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Managing depression – psychoanalytic psychotherapy, antidepressants or both?

The severity of the psychopathology of patients with depression can vary enormously. Some may be receptive to analytic psychotherapy, while others require treatment with medication. An analytic framework of understanding still has a place in work with the latter group, and can aid general psychiatrists in relating to their depressed patients. When trying to understand and relate to patients with depression, Freud and Abraham's seminal papers remain as clinically relevant, nowadays, as when they were first written (Abraham 1924; Freud 1917). Analytic thinking can help us to make sense of many of the symptoms of depression, including early morning wakening, diurnal mood variation, agoraphobia and hypochondriasis. It is also important to help the supportive relative with their countertransference experiences, when their partner is undergoing a depressive episode.

In this chapter I conceptualise depression as a situation where a pathological ego-destructive superego has taken over the driving seat (O'Shaughnessy 1999). In the treatment of depression, we aim to unseat this pathological superego and replace it with a more benign and mature superego that fosters ego development. Understanding depression in this way can provide an overall framework of approach to the treatment of this debilitating condition, whether we are treating the patient with antidepressant medication, psychotherapy or both.

In order to understand depressive illness, we also need to distinguish it from other causes of low mood and recognise its special psychopathology. Freud's seminal paper, 'Mourning and melancholia' (1917), helps us to go beyond ordinary empathy by recognising the

underlying narcissistic structure. However, Freud's insights are usually not incorporated within general psychiatric training and practice. Conversely, I would argue that psychoanalytic therapists do not think enough about depression in terms of a psychotic disorder, nor, as a rule, do they consider when medication might be needed in this context.

Different meanings of depression

We need to be aware that there are four quite different ways that we may talk about depression. Edith Jacobson (1978), in her studies on depression, referred to them as normal, neurotic, psychotic and grief reactions.

Normal depression

Jacobson's normal depression is akin to what Melanie Klein referred to as the depressive position. It is essentially a state of health, a capacity to bear guilt, stay in touch with mental pain and emotional problems and bring thinking to bear on situations. In Kleinian terms, we oscillate between our ability to stay with painful situations or seek temporary relief through splitting and projection, returning to the paranoid-schizoid position, or flight into manic idealisations (Segal 1973b).

Neurotic depression

Neurotic or reactive depression can be understood, simplistically speaking, as an exaggerated response to stress due to low ego strength combined with a failure of the external support system. Such depression is basically a cry for help.

> An asylum seeker was admitted to hospital after running in front of cars. A flatmate reported that he had tried to jump out of a window until he was restrained and then took a few paracetamol tablets. He clinically presented in a withdrawn and retarded state, as if undergoing a severe depressive episode, but was fine the next day after we indicated that, if

contacted by his solicitors, we would write a supportive asylum appeal letter.

Suicide attempts in cases of reactive depression can be seen as a wish for temporary oblivion and a cry for help in relation to clear external precipitants, such as a family row or break-up with a boyfriend. In such cases a supportive response from the carers can be sufficient to deal with the crisis and medication is not indicated. In contrast, in suicide attempts by patients with features of psychotic depression, who are typically older, there is a real intention to kill themselves, and the treatment would typically involve medication and admission to a psychiatric hospital (Lucas 1994; Stengel 1964).

Grief reactions

In 'Mourning and melancholia', Freud (1917) movingly described the process of mourning. In grief we try to turn away from reality and cling onto the lost object through a hallucinatory wishful psychosis, such as hearing the voice of our lost loved one. However, in submission to the reality principle we eventually have to relinquish the external object and reinstate it as a memory inside us. To do this we have to go through the work of mourning (Freud 1917).

Freud highlighted the similarities of mourning with melancholia, a condition that would now be referred to as a severe depressive episode (ICD-10: WHO 1994). In melancholia too, Freud surmised that a loss must have taken place; however, the nature of the loss in melancholia is more difficult to discern. He concluded that it therefore must have been an internal narcissistic loss, occurring at an unconscious level, and requiring to be understood in its own right (Freud 1917).

