THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH DEPRESSED PATIENTS

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Psychotherapy with Depressed Patients

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A depressive reaction is basically an acute feeling of despondency and dysphoria of varying intensity and duration. It is a response which is highly subjective in that what causes one individual to become depressed may leave another relatively unaffected. In this chapter the neurotic or pathological states of depression will be dealt with rather than the psychotic states or those transient states of mood typically referred to as dejection, pessimism or disappointment which are relatively common to all.

ONSET

A depressive reaction usually follows some unpleasant experience or event. Usually the event is unanticipated and therefore is experienced as being relatively traumatic. What marks the dysphoric reaction as pathological is that either the event is not one which typically evokes a dysphoric reaction in people or else the event may be realistically capable of precipitating a feeling of despondency but the person's reaction to it is overly intense and incapacitating or more prolonged than the usual response to such an event. Pathological depression is also marked by the fact that the person appears helpless to overcome it through his own efforts.

Among the events which may typically precipitate a depression are illness or death of a close relative, illness or loss of certain capacities in

oneself, loss of love or narcissistic supplies (that is, all kinds of compliments, attention, concern, etcetera), a financial setback or moving to a new location.

At a more conscious or preconscious level, depression is invariably the result of the experience of frustration that comes with the recognition that one wants something very badly but, at the same time, is helpless to do anything about being able to possess or achieve that which is craved and valued but is continuously being denied to oneself. However, at a deeper, more unconscious level this feeling of frustration is being experienced as a loss which tends to intensify an already existing inner feeling of deficiency, emptiness and worthlessness. Basically then, a depression is potentially capable of being precipitated by any event which produces a significant feeling of loss. The loss may be one of various types. For example, it may be the loss of a sense of security, a loved or needed person, self-esteem or some idealized image, valued possessions or something with which one has become identified, control or influence over the elements and events of one's life or some kind of adequacy, ability or sense of potency. The loss tends to be unconsciously interpreted as a diminishing of the self in one way or another. In essence, depression can result whenever the self is experienced as being significantly diminished. The experience of the diminishing of self tends to provoke an unconscious fear that one is moving in the direction of confirming the unconscious conviction of oneself as basically a worthless nullity. Therefore, intrinsic to an experience of a diminishing of self is the deeply

unconscious fear that one is moving in the direction of becoming totally nonexistent as a personal entity self.

Thus, whereas depression and other dysphoric states signify an experience of the diminishing of self, the elational states signify that one has had the experience, at some level of consciousness, of an accretion, aggrandizement or affirmation of the self. In the same vein, anxiety may then be understood basically as the reaction of fear that such a diminishing of self is *about to occur*, whereas depression may be understood as the reaction equivalent to the experience that the diminishing of self has *already* taken place.

SYMPTOMS AND EQUIVALENTS OF DEPRESSION

In addition to the dysphoric affect, one most conspicuously finds in depressed persons some, although not necessarily all, of the following: all activities and interests are highly constricted (including sex); affective response is significantly diminished; there is lowered self-assurance, apprehension, tears, heavy sighing, avoidance of people, guilt, fear of impending doom, feeling of intolerable anxious distress, somatic complaints, slowing down in psychomotor functions (although in some cases we find a motoric restlessness), impaired appetite, highly restricted narcissistic involvement with little interest in one's home or personal appearance,

inability to enjoy simple pleasures, hobbies, social contacts or one's work. Usually even the simplest routine task seems to require Herculean effort and is seen as a major endeavor by the depressed person.

Rather than the overt depression, many times one will see what is referred to as depression equivalents. To the somatic equivalents of depression especially belong fatigue and pain, the latter of varying localization and intensity. Fatigue is often the result of internal tensions created by deep-seated emotional conflicts. The tension is usually a consequence of the patient's intensive efforts to neutralize his up-surging aggressive impulses. Pain, usually generalized, vague and rheumatoid, or localized (for example, a headache), is another sign of the patient's attempt to neutralize inner aggressive trends. In other cases the pain may be the result of the ego's attempt to relieve or expiate the intense dictates of a guilty conscience via self-punishment.

Other equivalents of depression which may be observed are dyspepsia, nausea, a bad taste in the mouth, constipation and general irritability. In an attempt to escape from the extreme tension caused by an impending depression, persons with an especially weak ego may turn to artificially induced states of elation produced by such things as alcohol, drugs, compulsive eating, buying sprees, gambling, etcetera. When a sense of euphoria is achieved, then it tends to elevate feelings of self-esteem and

security which serves to inhibit the depression.

In other instances, especially in the adolescent or in the adult with a weak ego, the attempt is to escape from the depression by draining the tension associated with it through some kind of antisocial acting-out such as speeding in automobiles, petty thievery, aggressive outbursts, sexual promiscuity and the like.

Other depression equivalents that are frequently observed involve various forms of hyperactivity such as when one becomes overinvested in civic and social affairs. This type of person seems to be continuously "on the run." Compulsive smiling or laughing is still another frequently observed manicky reaction formation defense and equivalent of depression.

Whereas depression has many equivalents of its own, depression itself may at times also serve as a substitutive equivalent in the form of a pseudo-emotion in order to cover up some other, more basic emotion such as anger, fear or sorrow. These more basic emotions, for one reason or another, are intolerable to the self and must be defended against being consciously recognized and experienced.

PSYCHODYNAMIC FACTORS

In my experience, I have found it convenient to subsume the basic

psychodynamic causes involved in depression within five major factors. Essentially, I find one of these five basic psychodynamic factors operative in almost every case of depression. Several of these may occur together in any single case of depression. One factor involves an attempt to regain self-esteem which was lost or is threatened as a function of the withdrawal, or possible feared withdrawal, of love or narcissistic supplies. Another basic factor which is found centers around the depression being the result of hostility or sadistic impulses which are being blocked from expression and then turned back upon the self in a rather masochistic fashion. A third factor which is frequently found in depression relates to events, feelings or thoughts which have produced a great deal of guilt, and the depression reflects the attempt to expiate this guilt through the discomfort that it brings. A fourth factor is a mourning reaction due to the loss of a loved one. The fifth factor, which to some degree is also involved in the first four, relates to the depressed person's need to reaffirm his control and lost sense of omnipotence which is the primary means by which he achieves a sense of security. Each factor will now be discussed in more detail.

Depression and Self-Esteem

Fenichel points out that depression is based on the same predisposition as addiction and pathological impulses. A person who is fixated at the oral passive-dependent stage of psychosexual development is fixated at the stage

at which his self-esteem is regulated by how much he is given by others in his environment, and if his narcissistic needs are not satisfied, his self-esteem diminishes to a danger point. He is ready to do almost anything to avoid this.

