother was terrified when she could not find him. But when he returned, as we have seen; instead of expressing relief she cornered him behind a sofa and beat him unmercifully with a riding crop. Because the boy was unable to conceptualize the mother's terror over not being able to find him and thought the beating was for the game he was playing, having sexual feelings about girls became doing bad punishable things and being a bad person who deserved to be

abused. From then on he developed a fear of virility and a depression each time, as he put it, he "suffered the trauma of success."

But things did not stop there. Next he compounded matters by trying to extract gain from his horrible childhood and the abuse suffered from his mother. He used his childhood trauma to swathe himself in a protective passivity along the model of "I am ruined by my past." For this purpose he allowed himself to become depressed about being successful and even created his own bad luck, such as unfortunate encounters or life-endangering accidents, to keep him from success or stop it once it had started. Not content with this, he recognized he was on to a good thing when he discovered that he could use his trauma to retaliate, first against those who reminded him of his mother, and eventually against anyone who bothered or annoyed him. To them he complained about his bad childhood. Though he consciously believed he was abreacting an endlessly painful trauma, in fact he was getting his fill of anger and, where he felt he had been wronged, revenge against those he believed had wronged him. He replied to therapists who tried to reassure him that he would get over his childhood trauma in time with a hostile, "Baloney. You never do. Every day it gets worse." His injustice-collecting, demands for retribution, and escalating pleas for sympathy and compensation made the would-be helpers, not the trauma and not the depression, the new and ultimate target.

4. Advice to patients who are becoming annoying to others. Many patients who have suffered a loss complain that people reach out to them at first, then seem to ignore them. Their usual cry is, "I guess they just care for a while; then they forget about you and go back to living their lives. That shows you that we are all born to die alone." They overlook the possibility that they might have driven others away when, at the time they needed others most, they themselves were the most unpleasant to be around. Their friends and family feel that the depression is an attack on them. They sense the anger, and they wonder, "Is he envious of me because I haven't lost anyone, or because I'm healthy and he is ill?" Talking about how depressed one is and drawing others into the black mood and ill humor, though meant to be a way of relating, in fact creates an isolation that in turn creates more depression. The therapist must advise the patient to use his friends and family as the loving companions he needs at this time, not as targets for his existential despair. He should tell the patient that getting over depression involves the recognition that nobody wants to be around someone depressed, and he should advise him to keep his depression as completely to himself as he can.

In an example of the dangerous consequences of becoming annoying, a patient provoked her own admission to a nursing home:

An older woman became depressed following the loss of her husband. She took her helpless anger out on her family, hoping, like most depressives, to punish them (for nothing more than being happy) and be punished by them at the same time (for a semidelusional sense of responsibility for her husband's death). To retaliate for her present behavior and its reminders of past injuries suffered at her hands in childhood, they put her in a nursing home, though a home health aide would have been adequate. Like most

depressives, after the fact, the patient was shocked by what she had done to herself. She had only intended to punish herself psychologically, not to do real damage.

Once in the nursing home, a build-up of resentment made her even less able to accommodate to her new surroundings than would be ordinarily expected. She became very depressed and as a consequence of her depression became confused. The confusion was misdiagnosed as Alzheimer's, and she was transferred from the home to an intensive-care facility. Much of this could have been avoided by diagnosing and treating her reactive depression in its early stages.

Euphoria as well as depression can be annoying. Others sense the patient is forcing it. They do not find the patient as funny as he finds himself when he dresses in age-inappropriate outfits or cracks ill-timed and vulgar jokes. For him, having the depression, then getting it over with, might be much the better idea.

5. Advice to those who are destroying their physical health. The depressive who does not eat stresses his immune system, already stressed by his depression. If he now acts out by not taking precautions during sex, his stressed immune system may not be able to protect him as it once did. A homosexual man who was promiscuous for years did not contract hepatitis A until a personal loss left him and his immune system weak and depleted.

Overeating, overdrinking, and smoking not only destroy physical health but make the patient look bad and unappealing, putting him at greater risk for being sick and alone. He becomes obese from overeating, gets gray wrinkles and emphysematous facies from smoking, and may develop all the familiar negative consequences of drug taking. This is one urgent reason for the depressive to use any symptomatic loss of appetite to give up overeating, drinking, smoking, and taking drugs.

6. Advice to hostile drunks. The lay term "hostile drunk," when not used as a term of approbation, can be both more honest and more precise than the usual euphemisms. A hostile drunk is a depressed drinker who goes from characterological passive-aggression or hypomania when sober to explosive, impulsive, abusive hostile manic behavior when intoxicated. The usual explanation is that the alcohol releases pent-up hostility, but at least for some patients the drinking is merely one part of the disordered behavioral crescendo—a triad of drinking, cursing, and throwing things or hitting people.

The therapist should first tell the patient to apologize to those he has wronged. Then the patient has to stop drinking, along with any benzodiazepines he might be taking. The withdrawal period is long and difficult, especially when drugs are combined with the alcohol. The patient must endure perhaps six months of compensatory overeating and gaining weight, sleeplessness, mood liability, increasing rather than decreasing depression, restlessness, anxiety, and feelings of doom. But not only is it worth it, there are no real alternatives. (Some withdrawals should be done with the patient in the hospital.)

7. Advice to those who are blaming their fate on the world instead of on themselves. The therapist might suggest that they consider blaming themselves

for overreacting; making mountains out of molehills; being an alarmist viewing every minor setback as if all were lost; expecting and demanding too much (and always being disappointed); expecting the worst from everybody (thus assuring themselves that they will get it); or simply for being a difficult person, hard to live with.

One patient blamed provocative relatives when he should not be visiting them.

Another blamed the state of the world, though he viewed the world through the distortive lenses of his own depressed condition.

A third blamed his parents, the mother long since weakened by senility and the father dead, when he should be blaming himself for keeping them present in his living room and bedroom.

One homosexual man blamed his ill treatment at the hands of others instead of his own love for being ignored, abused, and otherwise traumatized. He handled becoming 50 by purchasing a new cooperative apartment, redecorating it to resemble a discotheque, blurring the distinction between himself and his apartment, then using his apartment to seduce young men, who predictably liked the apartment more than they liked him. At the same time he ignored friends and family who loved him and accepted him.

Another called his therapist a do-nothing, though he had exhausted his therapist's store of ideas by finding something wrong with each perfectly good suggestion.

Another condemned his therapist for refusing to hear him out, though he had been effectively silent session after session or, if talkative, had been speaking without saying anything.

Another provoked others to be sadistic, then complained of his mistreatment. He whined, worried, and proclaimed his vulnerability, which predictably elicited not the intended support but a paradoxical jab to the side.