Psychotic depression

In modern day terminology, Jacobson's psychotic depression would be termed a severe depressive episode with psychotic symptoms (ICD-10: WHO 1994). Depression is, in fact, a very common condition. Some 3 per cent of the population are seeking help at any one time, another 3 per cent who remain undetected are struggling on their own in the community, while 10 per cent also undergo manic

episodes. In manic depression, there is a 15 per cent risk of suicide, and up to 50 per cent of patients may have visited their GPs in the few weeks preceding suicide (Gelder et al. 2001).

It is useful to be familiar with the clinical presentation, as otherwise, if the patient does not complain of depression but only emphasises one of the many commonly experienced symptoms, one may fail to realise that the symptom is part of an underlying syndrome. The typical symptoms, familiar to all practicing psychiatrists, include the following: diurnal mood variation, early morning wakening, and psychomotor retardation – a slowing up of all physical and mental processes – with resulting loss of appetite and weight, decreased libido, amenorrhoea, constipation and retardation (stupor). Other features include agitation (a ceaseless roundabout of painful thoughts), poor concentration (depressive pseudo-dementia), agoraphobia, depersonalisation and derealisation, a loss of energy (mimicking anaemia) and hypochondriacal features including headaches, chest pain, stomach pains with associated cancer phobia, and atypical facial pain (depressive equivalents) and suicidal thoughts (Gelder et al. 2001).

There are compelling arguments in favour of regarding depressive illness as a biological disorder. Many psychiatrists see the symptoms of a slowing up of psychological and bodily processes as indicative of a medical disorder that requires physical treatment. Also in depression, common neurotransmitters in the brain are depleted, and antidepressants work by raising their levels, supporting the view of a biochemical disorder. According to traditional psychiatric teaching there is no place for psychotherapy, other than of a supportive kind, while the patient takes his medication and recovers from the episode. However, I would argue that the usefulness of psychoanalytic thinking is not restricted to the less severe cases.

The psychoanalytic understanding of depression

It is impossible to do justice in a précis to the richness of Freud's (1917) paper, 'Mourning and melancholia'. Freud points out that, in depression, the dominating internal relationship is with an object demanding total obedience, with the associated illusion of being totally looked after by the object. This absolute identification breaks down when needs arise, but not completely, so that the identification

with the idealised object still remains, and the ideal object is criticised for having let one down. As Freud put it, 'an object loss was transformed into an ego loss' (Freud 1917, p. 249). So, when the patient announces to the world that they are useless, they are not really criticising themselves, but a purported ideal that has temporarily let them down. Their apparent self-tormenting can then be understood as a tormenting of the ideal object that is felt to have abandoned them at a time of need. The sadomasochistic process of self-criticism that characterises depressive episodes continues in a relentless fashion until it has run its course.

Some experienced nursing staff will have no difficulty in intuitively understanding the need to let this process run its course in hospital, without demanding excessive physical interventions.

In depression no true mourning, which would involve relinquishing the object, can occur because of the unresolved ambivalent dependence on an ideal object. It is striking how, after months of self-berating, patients may recover their former composure without showing the slightest curiosity about their whole recent experience in hospital.

Freud emphasised the oral roots to the psychopathology of depression, with regression to oral narcissism, as evidenced by a patient's refusal to eat when in a severely depressed state (Freud 1917). Expanding on this theme, Abraham (1924) brilliantly and succinctly summarised the dynamic factors underlying depression, as follows:

- a constitutional factor of an overaccentuation of oral eroticism
- a special fixation of the libido at the oral stage
- a severe injury to infantile narcissism
- occurrence of the primary disappointment pre-oedipally
- repetition of the primary disappointment in later life.

The case of Mrs L described in Chapter 15 offers a particularly clear illustration of these dynamic factors at work. Freud initially referred to melancholia as a narcissistic neurosis. After the introduction of the structural model, he described it as a disease of the critical agency or superego (Freud 1917, 1923).

In his paper 'On narcissism', Freud compared the healthy state of taking in mental food from parental figures, the anaclitic state, with a self-centred state in which no development occurs, the narcissistic state (Freud 1914). In depression, the narcissistic state predominates

and takes the form of a delusion of not only being at one with an all-providing primitive godlike superego, but also living in fear of being cast out, as though from the Garden of Eden, if any questioning or curiosity develops.

If one develops any need, whether emotional or physical, such as a bout of flu, this is felt to be a criticism of the primitive god-like superego, who should have prevented it happening, or of oneself for not following the correct path to prevent getting ill in the first place and this may trigger another depressive episode of self-berating.