This kind of depressed person goes through life in a condition of perpetual greediness. He is, in a sense, a "love addict." The personality of the object or provider of love and narcissistic supplies is of little importance to him. He needs the narcissistic supplies desperately for the maintenance of his self-esteem; it almost does not matter who provides these. It does not necessarily even have to be a person; it may be a drug, alcohol or an obsessive hobby. As with any addictive personality, the basic drive which motivates this kind of depressed personality can be termed "the search for euphoria." He is basically in pursuit of the nirvana-type state which the infant experiences when he is well fed. In this search for euphoria he tries to coerce some person in his environment to "feed" him the narcissistic supplies and if he is unsuccessful in finding someone he will then usually attempt to feed himself by taking something orally which will produce the euphoric effect, such as drugs, alcohol, food, etcetera.

Early in life, due to the nurturant feeding process, being fed or given to becomes equated with being loved and therefore with a sense of worth or self-esteem. Being hungry or not being fed or given to becomes equated with fears of annihilation and later self-depreciation and unlovableness. Later in

life the tension and insecurity of not being loved is therefore capable of triggering the unconscious threat of not being fed, and as a result, fears of annihilation become aroused. I have consistently found that this kind of person unconsciously makes the basic equation that having no self-esteem means that he is totally worthless and if he is totally worthless he feels that he will have been reduced to being *absolutely nothing* and therefore he feels threatened with the extinction of his psychological self when his sense of self-esteem is lowered.

Still later the superego or conscience develops and takes over the inner regulation of self-esteem. No longer is the feeling of being loved the sole prerequisite for a feeling of well-being, but now the feeling of having done the right thing is also necessary. Conscience operates as a warning function. A punitive conscience creates minor annihilations or small diminutions in self-esteem in order to warn against the danger of a complete loss of narcissistic supplies. Thus, for example, the conscience says, "You have been bad, I shall have to punish you to warn you that if you keep on being bad something much worse will happen—mommy and daddy may cease to love and protect you."

A distinction can be made here between neurotic and psychotic depressions. In the neurotic condition the depression represents the attempt to induce some person in the environment to provide narcissistic supplies in

the form of love, sympathy, concern and the like. The receipt of these supplies enhances self-esteem which thereby reduces the threat of annihilation. In psychotic depressions, however, the complete loss of the love object in the environment has *already taken place* and the depression represents attempts to gain the narcissistic supplies exclusively from the superego.

Depression and the Feeling of Loss of Self

Some depressed people tend to react very strongly to loss of love not only because of the loss of narcissistic supplies and self-esteem but also because they become so overly identified with the love object that the loss of this person is experienced as a loss of self. Typically in these cases the over-identification with the love object is the result of a long-standing pattern which started early in the patient's life in which he first learned to feel secure by identifying with the most dominant, controlling parent through introjection and incorporation. This was considered to be necessary by the patient due to the fact that he felt that he had no self unless he incorporated the self of the parent within him to guide him and help him make judgments and decisions. The depression in these cases represents the loss of the introjected object with the resulting feeling of inner emptiness and nothingness; as though one were basically a void and therefore did not exist at all. In essence then, this kind of depression is a form of death anxiety.

Typically, the parent of this kind of depressed individual is usually a very critical parent who does not see her child as a separate self but only as an extension of herself and she proceeds to do most of his thinking and decision-making for him. As a consequence, the child comes to feel that he has no self or mind of his own. He then "swallows up" the parent which serves to fill the emptiness of self and proceeds to live by the dictates, values and directions set down by the parent. In addition, early in his life, he was usually convinced by the parent that self-direction would ultimately lead to his own self-destruction. As a child he usually tests out the parent's admonitions and at some point decides to follow his own will instead of the parent's will but invariably it turns out badly in some way. The child ends up being traumatically hurt either physically or emotionally. He thus comes to conclude that he is not able to protect himself and that if he is to survive he must incorporate this "all-knowing" parent as his guide through life. The will of the parent then takes on the security of omnipotent protection. His thinking goes something like this: "My parent knows everything. She said that if I tried to do this thing by myself I would fail and get hurt and I did. The only way to be safe is to do only what she tells me is right to do and never to allow myself to have a will of my own. My parent and I will become basically one."

This attitude is perpetuated into adulthood and with other parent surrogates. He just does not dare to govern his own life. He feels, "I need a wiser and stronger one to govern me in order to feel safe and secure."

Certainty and safety comes only with having an introjected parent figure directing and guiding him. He continues to try to escape from his feeling of inner emptiness by continuing to "swallow" love objects who serve basically as parent surrogates.

These depressed patients tend to react very possessively toward their love object because to lose the other is felt as a loss of self and complete abandonment to a helpless vulnerability and fear of nonbeing. They tend to be compulsively driven in their search for and accumulation of love objects. They usually want one permanent one and also the freedom to go out and collect others too in order to guarantee that they will never feel empty. It is also not unusual to find compulsive eating or alcoholism serving as a depression equivalent in these persons. The orality serves to defend against the depression by attempting to fill the perceived inner void.

Depression and the Need for Protection

Basically the depressed person craves safety and protection. His attempts at securing love and narcissistic supplies is his way of converting these into believing that because he is loved and valued, he will be protected. All this usually stems from the early emotional rejection by parents and also the sensing of their hostility toward him. Their emotional abandonment of him left him feeling extremely helpless and vulnerable. At first he tries to

regain a sense of security by asserting his omnipotence, but when his attempts to totally control his environment fail, he recognizes that he is not omnipotent and cannot guarantee his own security by himself and so he turns to the coercion of the environment to protect him by overplaying his suffering.

He demands demonstrable evidence of love and protection; verbal assurances of regard by others are insufficient because the early rejection by his parents has led to his own self-hate. He projects out his own self-hate and believes that others must be hating him; he is so involved with self-hate that he is unable to feel anyone's love for him.

Self-esteem by itself offers little protection to the depressed person and is therefore not his ultimate goal. He wants to feel protected, and the self-esteem is only a means to this end. It leads him to believe that because he has worth others will value and want him. The self-esteem is also necessary for him to protect his ego against the sadistic accusations from the superego. Thus, his intense demands for love and esteem really represent his craving for protection and security.