He plucked a worry from the air whenever he found himself unpleasantly peaceful. His worries ranged from momentous fears of illness to trivial fears that a check might bounce or that he had contaminated his cooking with drops of dishwater from hands that he had previously put in the sink.

In the vulnerability category were his schlemiel behaviors, which included carrying shopping bags laden not with purchases but with the day's portables; wrapping his newspaper in plastic wrap and wearing gloves to avoid getting newspaper ink on his hands; overuse of umbrella and rubbers when the weather report merely predicted rain; and taking the sugar and bread home after a restaurant meal on the spurious grounds that they had been paid for.

Perhaps it was the correctly perceived attack that elicited a counterattack, as it was with his sugar taking, which in effect said, "The world has deprived me; I want some back." Perhaps it was his envy codified as low self-esteem: "I'm bad off," meaning "compared to you." He believed others would overlook his envy of them or, seeing it, pass it off, and he repeated the depressive lie to himself, "If they don't understand and forgive, then they are no friends of mine." But his best friends failed his "stress test" and paid him back in sarcasm, retaliation, and removal.

In another case with similar motivation and outcome, a depressed homosexual man having just lost his lover wrote to a friend, "I am so depressed; but what gets me through is my

happiness that you have been able to find the joy I miss; that means that one of us is lucky, I guess." The hostility was apparent, and the friend understandably retaliated by retreating from the relationship in order to avoid further passive-aggressive assault.

Considering that self-blame is one of the causes of depression, increasing self-blame to cure depression seems just the wrong thing to do. But depression is also the result of feeling no longer in control of one's destiny. Self-blame helps reestablish this control, both because it promises to stop the behavior and because it suggests a way out of it, which is reform, also within the patient's control.

8. Advice to those whose ideals and accomplishments are insubstantial because symbolic. Depressives use insubstantial props and petty triumphs to support self-esteem and create identity.

One depressed borderline patient put his initials on everything he owned, not only, as his analyst believed, because he was in love with himself or because he was uncertain about who he was and, without his initials to remind him, felt he would disappear into oblivion, but also because he was excessively elegant and refined. He also believed that having a beautiful country home and wearing the latest fashions in clothes was an achievement, as he put it, somewhat sardonically, equivalent to having composed the Song of Songs.

Another patient, a somewhat paranoid depressive, improved his sense of inner well-being by finding bargains. His thinking was, "I am a good person because I spend less, accomplish a concrete goal, and get back at the crooks who are out to cheat me." (In his calculations he invariably overlooked the cost of transportation and the value of time.)

These "petty-triumph" depressives not only do not accomplish anything substantial, but in a perverse but psychologically revealing outcome, eventually develop the very reputation they consciously try to avoid. The patient who dressed elegantly was considered a fop; another was immaculate only to be considered prissy; and a third was frugal only to be considered cheap.

9. Advice to those who are narcissistic.

One patient when insightful referred to himself aptly as a grand diva without a voice. (This patient was depressed because he felt there were no suitable apartments for him in all of New York—perhaps even in the entire world.) On the positive side, his narcissism both protected and motivated him. Motivated to find the ideal apartment to impress young women, he searched the city for months and found an exceptional apartment indeed. On the negative side, his need to best everyone he met was daunting, especially for those who were competitive with him because they were similarly inclined.

10. Advice to those who are spoiled and selfish. Spoiled, selfish patients gratify their needs without regard for the needs of others, or deliberately at others' expense. On the positive side there are the real advantages of self-ism; on the negative side the patient misses the altruistic pleasures, and eventually others resent him and retaliate.

Selfishness is an ingrained characterological behavior pattern difficult to give up. Successful treatment can take years. In the meantime, however, the therapist's very survival can depend on reducing or eliminating selfishness in the transference.

A patient did not pay his therapy bill, instead using the money to take a vacation on a tropical isle. The therapist's insistence on prompt payment was met with, "But it's a symptom of a problem you haven't yet cured."

The therapist responded, "True, but I have to be paid promptly, and that symptom may be the last one to go."

Benign Neglect

What should the patient do when he wakes up depressed; with a crushing weight on his chest, and cannot shake the mood—when part of his bad mood is feeling bad about his bad mood? The therapist should tell the patient not to panic, because there is a limit to the length of time a person can remain depressed. He should tell him that the person who meets the mood head on discovers it is an enemy that resists, even enjoys, direct confrontation. Instead it must be treated like an adult with a temper tantrum, one who will not be soothed. Argue with the tantrum and it grows; ignore it and leave it be and it becomes quiet and rational, as if on its own. Also, because due to intraday (diurnal) and interday (course of illness) variation the mood comes in waves, it will almost certainly get better, if not by evening, then at least over time.

It may also improve if something happens to change it, as when somebody encourages, rewards, or compliments the patient or because he has worked the depression through implicitly—by reassuring himself about a worry, solving a real problem, resolving a dilemma, or convincing himself that all is not lost. This favorable outcome is typical of patients whose depression is like a light that goes on to indicate that a worry is "running" and goes off when the worry has been resolved.

As an example of implicit resolution by rationalization: One patient worried about having an operation until he was able to tell himself that "all the men my age have had one, so going in for surgery is really a normal thing to do."

The man who convinced himself he had AIDS because he had licked a borrowed postage stamp reassured himself, "It's out of my hands; there's nothing I can do; it is in the hands of God; and I know God is merciful."

In conclusion, the patient should go about his business if he can, occupy himself as pleasantly as possible, and await expected improvement. He should also accept a certain level of depression as part of life, instead of expecting to feel normothymic all the time.

Environmental Manipulation

The therapist should consider environmental manipulation in the following situation: when the environment is responsible for the depression; when the environmental problems are not mainly self-created; when there is a way for the patient to influence the environment; and when the therapist is willing to take responsibility for a manipulation that misfires. Whenever possible he should minimize the considerable risks associated with environmental manipulation by suggesting reversible changes, like a sabbatical, instead of irreversible changes, like a divorce.

An appropriate recommendation was a change of profession for a recent immigrant who was depressed about his job. When he first came to the United States, he entered a mundane, low-paying profession; now he had matured professionally, was still young enough to change, and had a family willing to support him during the transition.

Group Therapy

The cliché "misery loves company" is ominous in its critical implication but unclear in meaning. Does it refer to innocents who like to associate with already miserable people, or to sadists who like to create new misery around them just to have companions in despair? The company-loving miserable ones of the first kind, but not of the second, are well advised to seek support groups. These groups might be formed of miserable peers, say, people similarly victimized, for example by the same trauma. The group provides a forum where the members can wear their pathetic-creature costumes proudly. Horror stories can be exchanged, terrible experiences compared, traumas relived and made to sound worse and more permanent than they are, and twice-told tales of the ways others have failed them repeated—tales of lovers who have abandoned them, doctors who have made the wrong diagnosis, given the wrong treatment or caused the illnesses they were supposed to cure or prevent, and children who have been ungrateful.