The commonest symptom of depression is extreme agitation, as at the moment of curiosity or questioning, one feels separated from the godlike superego. This results in a feeling of being completely unheld, like a newly born baby left on a changing mat shaking with the 'Moro reflex'.

This central insecurity, which the patient experiences at the slightest challenge to their total submission to the narcissistic object, explains why anxiety is the most prominent of all symptoms of depression, and why general psychiatrists often use the overall term 'agitated depression'.

In her paper 'Mourning and its relation to manic depressive states', Klein (1940) also emphasised a central theme of insecurity in individuals with depression, explaining it in terms of their inability in childhood to establish their good objects and so feel secure in their inner world.

Bion's insights on the role of the maternal container add further depth to our appreciation of the nature of the agitation:

> Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother, the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore reintrojects, not a fear of dying made tolerable, but a nameless dread.
>
> (Bion 1967, p. 116)

Each of the various symptoms of depression invites consideration from a dynamic perspective. Agoraphobia might be understood in terms of fear of separation from the idealised identification, since having any separate identity would bring down the wrath of a jealous

god. An analytic patient of mine, when depressed, would develop agoraphobia, linked to fears of having developed a shape to her body, as if this represented individuality and would draw hostile notice to her.

Symptoms akin to mourning can be understood in terms of the feeling that the ideal object has been lost, with both the self (depersonalisation) and the outer world (derealisation) feeling unreal. Patients with depression typically wake early and feel worse in the morning, feeling better as the day goes on. Biological psychiatry has unsuccessfully tried to explain these features in terms of diurnal variations in steroid levels, but the symptoms can be also considered at an analytic level.

> A man with severe unrelenting depression, whom I saw supportively for a year, came weekly to the outpatient clinic accompanied by his wife. After I had left, he was admitted and received ECT, but sadly then took his own life. His problem was that he could not come to terms with the fact that, in a fit of rage during the war, he had killed a Japanese soldier who was on the point of surrendering, because the Japanese soldier had recently killed his friend, whom he had found with his head smashed open. He would wake up early from a recurring nightmare. In the dream, a man had been shot in the head. His skull was open and he was dying. The patient was holding him, waiting for the doctor to come. The man died just before the doctor came.

There were of course many striking aspects of this case, including the impossibility of reparation, as the patient could never forgive himself for having committed his murderous attack. However, the point that I wish to highlight here is the patient's waking early with the recurrent nightmare and then feeling worse in the morning, but improving as the day went on, that is his symptoms of early morning wakening and diurnal mood variation.

We have an internal as well as an external world, and this helps to make sense of the patient's experience at a psychological level. The patient wakes up early in order to escape a terrifying and critical internal world. Patients with depression feel worse on wakening as they find themselves totally dominated by their unforgiving internal world. As the day progresses they start to feel better, since the external world is a far more humanly responsive one than their internal world. Consideration of this dynamic may also introduce a way of talking with patients and their relatives about the internal experience.

The place for medication

Since the godlike primitive superego of patients with depression demands that all feelings or other signs of need be repressed, these feelings may be projected into the body and felt only as physical sensations, referred to as 'depressive equivalents'. While depression raises fascinating questions about the relationship between the mind and bodily experiences, as transmitted through neuronal networks, at the end of the day, we may be left with a patient with no insight seeking relief from very distressing physical symptoms. This is where antidepressant and anxiolytic medication enter the picture.

> A patient gave a history of being a corporal in the army many years ago. When he was 30, he had an attack of pericarditis. This destroyed his delusion of immortality. He held on to this belief by projecting his anger at the loss into his body. He became consumed with hypochondriasis, complaining of pain in every organ. If visitors came round to see his family, he would dominate the conversation and talk of pain from his big toe to his testis, abdomen, chest and head.
>
> If his behaviour became too much for the family, he would be admitted to give them respite and he would receive medication or ECT. I inherited him when he was in his sixties. On admission, he again talked incessantly about his symptoms. However, I was struck by the way he managed to chase the female nurses round the ward with his walking stick, in a sexually provocative way. Interestingly on the morning of his birthday, his mind temporarily returned to his head. He behaved normally, in a patients' group, inquiring about other patients' welfare. However, he then reverted to his former ways. This patient lacked any insight and all treatment inevitably remained at a physical level. However, we can still take a psychoanalytic interest in the way his mind was functioning.