Case Illustration

Mrs. Black was doing relatively well until her husband lost his job and told her he could not work anymore due to a progressively deteriorating

arthritic condition. This meant that for the first time in her life she would have to go out to work full time. She became very threatened at the prospect of relinquishing her dependent role and just could not let herself accept the reality of her husband's illness. She felt that her husband was competing with her for dependency and was just deliberately making himself helpless so he could lean on her. She became extremely depressed and could not take care of the house and children. In this way she tried to coerce her husband to take care of her.

When he persisted in asserting that his illness was making him just as incapacitated as she was, she became more desperate and attempted "suicide." She took a small overdose of aspirin knowing that it really would not seriously harm her, and she did so in her husband's presence in order to be sure that she would receive immediate medical attention. When even this gesture failed to move him into returning to work and showing her more concern, she put herself into a pseudo-psychotic catatonic condition. She expected that he would send her to the state hospital where she hoped to receive the care and protection which she craved. She thought that going to the hospital would also remove her from the situation of having to go back to work.

He compromised by sending her to me. I was not what she wanted, and as a result she was extremely resistant to communicating with me. It soon

became clear that she intended to hold on to her symptoms at all costs. I finally got the background of the situation from the husband, and when what was happening became obvious to me, I confronted both of them with the subtle “war” that was going on between them. She soon became much more communicative. When she was finally able to express her extreme hostility toward her husband her depression lifted noticeably.

Much of her hostility was related not only to the subtle competition between husband and wife for dependency gratification but also to the fact that she married him without love because he seemed to be in a position to be a good financial provider. She had married him for security and now she felt that he was reneging on this role. She was also attracted by the fact that he was big and strong and she felt that he would be someone she could lean on and be protected by.

In addition, when she married him he did not drink and she had always resented males who drank because her father drank and could not then be in a position to fulfill her dependency needs. She felt that her husband had begun to change in this respect as well. She became convinced that he was denying her everything for which she had married him, and as a result, she felt terribly deprived, cheated and angry—all leading to her depression.

The husband was subtly aware of her control of him and also her not

loving him and he proceeded to reject her needs as a way of punishing her. When some honest confrontation was finally brought to the situation and both expressed themselves cathartically, her depression lifted. In addition, after the release of all of the pent-up negative feelings, they each came to recognize that there also lay, underneath, some warm and positive feelings toward each other.

This case illustrates the importance of also working with the patient's mate or whoever the patient is looking toward for the basic gratification of his needs. I find that this expedites therapy quite significantly.

One of the most basic factors involved in treating depressed people is the vicious circle that causes them to be self-defeating in terms of the needs which they want satisfied. Because they feel so insecure, they become extremely coercive and demanding for love, attention, consideration, appreciation and all the other elements that typically comprise narcissistic supplies for depressed people. As a function of these extreme demands, the narcissistic or love object soon begins to feel overly controlled and manipulated. He comes to feel that he must reject the demands not only because they are excessive, but also because he needs to feel that when he gives love it is because he wants to and not because he is forced, threatened or tricked into it.

If the husband submits to his depressed wife's demands and threats, he comes to see himself as weak and submissive, which threatens his feeling of masculinity. He also typically feels that the more he gives in, the more she will demand from him and so he recognizes no choice but to reject her. The more the depressed individual is denied her narcissistic supplies, the more demanding she becomes; and the more demanding she becomes, the more she is rejected, *ad infinitum.* It is therefore crucial that the therapist help the depressed patient recognize how the vicious circle into which she has put herself is operating. The therapist especially needs to point out how it has become self-defeating for her.

I also try to point out to the patient that even if her husband gave her attention when she demanded it, it would do her very little good because a part of her would always know that she had to work for it rather than having it freely given to her. Attention and support, thus coerced, could never serve to alleviate her diminished self-esteem or her fears of not being loved.

Depression and Repressed Hostility

What is the cause of the experience of depression itself? Essentially the experience of depression is caused by the turning of a great intensity of energy upon the ego. This energy is usually destructive in nature. In simplified terms, depression is oftentimes experienced when the energy of

anger is turned toward the self instead of being expressed toward some object or the symbol of some object in the environment. This destructive energy is turned toward the self rather than externalized because somewhere along the way the patient has learned that such expression could lead to the destruction of some other person, feared retribution, loss of love and security, abandonment or the loss of a highly invested idealized image.

Case Illustration

Mrs. Jones was referred to me because of her depression and recurring headaches. The physician who referred her could discover no organic cause for her condition. She had previously been a nurse, but for the last five years, since her children were born, she had been home with them. She hated being home with the children not only because she preferred to be working in order to gratify strong masculine achievement strivings but also because her children were very boisterous and very hard to control. She admitted that she could not control her children because for a number of reasons she could not permit herself to get angry with them. She had a great need to be needed and was very fearful that if she got angry with her children they might not love her. Most of all she feared the loss of control of her anger. This fear related to an event that had occurred early in her life. She was a very tall and powerful girl and one day she lost control of her temper and nearly killed another girl.

For many years she had repressed her hostility toward her mother who was extremely controlling. Her mother selected what clothes the patient was to wear and later on in life even told her what career to select. All the other siblings in the family were boys. She noticed that her mother disliked aggressiveness in her boys, so the patient competed for attention by becoming the "good little girl." She never got angry, and never did anything naughty.

Her husband, who seasonally was out of work, would take out his frustrations on her and she would rationalize it away by saying that she knew he really did not mean it but that he just naturally had to get it off his chest. She had come to see that she had adopted the role, for the world, of the "human punching bag."

Her consistent and intense repression of her anger eventually caused her to become depressed. At first she tried to escape from her depression by compulsively becoming involved in civic and social affairs in an almost manic fashion, but soon she withdrew and seemed to lose interest in all of her affairs.

This need to block hostility from being expressed, which is so frequently the case in depressions, leads the body to assist the mind in holding the angry feelings in check, producing all kinds of physical complaints (for example, the

headaches here). It is also typical that in this kind of depression, due to the severe over-control which these patients impose upon themselves, they are also unable to achieve sexual release, for all "letting go" is experienced as dangerous. The blame for this sexual frustration is usually projected onto the husband and may lead to sexual fantasies about other men, aggravating the depression by the guilt that it engenders. This was also true for Mrs. Jones. In addition, her masculine identification made it almost impossible for her to cry, which would be a sign of weakness, femininity, vulnerability, etcetera. Thus she had no outlet for the release of her tension which had built up due to the repressed hostility and ungratified sexuality. As a consequence, her enormous tension, without an opportunity for release, was being turned in toward the self, resulting in the depression and the headaches.