COGNITIVE/BEHAVIORAL THERAPY

If the depressed mood comes first (for example for biological reasons), then produces depressive thinking, then to change the thinking the therapist might change the mood, perhaps with biological intervention. If the depressed mood comes second, if it is the result of depressive thinking, to change the mood the therapist might change the thinking, with cognitive therapy. When it is difficult to know which came first and which takes precedence, both may be done simultaneously.

Cognitive therapy may not help for obsessive depressives. Because mood and thought are kept isolated from one another, correcting thought will not improve

mood. It also may not help depressives who use mood to submerge thought, hiding cognitive error and so making it unavailable for scrutiny.

As for behavioral techniques, the simplest can be the most effective. One effective behavioral manipulation is the use of reverse psychology, giving the stubborn negative patient permission to be in control as a way to actually encourage his passivity. Another is assuming the patient's guilt, telling the obsessional, "I will be responsible for any harm that comes from your actions."

The following aspects of depression can yield to behavioral treatment:

- The learned aspects, such as the secondary gain of the onto-a-good-thing depressions.
- The cognitive fuses, so that the patient can abort a mood in its early stages before control is completely lost.
- The cognitive-behavioral manifestations of the mood, such as worry.
- The ideational consequences of the mood, such as low self-esteem.

Some of the problems encountered in doing behavior therapy are as follows:

1. Patients who use emotional illogic and who respond mostly to intrapsychic not extrapsychic reality may not respond to the unemotional logic and actual reality that is the focus of behavioral therapy.
2. Patients may react as if they are being ordered about instead of treated.

To avoid power struggles, a wise behaviorist only treated problems after the patient took the first step toward a solution. Then he confined his intervention to difficult junctures in the newly opened behavioral passageways.

3. Patients may resent being asked to manage the unmanageable, as happens with some stress management programs.
4. Patients may resist, with their noncompliance taking such forms as negative therapeutic reaction, masochistic triumph, and a hypnoid flight into health.

A homosexual who wanted to get away from therapy because he disliked being shocked while looking at pictures of nude men in essence hypnotized himself to convince himself and his therapist that he had become heterosexual.

Reasons for resistance are fear of success, fear of the loss of identity associated with change, the allure of primary and secondary gain, preference for staying the same (a liking oneself the way one is), and dependency, where the patient avoids improving because he is afraid of terminating the therapeutic relationship.

As for treating gross trauma behaviorally, it seems logical to bring someone to the scene of an early trauma to revive it in an attempt to resolve it. But the result may be a reexperience without a resolution, or worse, abject terror with decompensation. Severe traumata with unmanageable sequelae may be best forgotten, not revived, while traumata that are injustice collections in disguise, attacks on others, and/or attempts to manipulate others for psychological or

financial advantage are traumata best analyzed, not forgotten, and not simply revived.

PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

Insight-oriented approaches are indicated when trauma repetition occurs in disguised form, often when the original trauma is one of absence, not presence, as when the trauma is one of being ignored. Such trauma repetition often has a diffuse, characterological cast, as illustrated by the following case:

> One patient fixed on people who did not love him so that he might "extract blood from a stone." People who did love him did not interest him because he was not seeking love but undoing hate—convincing himself, "I wasn't hated, or if I was, it doesn't matter because I am newly loved." Naturally, once he changed people's minds and made them loving, he lost interest in the relationship and rejected them. Then he became depressed because though he had done the rejecting he felt rejected, partly because his old rejection trauma was "still waiting in the wings."
>
> Others were then depressed because they were traumatized in the way he had been traumatized and because in order to abandon the relationship without guilt he had made the victim responsible for the breakup, usually for nothing more than inadequately discharging a victim role. His potential victims could avoid depression only by recognizing early on that they were being used and avoiding him, or if they really wanted to maintain the relationship, rejecting him first.

Understanding the dynamics should not be a goal in itself but have a specific purpose. An oral fixation is identified to permit growth; an infantile trauma is identified to permit abreaction; or a maladaptive defense is identified to be undone or replaced with an adaptive defense (e.g., reaction formation to replace projection).

Insight-oriented approaches are less satisfactory when there is limited insight (as when mood submerges thought); when the depression originates mainly with others' negative opinions/criticism/abuse (because the depression lasts as long as the abuse or until the patient finds another person to salve his wounds); and when excessive guilt and need to suffer generally retard or forbid improvement.

As for unipolar/bipolar depressives, psychoanalysis may be considered for the unipolar/bipolar patient between episodes of illness, when mood disorder so typically expresses itself characterologically.

There are two main advantages of psychotherapy over pharmacotherapy. First, it tends to be less invasive, roughly analagous to a medical as compared to a surgical approach. Second, it teaches the patient a method he can use to handle problems that arise in the future.

INTERPERSONAL THERAPY

By interpersonal therapy is meant a focus on the interpersonal manifestations of what are often fundamentally developmental, behavioral, cognitive, and bi-

ological matters. Infantilism, conditioned avoidance, alarmism, and genetically determined moodiness are examples of fundamentally noninterpersonal matters with manifest interpersonal consequences.

In interpersonal therapy, transference may be used less to resolve than to exemplify and teach. In other words, while both the analyst and the interpersonal therapist are open to transference communication, the interpersonal "return letter" is more often clarification, confrontation, and corrective emotional experience.

The cornerstones of interpersonal treatment are encouraging identification with the therapist, understanding vicious interpersonal cycles, and interrupting immediately gratifying, but ultimately self-destructive, manipulations.

NOTE

1. Constant Lambert. *Music Ho!* Stonington, Conn.: October House, 1967.

CHAPTER 18
Dealing with Others in the Patient's Life

GENERAL PRINCIPLES

When families complain about a depressed relative to his therapist, the therapist should use the complaints not as a confirmation of his patient's evil nature nor as ammunition against a patient whom the therapist dislikes, but as raw data that describe the patient's behavior outside his therapy session and give information about the way the family caused and currently maintains the patient's depression.

Whether family should be admitted to the treatment session itself is to be determined both by the therapist's orientation and by the nature of the patient's problem. For example, even a therapist who does one-to-one treatment exclusively should see the wife of a psychopathic depressive, if only to check the patient's story. Therapists should not limit contact to the immediate family when it is others who are causing the problem and/or are in a position to help cure it.

The therapist who treats both patient and spouse in couple therapy should avoid affixing blame and taking sides. He should be as even-handed as possible. Otherwise he will fall into the "spousal trap." Here the spouses work together to tempt the therapist into taking one spouse's side over the other, planning all along to join forces, close ranks, and gang up on the therapist when he does. For this and other reasons he should confine himself to expressing the belief that it takes two people to create one depressive, then go on to search for life's unnecessary mutual provocations.