One has to accept that, for some people, the severity of their psychopathology is such that one can treat them only at a physical level. Others, whose psychopathology might not be so severe, may come for psychotherapy while taking medication, while others may opt for a purely psychotherapeutic approach.

When working with patients in psychotherapy, medication can be utilised to reduce the intensity of symptoms when these threaten to become incapacitating, for example, when patients are unable to get up in the morning to attend their sessions or when their suicidal

feelings threaten to become overwhelming. The doctor prescribing the medication, whether the general practitioner or specialist, can work in harmony with the analytic psychotherapist, provided that they share an understanding of the patient's condition and agree on the purpose of each aspect of the treatment plan.

It is very important to include the patient's spouse or partner in the management of all cases of severe depression. The partner needs support and education in the dynamics of the disorder in order to help them to endure extended periods where the patient will not listen to their advice. Understanding the transference and countertransference issues in depression can help the patients and their relatives as well as the professionals to understand and cope with the experience.

The transference and countertransference in depression

The transference

If one conceptualises a major depressive episode as a psychotic episode, then one cannot rely on one's ordinary empathy. It is necessary once more to tune into the psychotic wavelength in order to make sense of the disorder and understand the transference phenomena.

The patient has a belief that things should never have gone wrong. Their object relationship is to a god-like figure. If anything goes wrong, someone is to blame because it could have always been prevented from happening in the first place. There is no desire for understanding, only a wish to return to a previous trouble-free state.

> An example would be a man driving a car who knocks over another man riding a motorbike. The motorcyclist is lying on the ground unconscious. His motorbike is in flames. The driver gets out of his car and beats himself on his chest, saying to himself, look what a terrible person you are for what you have done, but he does not lift a finger to help the motorcyclist.

This leads on to the countertransference experience for those trying to help the patient, whether psychiatrists, analytical therapists or relatives.

The countertransference

The first issue to be appreciated is the clash of interest between the patient and the carers. Patients are not interested in gaining insight; their only concern is to find a way to regain their previous illusion of perfection. The therapist or relative, on the other hand, tries to persuade the patient not to be so demanding and critical of themselves and to take a more reasoned, forgiving and understanding approach. The countertransference feelings experienced by the carer are frustration and irritation, as anything that is offered in terms of helpful advice is rejected, while the patient persists in remaining in a troubled state.

While the process of self-berating goes on, it feels to the professionals and carers as though there is no sign of light at the end of the tunnel and that the process will go on forever. Often patients themselves will ask if their state of depression will ever end. The carers need help to appreciate that patients' self-berating over the loss of their illusion of perfection is an internal process that will go on with a momentum of its own until it abates. The carers may need help to understand that they should not take the patient's rejections of their offers of help personally.

The relatives' need for support becomes much more pressing when manic states arise (see Chapter 14), which involve an element of triumphing over the object of dependency. This is projected onto the nearest relative, with acting out behaviour of verbal abuse and sexual affairs. Such behaviour is potentially very destructive of relationships and once patients have come down from their manic state, there can be a real risk of suicidal behaviour. In such circumstances, it is even more important to help and support the relatives in understanding and coping with their countertransference feelings.

I will conclude with a discussion of the two superegos, the mature benign reflective superego and the ego-destructive superego that takes over in depression, as this can provide us with an overall framework for thinking about depression.

The superego in depression

Freud (1923) introduced the concept of the superego in *The Ego and the Id*. He described how one part of the ego sets itself over against the

other and judges it critically. The superego incorporated Freud's previous concepts of the dream censor, the special agency in the ego, ego ideal and unconscious sense of guilt (Laplanche and Pontalis 1973).

Klein described an early pre-oedipal stage to the formation of the superego. She thought that a very harsh superego was already in evidence at the oral stage, which becomes modified over time, with experience, gradually becoming more benign, less demanding and more tolerant of human frailty (Segal 1973a).

Freud commented on the particular characteristics of the superego in melancholia, noting an 'extraordinary harshness and severity towards the ego' in both obsessional neurosis and melancholia (Freud 1923, p. 53). However, the superego was more dangerous in melancholia where it could be seen as 'a pure culture of the death instinct [which] often succeeds in driving the ego into death' (Freud 1923, p. 53).