Therapy with this kind of patient should aim at helping her to learn to express negative affect, at least verbally, without feeling guilty. Sometimes the establishment of a negative transference toward the therapist may be necessary in order for the patient to learn that her hostility is not destructive and that people will not necessarily reject or abandon her just because she expresses herself honestly. For therapy with this kind of patient to be successful, of course, it is necessary that the therapist be secure about his own worth, so that he will not have to hurt her in any way when she starts to express her pent-up angry feelings onto the therapist.

Helping the husband to accept negative expressions from his wife is also helpful in the same way. It is not unusual, as was the case with Mr. Jones, that the husband is actually quite pleased with his wife becoming more assertive because her "good girl" role made it very difficult for them to communicate honestly and have a close relationship. Many times his anger toward her was a baiting of her in the hope that she would express the hostile feelings that he sensed were within her. He recognized that she was also making him feel very guilty by not responding to his anger.

Depression and Guilt

In some cases, depression represents self-punishment in an attempt to expiate guilt feelings related to a real or fantasied event or to unacceptable impulses usually of a sexual or destructive nature.

Case Illustration

Mrs. Brown was sexually molested at the age of twelve by her father and felt very guilty about this event for several reasons. One reason for her guilt feelings was that she had unconsciously wished for this to happen because her father's extreme seductiveness toward her had heightened and intensified her sexual fantasies. She also felt guilty because she enjoyed the experience much more than she felt she should have. However, she felt most guilty about the fact that this event ultimately destroyed the marriage

between her parents. Her depression was her attempt to produce the suffering necessary to expiate her guilt. For the most part, as an adult, she was never able to permit herself to respond and enjoy sex with her husband. However, on those rare occasions when he performed in such a way as to overly arouse her sexually she would respond the next day with a depression.

Depressive episodes also ensued after she would come from a visit with her mother. At those times when she visited her mother and found her to be especially unhappy it would trigger her earlier guilt. She felt responsible for her mother's unhappiness, and as a result, a depressive reaction would ensue. Once the patterns that were serving as the triggering events for the depression were discovered, it was not much longer before the reasons behind these episodes of depression came out and the patient experienced symptomatic relief. (Once the "secret," so to speak, is discovered by the patient and shared with the therapist, the patient usually feels relieved almost immediately.)

Where guilt is the problem there is usually an id versus superego conflict. It is crucial but sometimes very difficult to identify those id impulses that have been, or secretly desire to be, gratified. In those instances where the triggering patterns for the depression are not clear or where the source of guilt is too well hidden or defended, then it may be helpful to turn to projective personality tests and/or dream interpretations for clues.

In some cases of guilt it is more important to discover the source of the patient's understanding of the concept of sin than it is to focus on an id impulse. This is especially true of patients reared in an overly strict Catholic or religiously Fundamentalist home where the subject of "sin" is continuously discussed. For some patients almost every act or thought produces some kind of feeling of guilt. The normal sexual interests and fantasies during the growing-up period sometimes cause tremendous guilt and may even produce the conviction that the patient is a sexual pervert. The suffering involved in the depression is felt by the patient to be necessary in order to expiate the guilt.

These patients have usually been taught that angry or sexual thoughts are sinful. They are fearful that God will punish them unless they try to placate Him by making themselves suffer. This attitude is a projection of the perception of a strict and punitive parent onto God, making Him a wrathful and exacting Old Testament Jehovah. Also, the suffering is necessary because they feel worthless and sinful which leads to a strong masochistic-like need for punishment. The superego is unrealistic and savage and needs to be altered. Yet for some, their religion and the way they interpret it is so basic to their personality that to challenge any of their interpretations of dogma makes them feel that the therapist is attacking the very essence of their being. They become identified with their basic religious convictions, and to try any reconsiderations and reconstruction of these would threaten them with loss

of self.

In such problems, it is sometimes necessary to enlist the aid of some clergyman whom the therapist knows to be liberal and sophisticated in these matters and who can help these patients restructure their religious convictions. In some cases only then can the therapeutic work begin, and in some instances therapy is no longer necessary because the depression lifts with reassurance from the clergyman that the patient is not as sinful as she believed and that God will not punish her for her bad thoughts or misdeeds.

If the patient's religious convictions are not too intransigent, then the goal is to have the patient incorporate the therapist as the new "alter-superego," so to speak, via identification with the therapist's loving and forgiving nature until the patient can reconstruct his own superego along less punitive lines.

Pathological Mourning

To mourn over the death of a loved one is a normal reaction. Pathological mourning exists when there is either an excessively intense or violent reaction to the loss of a loved one or if the process of mourning is unduly prolonged or unduly retarded in its onset and development. Persistent absence of any emotion may signal undue delay in the beginning of the work of mourning. It may sound strange that the absence of grief can be

considered pathological, but the reality of the death of a loved one is inescapable and must be felt. The grief may be disguised in many ways: it may be transformed, hysteriform, obsessional or schizoid.

In most cases of pathological mourning I find typically that the grieving mate has always basically considered herself to be a "nothing" and considers her spouse to be "everything." The meaning and substance of her life had come essentially through her identification with her husband. When he dies, she is traumatically confronted by her nothingness again. She drastically attempts to avoid the conscious recognition of her emptiness and nothingness by becoming totally involved in obsessive thoughts and reminders of the lost loved one. In essence, she attempts to substitute for the lost husband a total involvement with his memory through obsessional thinking. Both basically serve as escapes from the real problem of her own inner emptiness and feeling of nothingness from which she has been trying to escape all her life.

Many times she will turn to alcohol or compulsive eating after the death of her spouse, not only to help her forget the grief of her loss but to fill her and to help her escape from the feared reality of her own lack of identity and inner emptiness. Various escapes only prolong the mourning process but helping her confront the real problem of the fear of her own nothingness speeds the resolution of mourning very rapidly.

In mourning reactions the patient essentially seeks relief not from the recurring pleasant memories but rather from the painfulness of the obsessional morbid thoughts. These morbid thoughts keep returning causing the patient to suffer because they were not fully acknowledged and integrated when the events first occurred. Thus, for example, as the patient was experiencing how the loved one died, the funeral, the burial and so forth, the mind was blocking out and filtering these events because a part of the mind was rejecting and attempting to deny the reality of the event. Because these events were not fully faced at the time of their occurrence, the memories of these events become separated from the self and are rejected as a not-self. As a result, they keep returning in an attempt to force the mind to put attention upon them so that they can be integrated and drained. However, each time the memories return the patient continues to try to escape from them by taking drugs, turning to friends or a variety of other distractions. Thus it is clear that the most expeditious means of resolving the morbid aspects of the mourning and preventing a prolongation of its effects is to encourage the patient not to try to escape from these memories but rather to look at them full-face, head-on. In a relatively short time, they lose their potency and the healing process takes effect. Unfortunately, the tendency is to look obliquely out of the corner of our eye at problems and at painful memories instead of confronting them head-on. As long as the patient continues to try to escape from these morbid memories, she retards the integration and healing process

and her suffering is prolonged.