In order to avoid revealing confidential information about a patient, the therapist who is seeing the patient's relatives, with or without the patient present, should limit his remarks to the patient's course and prognosis and to general advice on how, and how not, to handle depressives.

What Not to Do

There are traps for an unwary amateur who tries to treat a depressed friend or family member. First, when patients are already in therapy, encouraging them to talk about therapy outside of the therapy waters the therapeutic soup, sacrificing quality for quantity. Second, amateur analysts predictably detonate all the land mines ambivalent depressives lay. For example, criticizing a depressive makes him angry and guilty, while not criticizing him is misinterpreted as giving him permission to do forbidden things or as ignoring and rejecting him. Agreeing with the depressive that he has a right to be depressed alarms him ("I guess things are really that bad"), while not agreeing crosses him ("You don't understand and you don't care"). Excessive sympathy encourages the patient to maintain his illness for purposes of obtaining the sympathy, while lack of sympathy is perceived as remoteness and dislike. Giving advice is misperceived as pressure/exhortation/harassment/control, while withholding it and leaving everything up to the patient is misperceived as refusing to give a life raft to a drowning man.

What to Do

A therapist should advise the family of a depressed patient not to coddle him. They should ask him to act as normal as he can when in their presence. Any therapeutic intervention from the family should be limited to telling the patient that he is depressed, suggesting he seek appropriate help, recommending a therapist they think might be helpful, and giving positive feedback in the setting of continuing friendship, backed with regular phone calls and heartfelt invitations to visit. They should not give up after the patient's first refusal, because for depressives first refusals are not positional statements but tests of love, and the patient will eventually give in, either because repetition is the proof of love he needs or because he senses that others are about to give up on him. If the masochistic depressive complains to those giving the positive feedback that they are being nicer to him than he feels he deserves, this is best handled not with an apology or a retreat but with a summary, 'That's your problem, not mine."

SPECIFIC PEOPLE

The Boss

A boss must avoid the vicious cycle of destroying a worker's performance by criticizing him, then criticizing him for his bad performance. In other words, criticizing a worker is unlikely to improve his performance when it is the criticism that caused the worker's impairment and depression in the first place. It is both cheaper and more effective for the boss to undo what he has done by reversing

gears, apologizing, and giving positive feedback. This is not effective when things have gone too far:

A boss's apology did not suffice for a middle-aged teacher, depressed because, wanting to replace her with a younger teacher, the boss had asked her, innocently, he fooled himself into thinking, "Do you intend to stay around here forever?"

Parents

Instead of criticizing the acting-out child/adolescent for his acting out, the parents should try to understand their role in causing it, following the rule that most adolescent rebellion is really parental provocation. For parents, admitting their role in the adolescent's turmoil is often enough positive gesture to stop the acting out before it has reached a dangerous stage.

Spouse

A spouse should not harass his mate for such minor provocations as leaving articles strewn about. Instead the provocative behavior should be viewed as a meaningful communication, often one that contains within it a hint of what might be the harmful and what the helpful response. If one spouse is too tired or too preoccupied to put things away, the other spouse might reply not "You have to," but "I can help." If one spouse is retaliating for the use of cleanliness as control with the use of dirtiness as rebellion, the other spouse might respond not by calling the mate a sloppy so-and-so but by being less controlling. Because most spousal bad behavior is an attempt to get love and attention, giving love and attention stops most acting out.

One patient handled his live-in lover's sloppiness not by criticism but by keeping silent and straightening up himself. His lover so appreciated the positive gesture and was so relieved and thankful that he was not punished, that he became eager to clean up on his own.

If separation or divorce is being contemplated, the therapist, except when things appear hopeless, should first try to save the marriage.

One therapist told all feuding couples that in his opinion most marriages can be saved. The therapist said that most spouses, neither inherently evil intentioned nor malignant, will come around with a little love and respect; a little attention to their needs; a few apologies extended to make one party's bad behavior (should it continue) less appalling and hurtful (if this is the best the individual can do); and a promise of change, which helps if only because it removes the onus and sense of guilt from the victim. He concluded that divorce was like moving to a new house when you do not like the old house. By analogy, a simpler, more effective, less expensive solution would be fixing up the house one is already in. His favorite conclusion: "Don't move. Landscape."

If divorce appears inevitable the therapist should leave the final decision up the patients. He should not make it for them, but should confine himself to helping the patients implement a decision they themselves have made.

CHAPTER 19
Pharmacotherapy and Shock Therapy

PHARMACOTHERAPY

Antidepressants

As an orienting statement, depressions that are mild, secondary, reactive, cognitive displaying, acting out, and nonrecurrent tend to be manageable with psychotherapy, while depressions that are severe, primary, nonreactive, endogenous, mood displaying, non-acting-out, and recurrent require pharmacotherapy alone or a combination of pharmacotherapy and psychotherapy.

A secondary depression is a depression that is the by-product of another disorder, such as post-traumatic stress disorder, or is a relatively minor feature of a mixed disorder, such as a schizoaffective disorder. An acting-out depression is a disorder where the depressed mood is confined to a halo effect, surrounding central purposeless and/or self-destructive behavior.

Indications

Pharmacotherapy alone may be indicated for the uninsightful patient, for the patient who prefers pharmacotherapy to psychotherapy, as a way to help a patient become more amenable to future psychotherapy (unless the loss of motivation from partial relief counterbalances), and for the patient without a chemical imbalance who deludes himself into thinking he has a chemical imbalance and sees psychotherapy as a challenge to his delusion. In terms of preferring pharmacotherapy, patients without severe judgmental impairment should be allowed a vote in their treatment, especially since resentful abdications to others can in itself be a symptom of depression. However, the therapist must distinguish a real preference from a disguised wish to do things the hard way.

Psychotherapy may be employed to supplement pharmacotherapy when a biological depression is precipitated or intensified by life experience and/or intrapsychic factors. It may also be employed when the biological depression itself has become a life experience, with the cognitive and behavioral manifestations of the primary mood disorder taking on a life of their own, with removal habits, depressive world views, and job difficulty paramount and/or remaining even after the mood has lifted.

Complications

Antidepressants alone, without a covering agent, may increase paranoia by increasing rage; increase anxiety or cause a swing into hypomania via their amphetamine-like effect; or worsen addiction by superimposing an addiction to antidepressants.

Contraindications

Under no circumstances should medication be given exclusively as part of the therapist's agenda. One therapist gave medication to deny the emotional origin of depression, as a way to relive an unresolved countertransference problem with his own analyst.