Klein also referred to an early very harsh superego, formed as a result of a defusion of the instincts, which stood apart and was unmodified by the normal processes of growth (M. Klein 1958; O'Shaughnessy 1999). It is necessary to take the operation of this abnormal superego into account in cases of depression.

Bion outlined the characteristics of this ego-destructive superego in the following way: 'It is a super-ego that has hardly any characteristics of the super-ego as understood in psychoanalysis: it is "super" ego. It is an envious assertion of moral superiority without any morals' (Bion 1962, p. 97). He further comments,

> In so far as its resemblance to the super-ego is concerned [it] shows itself as a superior object asserting its superiority by finding fault with everything. The most important characteristic is its hatred of any new development in the personality as if the new development were a rival to be destroyed.
>
> (Bion 1962, p. 98)

The following example illustrates the extraordinarily murderous character of the ego-destructive superego.

> A patient with a long history of depression had reached mid-life. He had no previous history of self-harm. He had never worked and had lived with his mother until she died two years previously, when he went to live with his single brother, who went to work. He spent his days visiting different sisters,

> who remained very loving and supportive. He had recently become somewhat more agitated, but persistently denied suicidal feelings, including on the very day that he actually committed suicide by repeatedly stabbing himself with a kitchen knife, with his brother returning from work to find him dead.

His family needed help to understand that their loving feelings had been appropriately directed in supporting a dependent part of the patient that had never been allowed to develop by his ego-destructive superego. When the patient reached mid-life and this murderous part of him was called to account for its destructiveness in never having allowed the patient to develop a life, it turned on the ego and killed it. In my discussion with the patient's relatives in the aftermath of his suicide, one of his sisters recalled how months previously, he had said that his body was tired of living, which suggested that his ego had been located in his body where it could be attacked by the superego.

Bion thought that the pathological superego arose out of early failures in communication between the infant and mother. In depression, the ego-destructive superego takes over the driving seat and attacks the self. In such a situation, O'Shaughnessy (1999) summarises:

> No working through can take place, only an impoverishment and deterioration of relations, with an escalation of hatred and anxiety that results in psychotic panic or despair. In this dangerous situation, the significant event for the patient is to be enabled to move away from his abnormal superego, return to his object, and so experience the analyst as an object with a normal superego.
>
> (O'Shaughnessy 1999, p. 861)

To end on a more positive note, in contrast to the previous example, there are also cases where patients may actively seek help through analytic psychotherapy.

> A young woman came to therapy with a five-year history of disabling depression. She had been hospitalised early in the illness and had been on antidepressant medication for a number of years. She came from a strict religious background. She wished to develop her own mind, while facing up to the guilt of developing a different attitude to her parents. She was determined to come off medication. She described her feelings in therapy

as going round and round in reflecting on painful events; however, the movement was like a spiral rather than a circle, so that there was a gradual forward movement. The active involvement of the therapist on the side of a mature reflective superego helped lessen the effects of the patient's ego-destructive superego and support the development of her own mind.

Prior to analytic therapy, this young woman would typically wake in an exhausted and tense state, often unable to get up for the day, and recalling recurring nightmares of being chased by gunmen. After some time in the therapy, she had a different dream in which I was associated with helping her with her internal world. She reported waking from this dream in quite a different state of mind, with a pleasant feeling rather than an exhausted one.

Summary

It is vital to distinguish major depressive episodes from low mood. If we regard major depressive episodes as manifestations of an underlying psychotic disorder, we need to make a special effort to tune into the wavelength of the psychopathology in order to understand it and become empathic to the ongoing process.

Psychoanalysis as well as biological psychiatry has much to contribute in the understanding and management of depression. A biological and a psychoanalytic approach are not necessarily mutually incompatible.

The psychoanalytic theory of an abnormal ego-destructive superego operating in depression has implications for the overall framework of approach to treatment of this condition. The priority in treatment, whether through medication or analytic psychotherapy, is to unseat the primitive ego-destructive superego and gradually enable its place to be taken by a more mature and reflective superego. Only when the reflective superego is back in place can any meaningful analytic work be done to strengthen the patient's ego or individuality.

PART FIVE

Implications for Management and Education