Therefore the patient should be encouraged not to try to escape from the pain of her grief but rather to immerse herself fully into it and let that grief express itself as it will. She may cry and cry until there are just no more tears left to cry and the wound will be healed and the mourning is over. There may still be a scab on the wound but at least the bleeding has stopped. It isn't that the patient decides that the mourning is now over, it is just over. The pain of the feelings related to the loss of the loved one have been confronted (for example, feelings of abandonment) and integrated into her awareness and so the grief has been worked through and resolved. But if the patient does not permit the full confrontation and expression of the pain of the grief to occur, then the wound is preserved and never heals and is later triggered by related kinds of conscious or unconscious reminders.

Mourning becomes even more complicated if the relationship of the mourner to the lost object was an extremely ambivalent one. In this case the incorporation of the lost loved one then not only represents an attempt to preserve the loved object but also an attempt to punish the hated object. If a hostile significance of this kind is in the foreground, the incorporation will then create new guilt feelings.

Case Illustrations

Mrs. Blue, aged fifty-nine, was referred to me by her family physician who was concerned about her because it had been over a year since the accidental death of her grandson Donald, age nine, and she was still suffering extreme grief.

Mrs. Blue found it almost impossible to talk about her grandson without weeping bitterly. She indicated to me that she cries nearly every night since the boy was struck and killed by an automobile. She told me of a dream she had recently in which she noticed that there was no snow on Donald's grave but all of the other graves were covered with snow. In the dream she had said to her husband, "No wonder Donald has no snow on his grave, he was always so warm and loving. He was my whole life." Then she remembered that she screamed and awakened herself.

She related that some fifteen years ago she had suffered a "breakdown" when her first husband abandoned her and left her alone to care for her young son. She expressed the concern that she "never had much luck with males." In addition to her grandson dying and her first husband leaving her, she indicated that her younger brother hated her, her son turned against her when his father left home, and she never had a satisfactory relationship with her current husband. However she did admit that since the death of her grandson her present husband has been very comforting and supportive of her. She acknowledged that she was implying that perhaps she is a curse or

jinx to males and felt that whomsoever she loved would in some way suffer. For this reason she has feared letting herself love anyone and indicated that when her grandson, Donald, was first born, she was afraid to touch him for fear that she might drop him or hurt him in some way.

She reported that since the boy's death she has had recurring visions of seeing the boy and confessed that she still believes that Donald is somehow still alive. She admitted that she had let herself get very close to Donald and was really blaming herself for the boy's death; because of this she could not let herself believe that he was really dead for then she would also deserve great punishment. She came to recognize that her mental anguish was her attempt to expiate her intense guilt feelings. However, she admitted that there were many times when she felt extremely hostile toward the boy because he would not let her control him. She was able to further admit that she has needs to control others and that she turned to Donald for the gratification of these needs because her son and daughter-in-law and her present husband all resented her need to control their lives.

It was only after I labeled the guilt that I felt she was hiding that she finally confessed her secretive feelings and soon after this her grief lifted. She was also able to establish a better relationship with her husband. She remarked, "No wonder my husband was angry with me. I turned all my attention to Donald and left him out in the cold. I must have been blind not to

see that."

I have also used the directed daydream technique with intransigent cases of prolonged mourning and find it to be an extremely helpful tool. One 17-year-old girl whom I was seeing in therapy in a woman's reformatory continued to deny the reality of the death of her brother. She kept insisting that her brother was waiting for her at home. After her brother died, she attempted to run from the reality of this event by "losing herself" in all kinds of acting-out, primarily sexual activity with boys who in some way reminded her of her brother. Eventually, this behavior landed her in the reformatory.

Suzi and her older brother by five years were both abandoned by their parents when the children were quite young. They lived with several different sets of foster parents and because of their mutual insecurity they became very close to each other. They repeatedly reaffirmed their vow that neither one of them would ever marry and that they would always take care of each other. The brother died suddenly in a car accident when Suzi was fifteen years old. When I first saw her she was extremely hostile about everything. She claimed that she was now unable to love anyone and enjoyed making fools of men by laughing in their face and showing them how stupid and inadequate they were, especially sexually.

In the directed daydream technique used with her, the symbolism will

be readily apparent to all sophisticated therapists. With her eyes closed and quite relaxed she spontaneously pictured a beach and an island (representing a distantiated part of her psyche) far off from the mainland. I encouraged her to take a boat out to the island. She did so, but she found the water extremely rough, tossing and tumbling her small rowboat from side to side. When she finally arrived at the island she was exhausted and just felt like quitting everything and going to sleep forever. When I encouraged her to explore the island, she wandered lost for a long time in dense forest and then suddenly she saw a clearing up ahead. When she approached it she saw a casket lying there. At this point she wanted to terminate the daydream but I encouraged her to continue. She went over to the casket and I encouraged her to open it and describe what she saw within. She offered much resistance in regard to this but when she finally opened the casket she let out the most mournful scream that I have ever heard. "It's Harold," she repeated over and over, "It's my brother Harold and he's dead." She cried with profuse tears for the first time since her brother's death. When she finished crying after many minutes, she remarked, "I'll be all right now. I know he is dead. It hurts to think about him like that, but I feel that I can make it okay now." Her adjustment, in the institution, after that cathartic confrontation was quite noticeably improved and about two years after this experience she became engaged to marry and is currently making an excellent adjustment outside of the institution.

Depression and Omnipotence

An infant's existence and security is affirmed because he feels himself to be the only principle in the universe and so he feels omnipotent. However, as he matures he comes to recognize that there are elements, both internal and external, in his world which he cannot influence or control. With love from his parents he can give up his need for omnipotence because he feels that he will receive from them the necessary protection and security which he needs to have. However, without such love and a feeling of being valued, he loses his sense of security and feels very vulnerable. As a result, he needs to continue to maintain the illusion of his omnipotence in order to feel secure. But when the events in life clearly point up to him that he cannot always control and influence it, he becomes severely traumatized and regresses into a dependent and depressed state in an attempt to get persons in his environment to protect him.