Inappropriate Usage

Antidepressants may be ineffective/harmful when the depressed mood is really schizophrenic anhedonia.

Administration

Antidepressants should be prescribed in adequate dosage over an adequate time period. The patient must not use them as if they were aspirins for a presumed short-term effect. They should be started at a low dosage and the dosage increased to maximum. In time, after stabilization, the antidepressants may be withdrawn slowly, with the amount of each step in the reduction dependent on patient need, not capsule size. From methadone withdrawal we have learned the necessity of going very slowly when approaching zero, even if this necessitates shaving a tablet into fragments or crumbling it into dust. The anxiety and agitation of returning depression should be differentiated from the anxiety and agitation of antidepressant withdrawal, and the therapist should respond accordingly, in the first instance perhaps increasing the dose, in the second perhaps continuing to withdraw, but now less rapidly. (More on this is in Chapter 20.)

Medication for Insomnia (Other than Antidepressants)

Medication for insomnia is best employed for the short term. Sleeping medications are especially helpful under the following two circumstances:

1. The precipitant is acute, sudden, and short lived, which allows the medication to be readily discontinued.

2. The insomnia is associated with a discrete physical illness. Withdrawal is easier when any pharmacological addiction is associated with aversion, as was the case in the patient receiving chemotherapy for breast cancer, where the insomnia was due to nausea.

There is no good sleeping medication for the long term; sleeping medication is addicting, and also it rapidly becomes ineffective. The patient who tries one sleeping medication after another looking for nirvana should heed the words of the patient who called one popular benzodiazepine "Valium with a D" and another "Valium with an H."

If the patient cannot sleep, advise a banana or a milk-based food, like yogurt. These induce sleep both chemically and by reminding the patient consciously/unconsciously of the nursing experience. To minimize weight gain, the patient should save the calories from his lunch or dinner. Also helpful is the use of a sound machine, like a wave machine or an air conditioner.

Some patients lull themselves to sleep by playing music. A compact disc changer permits the patient to choose his own lullabies. If he leaves the choice up to others by putting the radio on, he will too soon discover that some announcers, because they envy him his sleep, play wake-up music just to get even. (One patient complained about lulling himself to sleep with classical music, only to be awakened in horror at 3:00 A.M. to a soprano recitation to music of the tale of Pinocchio.) If the patient has a noisy bedroom he might hire an acoustician.

If his bedroom is too hot or too cold, he should use a thermostat to adjust the temperature to his liking. When two people in the bedroom have a conflict over temperature, the patient should decide whether altruistic self-abnegation is more or less sleep-inducing than having his own way, factoring the partner's reaction into his decision.

Heroic measures are not indicated for insomnia. Not only will the patient eventually sleep, but he can probably function better without sleep than he thinks. Even if he does function poorly, that will not be the matter of life and death that he fears. Even if one day's performance can break a career, which except in unusual circumstances it cannot do, there are other things more important in life than work performance. For example, the patient might decide that it is more important to be addiction free, for himself, than to prepare a good report, for his company.

Finally, the patient should not be overly put off or annoyed by such bedroom events as a partner's snoring or restlessness. For one patient, remembering what it was like to sleep alone was enough to quiet his complaints about his partner's snoring. Sadistic behaviors like suggesting a tracheotomy for snoring, unless medically emergent and advocated by more than one consultant, are absolutely out of the question.

Two myths about insomnia are worth questioning. The first is the myth that one should always treat insomnia by getting out of bed, leaving the bedroom, and staying awake until fatigue sets in. This works for some, but for others the best plan is to stay in bed and lie quietly until sleep comes, all the while trying

to work out in self-analysis what it is that is keeping him awake. The second is the myth of avoiding wide-awake activities, like reading, in the sleeping room because this forges an association between staying awake and going to sleep. Introspective patients, like brooding obsessionals who are not very driven by such associations, may safely disregard such advice.

Palliatives

Barbiturates/codeine plus aspirin for depressive headaches are relatively contraindicated because of the possibility of habituation, dependency, and addiction. Laxatives for constipation can produce a paradoxical effect similar in principle to the nasal stuffiness that complicates the prolonged use of nose drops.

Stimulants

Amphetamines merely add a level of stimulation to a continuing depression.

Benzodiazepines

It is tempting to use benzodiazepine as antidepressants because they seem to have fewer adverse effects than tricyclics/monoamine oxidase inhibitors. However, benzodiazepines are usually less effective than antidepressants for depression and can be counterproductive if they destabilize the patient by causing anger outbursts/temper tantrums. (This effect is especially apparent when alcohol is used simultaneously.)

Vitamins

Vitamins may be useful for malnutrition, a symptom of depression, say a consequence of depressive anorexia, or a consequence of failed attempts to cure depression by dietary means. A patient attempted to cure a chronic constipation due to depression by eliminating all vegetables and fruits believed to be binding from her diet.

Vitamins may also aid in treating the social malnutrition found in subclinical depressives, especially those in large cities. There are the depressives of everyday life, whose depression manifests itself by a stinting on nutrition, having a bagel and coffee for breakfast, a sandwich and a soda for lunch, and a decorative but nonnourishing dinner, not only, as they tell themselves, because they are too busy, but also because they secretly want to injure themselves, perhaps to pay themselves back for their success.

SHOCK TREATMENT

Shock is used less now than before. It tends to bring on distortive fantasies, both on the part of the psychiatrist (some psychiatrists use shock as part of a

ritual exorcism) and on the part of the patient (many patients actually believe shock "blows out their brains"). Shock therapy was also really abused in the past—when it was used for trivial indications (some patients were said at the time to be given shock merely for weeping). There is a possibility of brain damage even when shock is done correctly. With the advent of effective pharmacotherapy, shock became a treatment of choice predominantly for depressions that are refractory to pharmacotherapy.

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CHAPTER 20
Dark Sides: Complications and Errors of Therapy

Every therapeutic modality may be said to have its dark side. Most analyses take a long time. Some behavioral modalities appear to be superficial and simplistic. Cognitive therapy overemphasizes thought over emotion and mood. Pharmacotherapy and ECT overlook causality and can have significant side effects.

Specific therapeutic techniques also have their dark sides. Getting a patient's anger out can make him guilty. Encouraging him to be assertive but not aggressive can leave him vulnerable to aggressive competitors. Telling him to get closer to others puts him at risk for being overwhelmed. And telling him to remove himself from others puts him at risk for feeling or being isolated.

Complications can appear even when treatment is appropriately prescribed and done well. An antidepressant may reveal a paranoia previously too well hidden to have been suspected, or an appropriately prescribed antidepressant may cause an idiosyncratic hypomania.

