Psychodynamic psychotherapy and the treatment of depression

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Depression is a common yet complex disorder. Clinical experience, together with longitudinal studies of depressed people, shows that it can often be a chronic, lifelong, relapsing condition, rather than a 'one-off' illness.[1] The psychological burdens of depression are not only symptoms of an illness, but have a quality which is in some form familiar to everyone. In this way, depression can be seen as involving a personal, ongoing struggle with the universal life challenges of sadness, disappointed hopes and the mental pains of grief and guilt (see, for example, the Book of Job, *c*. 450 BC). Put simply, our struggles with depression are part of what it is to be human.

The psychodynamic explanation of depression is that it has its origins in infancy and in childhood experience. In this model, the unique make-up and early experiences of an individual can lead to vulnerability, which, in interaction with life events, culminates in adult depression. Although the mainstay of medical treatment of depression has been pharmacological, surveys show that patients are overwhelmingly interested in talking treatments as well. Certainly, the subjective experience of depression, as described above, is central to the condition. Dynamic psychotherapy, in its way of engaging with the patient, reflects on the problems of living and relating, which are the focal point of concern for many patients.

This contribution gives an account of the main themes of the foremost psychoanalytic/psychodynamic accounts of the nature and origins of depression, followed by a review of the evidence for the efficacy of such treatment.

The psychoanalytic model of depression

Freud's canonical *Mourning and Melancholia*[2] compared and contrasted the mental processes involved in mourning with those in depression. He postulated that mourning and depression are different types of reaction pattern to the same sort of event – namely loss. The common basis of both states of mind explains why they have a family resemblance. The depressed person sometimes can

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find no conscious reason for his distress but he exhibits some similar features to a person who is mourning.

Freud postulated that in depression the loss is unconscious but the patient is unable to retrieve or acknowledge it, whereas in mourning the person is in no doubt about what or whom they have lost. Freud also noted a key difference: in mourning the world is felt to have lost meaning; in depression it is the self that is experienced as reduced.

Identification

The explanation of this key difference rests on the psychological concept of identification. Freud argued that part of the self had undergone a change in depression through its becoming identified with (becoming the same as) the lost object (object is the psychoanalytic term for a person). Depression arises from the inner (but unconscious) antagonism and complaints between one part of the self and another, which is identified with the lost, and therefore disappointing object. In this identification, 'the shadow of the object falls upon the ego' (i.e. the Self), which is a composite of identifications, is felt to contain a negatively identified aspect – and therefore to be 'bad'.[2] If I am 'like' my father, then this makes me 'bad' like him.

Ambivalence

Freud stressed the role of heightened ambivalence in depression; that is, feelings of love and hate directed towards the same person. In mourning, anger towards the lost object is overcome by feelings of sadness, longing and love, while in depression we encounter a higher level of anger and destructiveness.The balance is tipped so that love does not 'win out', which would lead to the acceptance of loss, as happens over the time course of mourning.

The ability to mourn is an adaptive capacity. It is both a product of mental health and resilience, and a component of them. In depression, on the other hand, there is no relinquishment (letting go of what has been lost) but identification and as a consequence there can be no adaptive alteration. The inability to relinquish – becoming stuck in identification, in grievance, and being unable to forgive in reaction to early disappointment and loss – becomes internalized, sometimes expressed directly as character traits and sometimes more as a susceptibility to depressive disorder in adult life (see Figure 1).

The superego

Alongside the ambivalent identification process, Freud also pointed out the increased severity of moral judgement that occurs in depression ('I'm so bad, I don't deserve to be happy'). He was concerned to understand how this happened. He described the setting up of a 'critical agency' within the ego, as part of child development, which 'henceforth will judge the ego'. This is the superego, and Freud suggested that 'the relationships between the ego and the superego becomes completely intelligible if they are carried back to the child's attitude towards his parents'. The superego is coloured by the child's own hostile and rivalrous feelings, so that 'the more a child controls his aggression towards another, the more tyrannical does his superego subsequently become'.[3]

The superego covers a wider range of conscious and unconscious operations than the notion of conscience to which it is clearly related. In healthy development the superego may take on, over time, a benign guiding role, but in those with a predisposition to depression, the superego acts in a spoiling, superior and sadistic way, becoming hyper-moral and tyrannical towards the ego. The tension between the ego and the superego is manifested as a sense of guilt and worthlessness. When very severe, it has the power to degrade the ego's capacity through murderous impulses directed at the self, sometimes culminating in suicide.

Case study 1

Mr A's marriage was spoiled by powerful feelings of anger and hostility for which he could not account. When these feelings got out of control he feared they were destroying his marriage, leaving him feeling depressed, abandoned and bleak. The patient felt that his wife, N, was 'addicted' to her family; in particular he hated the attention his wife gave her sister, who was still breastfeeding her son. Mr A felt his quarrelling to be compulsive. 'I cannot stop having a go at her about her sister,' he said. N had got angry, calling him an 'inquisitor'. He had smashed a valuable bowl during one row. That night he had the following dream.

'*There was only a flat sandy island with water all around. There had been a nuclear explosion. The ground was contaminated by radioactive fall-out. Everything was finished. There was no chance of escape for me and the other people there. N was amongst them and she had decided to leave me. I was crying, "Do you really like hurting me? You were doing this because I have put all my hope with you."*'

The analyst saw this dream as illustrating Mr A's internal world. In the conflict of love and hate, the nuclear explosion represented the patient's anger and the radioactivity the emotional fall-out of this explosion. The atmosphere is that of a nuclear winter. Nothing good in Mr A's inner world is felt to survive his rage. No sense of life, nor good, nor hope in the future seems possible. The prevailing sense of the internal world centres around warfare and the infliction of hurt. The patient experiences himself as abandoned to a desolate fate. In this way the complex affect of depression can be seen to arise meaningfully out of Mr A's powerful feelings of infantile need.

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The role of aggression in depression – further developments in the dynamic theory of depression

Karl Abraham influenced thinking on the causes of depression by highlighting the role of aggression and destructiveness (Figure 2).[4] When treating seriously depressed patients, he observed that the patient's capacity for love was being overwhelmed by feelings of hatred and that they were profoundly upset by this. Melanie Klein, who analysed children, was impressed by the role of an innate destructiveness and aggression in depression, which could be much increased by adverse experiences.[5] In the USA, Edith Jacobson also emphasized aggression and its role in depression, but she tended to view it much more as a reactive phenomenon rather than one with primary roots.[6]

Other psychodynamic approaches emphasize different aspects of the depressive constellation. Kohut viewed depression as coming