This kind of depressed person adds to his suffering by taking the blame for all that happens not so much because he likes to suffer but primarily because he needs to hold on to the omnipotent belief that nothing could possibly happen to him that is somehow not under his direct influence and control. A classic case in this respect is described by Smucker of a woman who had convinced herself that she had murdered her own child. The child had died of a childhood disease but she was unable to accept the fact that the child could have possibly died without her wish and agency (not only wanting it to happen but in some way actually making it happen). So, even though she

made herself suffer with terrible guilt and convinced herself that she had murdered her child, in so doing she preserved the more important illusion that she was still omnipotent.

In addition, because her therapist was a very loving and accepting man she set out to make him hate and reject her in order to affirm her capacity to control. The more accepting the therapist was, the more depressed and desperate she became. The more he encouraged her not to feel guilty about the death of her child, the more this would disturb her because she felt the therapist was threatening her sense of omnipotence. She finally had to declare her "love" for the therapist before he was able to give her the kind of response that she could interpret as rejection. Only then, because she felt in control again, could she relax her demanding attitude and only then did her depression lift sufficiently for her to get along without further intensive help.

This kind of depressed patient is by far the most seriously disturbed of those discussed and it is not unusual for them to move in and out of periodic psychotic episodes precipitated usually by some confrontation of loss of omnipotence which drastically undermines their security. As stated earlier, most depressive reactions are brought on by the onset of some sort of traumatic experience. It is traumatic to the depressive personality because the ego, which tends to protect and defend itself via the use of its anticipatory function, is caught off-guard and is shockingly confronted with an event

which was totally unanticipated. The ego is then inundated with energy it cannot contain, avoid or deny and it regresses in an attempt to escape.

The essence of the trauma then lies in the patient's unconscious realization that her omnipotence, which she has secretly been holding to, is just illusory. At this point all security is undermined by the recognition that she is not omnipotent and the patient then searches for a parent-type figure to provide the protection that she needs. She projects on to this parent figure all kinds of omnipotent qualities as she formerly had done with her parents earlier in life. That is why doctors are so often chosen for this role by depressed patients. There is a tendency on the part of the population and also some doctors to see omnipotent qualities in the knowledge and healing capacities of persons in the helping professions.

These depressed persons are almost continually bitter because life is such that trying to prove one's omnipotence in the everyday world is futile. Thus they are always "hurting." The bubble of this illusion must eventually burst, and depression or worse becomes inevitable. They live only with phantoms of security in the form of the belief that the fates protect them. They require some real sense of security, which makes it necessary to work very closely with the immediate members of the family.

Depression and Existential Issues

Apart from the more pathological forms of depression there is another form of depression worthy of discussion because psychotherapists are encountering it with a rapidly increasing rate of frequency. I am referring to depressions which appear to be related to existential issues. In some part the presence of these existential issues can be attributed to the progressive complexity and depersonalization that one experiences in society today but there are many other important reasons as well. One such reason relates to the fact that in generations past, much of one's felt insecurity was attributed to the realistic lack of economic security. The prevailing tacit attitude and assumption that existed in those days was that economic security, once attained, would serve as a panacea for all of the mind's insecurities and needs. However, in today's world, many persons in their hierarchy of needs have fulfilled their need for economic security and therefore their current insecurities reflect other, more complex, kinds of issues and needs, some of which may be classified as being basically existential in nature.

A patient suffering from depression related to existential concerns is likely to bring into therapy one or more of the following typical complaints: life has lost its personal meaning or direction; a chronic feeling of boredom or inner emptiness; a loss of all motivation and ambition in regard to a career that once was held to have extreme value; a deep sense of confusion or anxiety concerning his most basic identity; feeling burdened with vague fears of deterioration or death; a feeling of being trapped, with an accompanying

fear that it may already be too late for his current situation or condition to be changed, or the related feeling that life has somehow passed him by; concerns that his marriage or family life has lost its vitality and meaning; a profound sense of loneliness or alienation from others; or he may report only an indistinguishable malaise, restlessness, or sense of desperation.

The onset of this kind of depression most usually occurs around the age of forty or at a time which the patient equates with the beginning of the second half of life. Quite often it occurs when the patient seems to be at the pinnacle of his career. In women it may typically occur when her last child has grown up and has left the home or when a parent that she has long been caring for has died.

What is generally at the base of all of these existential depressions is that the early long-range ego enhancing and ego affirming ideals or career goals that the patient had set for himself, as the anticipated means of attaining a sense of absolute worth, fulfillment, identity, security, or meaning to his life, although fulfilled failed to bring with it a real sense of fulfillment in terms of the specific absolute benefits that he expected that the attainment of these goals would bring. As a result the patient feels a tremendous sense of despair because he believes that his entire life has basically been a waste. In addition, he feels very angry because he believes that he has been misled and deceived by persons important in his life in regard to the rewards that would accrue to

him as a function of his attaining those goals which they laid out for him to pursue. Early in his life he was implicitly or explicitly led to believe, by society, parents, church, etc., that if he surrendered and subjugated his own real and spontaneous inner yearnings, interests, and abilities, and replaced them with a set of pursuits, values, ideals or direction in life more in accord with those who were trying to influence him that his life, in the future, was certain to be highly rewarded with a sense of joy, fulfillment, esteem, security, identity, meaning, and the like. The future has now become the present but he finds that the goals that he strived for and attained returned no big payoff. There was "no pot of gold at the end of the rainbow."

His depression begins to arise the moment he attains the clear conscious recognition and conviction that his life, as he is currently living it, will never offer him any of the rewarding consequences that he thought would be his when he finally achieved his ideals and goals. He finds, for example, that he still feels basically empty inside, or confused about his identity, worth, security, or the meaning of his life. His resulting sense of helplessness, hopelessness, frustration and anger all contribute significantly to the development and maintenance of his depression. How some of the specific existential issues relate to depression will now be described in more detail.

For many of these kinds of patients the depression symbolically

represents the death of what he holds to be the most basically real part of himself. Essentially, the existential issue or problem is one of an identity crisis. He identifies his real self with those most basic experiential realities and personal yearnings which he felt compelled to ignore or surrender earlier in his life in order to pursue the externally imposed ideals or values. He feels that he has sacrificed all of the essentially real and important aspects of himself on the altar of his great need for acceptance by others. Now he has suddenly awakened to the realization that the personality that he has molded himself into is just not real nor is it anything that he really wants to be. He was never able to discover this truth before because he always held to the belief that if he achieved all of his goals that he would then be a totally fulfilled person. Now that he has achieved his goals he discovers that it is not true. It seems to him to be too late now to ever express and fulfill his true yearnings and abilities. In a sense he feels that something in himself has died or is irretrievably lost and that he has closed the lid over his own coffin. His deep sense of frustration and hopelessness and his mourning over what he feels that he has lost precipitate his depression. His anger toward himself for permitting himself to be so manipulated and misguided by others and the unexpressed anger that he feels toward those he holds responsible for his current state of loss and confusion also contribute significantly to the development of the intensity of his depression.