Though admittedly there is overlap, therapeutic errors differ from dark sides/complications. Though this is an oversimplification, it may be said that dark sides/complications are the unavoidable results of treating complex human beings with multifaceted problems using complex therapies, while therapeutic errors are actions that could have been avoided with greater knowledge, sensitivity, and/or care.

FALSE ERRORS

An example of a false error is a mutual misunderstanding, for example, one due to a mismatch between patient and therapist. It may be that a therapist's reasons for doing therapy (e.g., to decrease dependency) do not match the patient's reasons for having it (e.g., to be a more successful dependent). It may

be that the therapist is not pitched to the patient's level of abstraction, as happens when the therapist gives complex, subtle, layered, convoluted, highly intellectual interpretations to a patient who thinks simply and concretely, say, in terms of being all loved or all hated. Or it may be that a given therapist's style is wrong for a given patient. Some depressives like an active therapist who orders them to submit to a manipulation or take a prescription. These will dislike a passive therapist who encourages self-discovery and self-realization, avoids giving direct advice, says everything by innuendo or revealing association, and generally eschews simple heartfelt, direct responses.

One depressed patient described it this way: "I appreciate his teaching me to fish instead of buying me a meal, but until I learn I have nothing to eat. I am left floundering—my independence intact, but my life shattered."

Another depressed patient said, "He was so distant I tried suicide just so I could get his attention."

Depressives whose dependency is ego-dystonic may dislike active therapists because they perceive them to be infantilizing them and making them more dependent than they want to be.

TRUE ERRORS

Misdiagnosis as a Reason for Mistreatment

There are different ways to misdiagnose depression and different consequences of improper diagnosis.

Overdiagnosing

Some clinicians diagnose depression in the presence of illness, but in the absence of such signs/symptoms of depressive illness as depressed mood, or in the presence of such nondepressive signs/symptoms as schizophrenic anhedonia. Some even go on a "witch hunt" for the abominable depression. Then, after predictably finding what they were looking for, they extrapolate to conclude that depression is the root of every behavioral tree, postulate a depressive core or heart for nondepressive pathological behavior ranging from addiction to homicidal paranoia, then set about enucleating nonexistent depressive cores psychotherapeutically or with drugs and/or shock.

The recent literature refers to these practitioners as "affectophiles." These affectophiles often treat depression when another, more significant, disorder requires treatment. In a typical scenario a secondary depression is treated while treatment of the primary disorder is administered incorrectly or withheld. In a secondary depression, the depressive response is to another emotional or physical disorder, not much different from the way any severe illness, emotional or physical, can cause the sufferer to become depressed. Schizophrenics, obses-

sives, phobics, and patients with recurrent anxiety or panic attacks commonly have secondary depressions, and it is the underlying disorder, not the depression, that should receive the lion's share of the attention.

A patient with a primary post-traumatic stress disorder became depressed each time she had a recurrent dream. One depressive episode followed the dream, "My son was stabbed by men who entered the house." (The dream itself was essentially a reproduction of the details of her own trauma, here displaced onto the son.)

Still others diagnose depression from depressive-like symptoms that are in fact part of another syndrome. Because symptoms characteristic for depression are also characteristic for other disorders, most depressive symptoms have a differential diagnosis. A simple medical analogy is the sore throat, which may be mechanical, viral, or streptococcal, or the so-called cough of flu, which may be revealed on X-ray to be the cough of pneumonia or lung cancer.

A patient was misdiagnosed as "depressed" because she was unable to relate to others. But further evaluation indicated that her "depressive inability to relate" was really paranoid, characterized by an inability to meet people because of a fear they would spot her blushing and a conviction that they could read her secret homosexual thoughts. When given an antidepressant she became overtly suspicious and homicidal. This was attributed to a side effect of the drug but in fact was caused by the drug working too well: by removing depressive contaminants, the drug exposed the patient's underlying paranoia.

A patient who lost interest in sex was treated for a depression even though the real reason for his loss of interest was a retentive obsessive cheapness that even prevented him from treating a girl to dinner.

Another patient was misdiagnosed as depressed because of loss of interest both in his work and in his relationships with others. Actually, however, interest was not lost but was obsessively neutralized and undone out of guilt and fear of success.

Self-diagnosis too often is allowed to prejudice the clinician's diagnosis of a case. Schizophrenics who self-diagnose a depression should not be referred to depression clinics where therapists routinely get the anger out. Depressed patients who want treatment for "causing my family difficulty" should not be treated exclusively as part of a "family in crisis" without being also treated separately for their depression. Though the same health-giving message can be conveyed in different "languages"; though any one treatment has a wide range of applicability (e.g., shock can help schizophrenics and depressives alike); though different treatments are more alike than otherwise (the analyst who does not comment on a patient's worry is conditioning him behaviorally not to worry); though successful outcome usually depends as much on the talent, training, and attitude of the therapist as on the type of treatment given; though much mistreatment is merely theoretically so, and so-called mistreated patients usually get no worse on account of their mistreatment and often get better, nevertheless, some mistreated patients will deteriorate, especially paranoids asked to get the

anger out and/or given activating drugs without covering medication. In fact, the resultant agitated suicidal states we read about, incorrectly attributed to "side effects" of drugs correctly used, are often ill effects of drugs incorrectly used—because the patient is suffering from paranoia, not depression.

Other clinicians diagnose depression in the absence of illness. This happens when normal moodiness is misidentified as depression. Here the clinician fails to distinguish getting depressed from having a clinical depression, the symptom from the syndrome.

Underdiagnosing

Here depression is missed—particularly tragic for acute simple reactive depressions that become chronic because effective measures have not been taken.

Biological Reductionism as a Reason for Mistreatment

A biological reductionism that overlooks stressors or relegates them to a minor role may lead a therapist to falsely call an emotional depression a chemical depression, treat it pharmacotherapeutically instead of psychotherapeutically, and then blame treatment complication/failure on side effects of or nonresponsiveness to medication. The following cases illustrate the therapeutic consequences of this:

A 56-year-old married woman suffered from recurrent depressions every five years. The therapist considered these "unipolar" or "endogenous," a mislabel, since in fact they were a reaction to specific stress.

Treatment with medication without psychotherapy had been moderately successful in the past. Now, however, she became paranoid following treatment with fluoxetine hydrochloride. Though believed a side effect of the medication, the paranoia was due to anger with her therapist. She thought, "He gives me drugs, but he refuses to listen to a thing I have to say about myself."

A man in psychotherapy for twenty-five years turned 65 and was dropped by his therapist because "I don't take Medicare patients." At the same time, his mother, his only living relative, became senile and so remote. Even in the presence of these obvious precipitants, the diagnosis of endogenous depression was made and pharmacotherapy without psychotherapy recommended.