For other patients the depression and existential issue is related not so

much to a problem of identity as it is to a problem of needing to find a sense of absolute worth and meaning in one's personal life. This problem quite often manifests itself as a concern or preoccupation with the meaning of the whole of life, for one's personal life cannot be deemed to be meaningful unless the whole of life is first established as being meaningful. One typically finds in this kind of patient that for one reason or another the meaning or feeling of significance has gone out of his career which once was invested with very great meaning and significance. Quite often this kind of person is also involved in a marriage or family life which is loveless and which he also perceives as being meaningless so that his entire life seems to him to be totally empty and devoid of any meaning or significance.

At a deeper level one discovers that this kind of patient is extremely fearful of death and one who is desperately searching for some means of denying his own impermanence. He operates under the assumption that if he could find some personal meaning to his life that he would then be able to face his own termination in death without his extreme fear and trepidation. He generally concludes that the best way to establish that his life has meaning is through some kind of absolutely meaningful and uniquely personal contribution that he hopes to make to the enhancement of mankind. His fantasy is that his meaningful contribution will endure long after his death and that this would preserve a sense of continuance of his own existence through his identification with the enduring contribution that he has left

behind or through the memory of him which will endure in the minds of many people as a function of their association of his name with his lasting good works.

However, he must first attempt to establish that life as a whole is meaningful for if life as a whole is not meaningful then there will be no way for him to establish that his own personal life has meaning. His first impulse is usually to read widely in areas such as philosophy, psychology and religion in the hope of establishing the validity of some kind of deeper conceptual meaning to life or he may instead seek to join some kind of social movement, cause, or organization that he feels is already involved with doing meaningful things and making significant contributions to the well-being of mankind. However, after some period of time this kind of activity usually palls and he begins to feel a deep sense of despair and total loss in terms of where else to turn to find meaning in life. Some of these persons will then seek out psychotherapy in the hope of resolving their doubts and questions in regard to this existential issue as well as their fears and depression.

Concerns around fear of death are quite often also at the root of the depressed patient who feels that having reached the pinnacle of his career he has run out of significant goals to achieve or significant challenges to conquer. In these persons living has become equated with the striving toward some kind of becoming, that is, movement toward some kind of goal of self-

enhancement. Its opposite, stagnation, becomes equated with death. It is not unusual to find in many of these cases that here, too, there is a marriage and family life which seems to have lost all of its sense of vitality and excitement and the feeling of boredom associated with the stagnation in the home life intensifies his unconscious fear that his psychological self is dying. This kind of patient requires an almost continuous sense of excitation and self-enhancement striving for him to feel that he is really living. In an attempt to engender such feelings in his life he may typically get involved in extramarital sexual affairs, compulsive traveling, or in some kind of recreation or hobby by which he can continue to feel that he is enhancing himself such as improving his golf scores, learning a musical instrument, or the development of some other kind of new skill, or, as many do, he may go on some kind of self-indulgent buying spree. However, after a while, frustration and boredom inevitably set in again and his depression is the resulting unconscious symbol that he feels that his psychological self is dying.

The last such patient to be discussed in terms of existential depression is the person whose depression results not from the fulfillment of career or long-range goals but rather because of the frustration of such fulfillment. His feeling is that the time is now too late for him to fulfill his life-long ambitions and he still holds to the belief that without the fulfillment of his goals that he will be affirming that he is absolutely inadequate and worthless. He feels himself to be rapidly deteriorating or “going down-hill” and he desperately

would like to make time stand still so that he could accomplish all of his major goals. He sees his life, essentially, as amounting to zero, as though he had never lived at all. Analogously, he feels that the sun of his life has risen, passed its apex, and is now past noon and beginning to set but his harvest has not yet been brought to market. He feels tortured and panicked by the realization that his efforts and goals will likely never reach fruition and that sense of hopelessness along with strong feelings of self-condemnation results in his becoming severely depressed.

In summary, one finds three basic factors underlying the development of existential depression. One is a long-standing self-alienation and rejection of what has been real in oneself, and an identification with conceptual and imaginal ideals. After a long period of time the self-alienation becomes extremely painful, especially when one comes to the belief that it is now too late to give expression to those realities of oneself. A second factor relates to one's awakening to the realization of the tenuousness and impermanence of one's personal existence. The third factor seems to relate to the need for some persons to find some higher motivating principle for their life than just the devotion to one's own ego-enhancement in order to achieve a real and deep sense of fulfillment in life. The psychotherapist would do well to reflect deeply on these issues himself first before considering taking on such a patient in psychotherapy.

On the whole the prognosis in psychotherapy for these kinds of depressions, as with most forms of depressive reactions and other neurotic disorders, is usually quite good. The prognosis is good because in these kinds of disorders the ego is relatively strong, otherwise the patient would be exhibiting some kind of habitual acting-out or character disorder rather than a depression, and also because the extreme discomfort of the depression tends to maximize motivation for change. Spontaneous recoveries are also relatively frequent in depressions usually due either to some kind of expiation of guilt feelings through interpreted "punishments" that spontaneously occur in the patient's life or perhaps through the appearance on the scene of a new source of self-esteem such as a new job or love object which can greatly enhance feelings of worth and security.

A MEDICAL EXAMINATION IS ESSENTIAL

Prior to any psychotherapeutic work with depressed patients it is essential that the patient have a complete and thorough medical examination because the affective state of depression can quite often be the result of some hormonal or other organic dysfunction. When one is not feeling well physically, there is a greater tendency for dysphoric states to also be present. I had one such case referred to me by a physician after a rather cursory medical examination. Apparently he felt certain that the patient's depression was psychogenic in nature due to the fact that her depressed affect seemed to

be cyclical. After a few sessions with her she one time casually mentioned something about having frequent colds especially during the time of year in which she also seemed to get depressed. This corresponded with the time of year when the pollen count was highest. The possibility of some allergic condition made me refer her back to her physician even though she insisted that she had never been diagnosed as having such a problem although she did remember always having frequent "colds." The physician subsequently diagnosed her as being allergic to a wide variety of substances.

Apparently what was happening was that the allergic condition was clogging her breathing apparatus making it difficult for her to ingest sufficient oxygen. This tended to make her feel very tired and listless making it very difficult for her to do her chores around the house. This produced self-depreciatory attitudes which were further aggravated by her husband's criticism of her for not being able to handle her household chores. Relatively soon after the treatment for her allergies was initiated her depression lifted and did not return. She has now passed two seasons during which she had previously developed a depression and has not, as yet, experienced any such episodes.