A 45-year-old woman described her depression as chemical, saying in effect that its premenstrual timing eliminated the possibility of emotional cause. Nevertheless, the depression improved during the psychotherapy session after she resolved a problem with her husband and confessed that she was guilty about her secret wish to leave him and move to Florida.

A 47-year-old man became depressed each Easter, though he could not think why. Light treatment and pharmacotherapy were ineffective. In time, psychotherapy revealed that his loneliness intensified around Easter because "everyone else is emerging from the long, cold winter and I have no one to emerge with, and no place to go."

A 43-year-old psychiatrist's self-diagnosis of his depression as chemical was a "not-me"

view that disinvolved him from his own depression by medicalizing it, by comparing it to a foreign body in the eye. "It's not me but my chemistry" really meant, "I'm not to blame for being weak."

Even when therapy based in biological reductionism works brilliantly, this may be due not to the therapy itself but to the chimera of the theoretician and/or to the patient's eagerness to please, submit, and deny reactivity in order to have a positive relationship with the therapist.

In conclusion, the therapist unable to make a correct diagnosis and a complete differential diagnosis may give his patient antidepressants for a nonexistent depression, antidepressants when a talking cure would be more effective, or a talking cure when antidepressants are needed. He may also do harmful psychotherapeutic things like making paranoia worse by getting the anger out; uncovering sexual and hostile fantasies that, because they cannot be handled by a fragile (for example schizophrenic) ego, are best left covered; or decreasing guilt when more, not less, guilt is needed.

Errors of Omission

Some resolute psychoanalysts overlook the significance of the here and now.

A noncredentialed analyst told his psychiatrist patient, depressed after he moved from one office to another, that he suffered from "childhood reminiscences relit" and recommended analysis of his maternal transference to his office. In fact, however, the stress was really from the psychiatrist's patients' complaining all at the same time about the change and punishing him for making it. The cure: simple forebearance until his patients became accustomed to their new surroundings.

In brochure superficiality, the clinic's or therapist's seductive press release says it all. Special care is promised, but run-of-the-mill, bland, unexceptional therapy is given.

Countertransference Errors

Unprovoked by the Patient

1. Lack of empathy. Lack of empathy, though usually blamed on innate insensitivity, is more often due to emotional/cognitive preoccupation or countertransference anger/paranoia.

Lack of empathy due to paranoia was expressed in epithets directed at a patient: "resistant" and "unanalyzable." The epithets obscured the real problem, a blaming of the patient along the lines of, "It's not me, it's you," for questioning an interpretation that was but

partially correct, for discounting one that was wholly incorrect, and for not improving from drugs that should not have been prescribed.

2. Rigidity. Rigid therapists thrive and prosper because there are few universally accepted standards for diagnosis and treatment.

A well-known shock therapist had a secret wish to give ECT to all depressives, expressed in the following Freudian slip. When announcing a speaker with impressive credentials, instead of saying, "We are all deeply impressed," he said, perhaps hopeful of his own improving finances, "We are all deeply depressed."

Another well-known shock therapist appeared to view the depressives of the world much like apples that needed to be cored, with depression a devil that needed to be exorcised or a contaminant that needed to be sterilized—in each case by shock. Be aware that he told the patient not, "I need to core you like an apple, exorcise your demon, and clean the evil out of your system," but "in my medical opinion you need six to twelve ECTs."

Provoked by the Patient

Depressed patients often make their therapists angry. If the patient is not taken to task, the therapist may unnecessarily blame himself and have the patient's depression for him.

One patient devoted his therapy to putting his therapist in a no-win situation. When told to relax, he said he was made more tense because he felt ordered to do something he could not; when reassured, he said his therapist overlooked the gravity of his plight; and when exhorted to "act better, you can do it," he said he was being accused of deliberately and willfully simulating illness.

The therapist must resolve his countertransference anger, to avoid retaliating and wounding the patient in such a way that the patient carries the therapist around for the rest of his life as his "red badge of treatment."

In a typical retaliation a therapist undermined an isolated schizoid depressive who delighted in his apartment, which he called his "life saver." The therapist, angry that the patient had an apartment better than his own and feeling the patient was rubbing the therapist's face in it, squelched the patient's delight by reminding him that his real goal was not having a beautiful apartment but meeting people and developing close relationships.

Errors in Pharmacotherapy

Errors of Cognition

No pharmacotherapist should be entirely convinced that in its present state of development pharmacotherapy reverses a specific biological disorder, as vitamin C reverses scurvy.

Errors of Administration

Some therapists underdose with antidepressants, then proclaim the patient or his illness refractory, while others overdose with antidepressants, then have to stop the medication prematurely on account of side effects. As a general rule, antidepressants should be started at a low dose, the dose increased slowly and gradually to maximum therapeutic level, the drug given adequate opportunity to work, and the patient carefully monitored both for drug and side effect. It is ineffective or dangerous to start a patient on the maximal dose of a drug and then not see him regularly, or at all. The side effects of a drug should be distinguished from worsening symptoms of depression, and the dosage decreased or another drug substituted. When a patient is being withdrawn from antidepressants, signs of withdrawal from antidepressants should be distinguished from a recurrence of the depression itself. In the first case it may be necessary to slow the withdrawal, while in the second case it may be necessary to reinstate the original dose.

Cross-cultural Misunderstanding

Because "normal" mood differs from culture to culture, therapists from different cultures may disagree with one another as to what constitutes normal and what pathological mood for a given culture. The diagnosis of depression tends to be overmade in patients who come from manifestly reserved cultures, while the diagnosis of hypomania tends to be overmade in patients who come from manifestly more emotional cultures. Too, the manifestations of pathological mood can be subtle enough to elude evaluators from cultural backgrounds different from that of the patient they are evaluating.

Poor Technique

Scattershot Therapy

An uncertainty of therapeutic direction confuses and disorganizes the patient and conveys a sense of urgency or panic that gives him the feeling that he is sicker than he thought.

Overlooking Resistances

1. Cynicism. Unless explained, some treatment approaches virtually beg to be ridiculed. (Explanations are properly withheld when the therapist is employing suggestion/placebo effect.)

A patient ridiculed his therapist's stop-thought therapy. (The therapist asked the patient to obsess out loud, then yelled stop in the midst of his obsessions.) The ridicule ended when the therapist offered a simple explanation of the principles of aversive conditioning.

A patient ridiculed his therapist for doing music therapy, until the therapist explained that even if music has no special powers it is at least a soothing diversion, and attending concerts is at least a worthwhile social activity.

2. Displacement. Patients admit to a chemical imbalance to avoid admitting to intrapsychic conflicts, use insight into their past to avoid understanding their own contribution to their present, blame reality to avoid blaming themselves, and/or blame themselves to overlook such unpleasant reality as a loved one's malevolent intent.