It should be made clear, however, that although metabolic complications are often implicated in the etiology of depressions, psychotherapy can still be valuable in dealing with its psychological effects.

GENERAL COMMENTS IN REGARD TO PSYCHOTHERPY WITH DEPRESSIVES

Prolonged orthodox analysis is hardly ever required to cope with most cases of depressive reactions. Some form of brief, active psychotherapy is usually the therapy of choice. The most basic ingredient in working successfully with depressives is the establishment of a trusting and honest relationship with the patient, toward which a sincere, empathic attitude on the part of the therapist is an essential contributor. The meaningful relationship in which the patient is valued as a human being contributes more than anything else to the achievement of a sense of personal worth and importance. Because they usually have experienced a long history of rejection, they feel themselves to be as "valuable as feces which ought to be flushed down the toilet." For this reason, logical arguments on the part of the therapist, in an attempt to prove to the patient that she is not as worthless as she feels that she is, are basically a waste of time. The patient's experiences in life have conspired to convince her that she is valueless.

Only the therapist's sincere valuing of the patient can begin to overcome her deeply entrenched conviction of her worthlessness. Thus when the patient discusses her most recent rejection, the therapist ought not to come out with a statement to the effect, "there are other fish in the sea." This kind of statement does not comfort because it lacks empathic understanding and also fails to recognize that one of the things that frightens the patient most is the

thought of being rejected again. This kind of statement also communicates to the patient that she ought to quickly put away her hurt feelings or that she is foolish for harboring hurt feelings—both of which only contribute all the more to her feelings of humiliation.

Because a good, empathic relationship is so crucial to the success of working with depressed patients, the major deterrents to this success are the therapist's own negative countertransference feelings toward the patient. If the therapist is to work successfully with these patients, he must not be overly sensitive to feeling manipulated and used by them. Otherwise he will surely react negatively to the patient as soon as he recognizes that he is subtly coercing him into giving narcissistic supplies. Depressed patients can be extremely demanding and the therapist has to expect this from them.

Many therapists become upset when they begin to recognize that the patient has lured them into taking responsibility for their depressed condition. Essentially the patient is saying to the therapist, "It's up to you to get rid of my depression. There is nothing at all that I can do about it." Many therapists become extremely resentful when they finally come to discover that the patient is not coming to therapy to change or give up symptoms, but only to get his dependency and narcissistic gratification. The therapist has to be careful not to yield to the temptation of using insight as a "club" against the patient in an attempt to force him to giving up his depression.

I am not one who readily encourages the depressed patient to turn to medication of one kind or another, except in extreme cases. Medication can certainly be an important adjunct in the treatment of psychotic cases. However with less severe cases I find that medication tends to "feed" the patient's dependency needs and later it becomes very difficult for him to give it up without feeling a kind of abandonment which can precipitate an even more intense depressive reaction. I have also found that suggesting that the patient take medication communicates to him that I think that he is weak and needs a crutch. It is very important for the patient's ego strength that he recognize that he is getting better and it is very difficult for him to feel that he, not the pill, has achieved the growth and improvement. In a sense, medication may cheat him out of an opportunity to take credit for his own achievement undermining his self-esteem and confidence in himself.

However, most importantly, I try to explain to the patient that the depression is part of him and is being produced by some aspect of himself and that he ought not to treat the depression as a not-self. Resorting to a pill is forcing the patient to take sides between the conscious part of his functioning which declares that the depression is bad and "I don't want it" and the unconscious part that says, for example, "I need to be depressed in order to get relief from guilt or to achieve the gratification from others that I need."

I feel that it is a great mistake to encourage the patient to distantiate a

symptom from himself and then set out to rid himself of it, in a sense, forcefully. This only intensifies conflict and tension. I find it extremely helpful, therapeutically, when the patient begins to recognize the importance of accepting all feelings, thoughts and behavior as part of self. It contributes greatly toward the integration and wholeness of personality which is essentially what the therapist is attempting to help the patient achieve.

Essentially the depressed patient is encouraged not to try either to escape from or fight to overcome the depression. Fear invariably occurs when one tries to run from what is. To contest the depression and try to overcome it is also inappropriate because it only heightens the patient's state of tension and conflict. The unconscious desire or need for the depression becomes pitted against the conscious desire to eliminate it. The more one fights a problem, the more life and strength one gives to that problem. Depression or discontent of any kind is painful only when it is resisted. When the patient is depressed he *is* the depression and not just the experiencer of the depression. This duality only heightens conflict and the depression. To fight the depression is to fight oneself. To become one with the depression and not outside of or separate from it is to end conflict and produce the integration necessary for the creative healing process to take effect.

This is the essence of the entire creative process. When a person is in the state of experiencing—that is, when the experiencer and the experienced

are one—then the person is in the state of *creative understanding.* When the experiencer or awareness of self is eliminated by the patient's total attention to the problem, without making any effort in regard to escaping from, contesting or solving the problem, then the hidden aspects of the problem become immediately revealed because there is no longer any barrier of the self-interposed between conscious and hidden aspects of the problem. The problem then is seen in its totality and a direct and immediate understanding of the problem occurs.

The patient needs to understand that in a passive way, he needs to permit the depression to operate upon his mind rather than to force his mind to operate on the depression. It is crucial to understand that freedom from the depression comes only through the patient seeing for himself the truths behind his depression rather than through any effort he might make to escape it. This realization or self-discovery by the patient of the truth and understanding of his depression is *the* essential ingredient in producing a release from depression.

In addition to helping the patient understand the content of his problem, the therapist who works with depressed patients must also have a quality of inspiration about himself and the way he perceives life. In dealing with persons with severe depressions, logic and reason alone are generally insufficient tools. It is the inspirational quality which reaches the depressed

patient at the level at which he needs to be reached. It makes contact with a void in him which can be filled only by inspirational feeling. Even when the patient does not hear every word the therapist is saying, he is still moved by the feeling tone of what is being experienced. A mechanical, intellectual approach reaches and remains only at the surface of the patient's consciousness and by itself can never move the patient away from his morbid preoccupations. Inspiration helps to lift the patient away from morbidity on the wings of its own intensity. The source of this inspiration can only be love; that heightened sensitivity, openness, inner feeling of beauty, tenderness, compassion and unselfish concern toward all struggling humans beings which can come into being only as the result of the therapist's profound self-discovery of the highest in himself.

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