3. Seduction. A self-destructive patient may persuade the therapist to allow him to "cut off his own nose to spite someone *else's* face," and to be self-destructive with the destruction of another in mind.

Double-binding the Patient

Therapists anger, confuse, disappoint, and panic their patients by telling them what to do, then punishing them for doing it; ordering them not to do something, then when they do not do it accusing them of being uncooperative; and telling them to do something that does not work, then holding them responsible for the failure. In a typical double-binding scenario, a patient is told to say everything that comes to mind without fear of consequences, then is attacked and expelled because he says something the therapist does not like to hear.

Giving Bad Advice

Therapists should recognize the dark side of some oft-given advice.

1. "Remember that life is short." Most patients know this already. Not only are they not inspired to health by being told that "life is too short to make yourself suffer this way" and commanded to think about what they are missing or generally to cheer up, but they respond negatively, because they hear that they are mortal and will die.

2. "Cheer up." Instead of telling a patient to cheer up, it is better to tell him to occupy himself as well as he can while his depressed mood improves—putting his mood on the back burner, so to speak, ignoring it, and checking back with it every once in a while to see if it has lifted.

3. "Be a nicer person." It is unwise to be nice to others who do not deserve it or misuse it by taking advantage.

4. "Get the anger out." This is a psychotherapeutic technique that has been much overdone, for at least four reasons:

- Depressed people need more friends, not fewer, and even normal assertiveness can insult, humiliate, and hurt.
- The person to whom the anger is directed may dislike angry people. If he himself is an assertive person—or is receiving the same assertiveness training as the patient—he may counterattack.

- Anger makes depressives feel guilty, and when a depressive does something that makes him feel guilty his depression increases. Depressives should always behave in a way for which they can later be proud. Then they will know they have behaved as well as they can, and for this they will be able to give themselves a vote of confidence.
- Being constantly angry suggests a degree of ongoing involvement that is often excessive, often inappropriate. The angry depressive should ask himself, "Why am I so caught up in this? Why am I letting it get to me? Do I have to pay this so much mind? Can I put it behind me and think about something else more important?"

5. "Keep busy." This fails when the patient is too anergic to follow the advice.

6. "Don't care what others think." It is impossible for most depressives, concerned as they are with being loved and accepted, not to care what other people think. Because consensual-group validation is a better remedy than denial, the therapist should tell the patient to remove himself from people whose thinking he dislikes and find others who think the way he wants them to think, and/or who think the same way he thinks.

7. "Don't let little things like that bother you." This is destructive criticism for a patient whose illness is mainly composed of letting little things bother him.

8. "Look at the important things in life." This is better than "Don't let little things . . . " because it is a suggestion, not a criticism. But it can supplant what is important for the patient with what is important for the therapist.

9. "Devote yourself to your work." This expresses a preference for work over rest and love, along the lines of the above-mentioned "Look at the important things." Also, if patients afraid of success are told to devote themselves to their work, they will often become anxious and depressed.

10. "Give to others who are worse off than you are." Giving to others makes some people proud but depletes others further—especially depressives who already pay more attention to the needs of others than is healthy.

11. "Go on a long trip." Long trips make many patients anxious because they feel isolated and alone.

12. "Quit your job; retire." The patient may find it less depressing to be working than to have no money and nothing to do.

One patient, with justification, blamed his therapist's advice that he retire for condemning him, in effect, to a lifetime of deadheading flowers, which he called "petunia pulling."

13. "Be true to yourself." Self-fulfillment is impossible for the ambivalent patient until he knows which side of the ambivalence to fulfill.

14. "Start all over again." Therapists tell patients they are young enough to get a divorce, start a new career, and so on, often when they are not. They give their patients this advice to reassure them that they can still do the same things now that they could do when they were young and that they are not too old to change. But the wise therapist knows that with age comes restrictions, and every

day that goes by makes it too late for something. He recognizes age-inappropriate ideals as clearly as he recognizes age-inappropriate behavior. Quite pathetic in the late 1970s and early 1980s were people at a relatively advanced age being told to divorce their perfectly adequate mates, only to find, as one patient put it, that "a trip to the disco was no substitute for a trip to the shopping mall." For many patients, belittling what they already have is not part of the cure but part of the disease.

Patients who get a divorce often find that the next marriage is like the last, and not necessarily because the patient acts out the same pathology over and over again. First, as one philosophic patient said, "All marriages are rather alike; it's in the nature of the beast." Second, a depressive's evaluation of his current marriage is often based not on its reality but on the reality of his depressed mood. In other words, though the patient thinks his marriage puts him in a bad mood, it is as often that his bad mood puts him in a bad marriage.

One therapist told his patients that he considered a marriage successful using the yardstick of there being more advantages than disadvantages. He also told patients who wanted to get a divorce because the honeymoon was over that all marriages have two stages of romance, acute and chronic, the first hot but transient, the second warm but permanent, each rewarding in its own way.

15. "Try to keep the family together. Visit on the holidays." This does not work if the patient finds the holidays are a source of stress and erupts after every holiday visit. Such a patient should visit at other times or not at all.

16. "Improve yourself: lose weight, dress better." Such depressive equivalents as sloppy appearance are there for a reason. Some dress sloppily to tithe to their punitive conscience, and some obese people use their obesity to avoid being envious, criticized, rejected, or raped. Indeed, one way to make depression worse is to push a patient out of the comforting shadows before he is ready, if he is ever ready.

17. "Be moral; guilt and remorse are moral." Self-control is good; self-evaluation is good; constructive self-criticism is good; but guilt and remorse are excessive replies to understandable human imperfection, peace offerings to critics, or instruments of self-torture. Instead of confusing guilt with being a good person, one should be a good person by correcting the errors and ways that created the guilt.

18. "Get a pet." Some pet therapists underestimate the liabilities of pets. Pets are loving; pets are companions; but pets are sometimes a nuisance. A dog that barks constantly may be a great annoyance. A pet that requires so much care that the patient is kept from traveling to visit relatives, creates the very loneliness it was intended to relieve.

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ABOUT THE AUTHOR

MARTIN KANTOR is a psychiatrist currently on the staff of the East Orange Veterans Administration Medical Center, Brick, New Jersey. With more than twenty years' experience in psychiatry, Dr. Kantor has been active in residency training programs at several hospitals, including Massachusetts General and Beth Israel in New York. He also has served as assistant clinical professor of psychiatry at Mount Sinai Medical School. He is the author of several books; these include *Problems and Solutions: A Guide to Psychotherapy for the Beginning Psychotherapist* (Praeger, 1990) and *Diagnosis and Treatment of the Personality Disorder* (1991). As coauthor of a number of journal articles, he has written on post-traumatic stress disorder and the musical expression of psychopathology.