

## Psychotherapy of the Depressed Patient<sup>1</sup>

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THERE IS A TRADITION OF EXCEPTIONAL difficulty in the psychoanalysis or other psychotherapy of depressives. Edith Jacobson (1954) spoke of a more intensive affective involvement with them. She referred to intervening with a "spontaneous gesture of kindness or even a brief expression of anger, " but wisely added, "... since these patients are frequently very provocative and exasperating, such a deliberate show of emotional responses naturally presupposes the most careful self-scrutiny and self-control in the analyst." Sullivan (1954) commented on the depressive's functioning as particularly difficult to comprehend and deal with, the person "remaining, " as he expressed it, "most remarkably obscure and unknown." Freud (1959) found in the depressive "an attitude of revolt, " which is a formidable barrier to productive therapeutic collaboration. Frieda Fromm-Reichmann (1959) noted the depressive's "lack of interpersonal sensitivity, " which we can recognize as an emphatic hindrance in exploring interpersonal experience; she may also have been referring to a quality in the depressive which Freud (1959) characterized as "incapable of love." Despite the distinguished status of the analysts here referred to, and many more could be quoted to confirm the arduousness of working with depressed people, I feel safe in suggesting, as the most impactful single reference to cite, one's own personal professional experience.

This sketchily indicates a consensus regarding an inherent difficulty in psychotherapeutic approaches to the depression prone person. There is, however, an additional complication because of considerable divergence of views regarding the nature of and dynamics involved in depression (reviewed by Arieti and Bemporad 1978) ; (and Mendelson 1974). What follows shall be confined within the framework of a single personal dynamic concept of depression prone human beings (Bonime 1976). Therapy is naturally derivative of these dynamic concepts. It will be illustrated with examples and discussion of the clinical difficulties the depressive person presents. The ideas and examples will be reinforced by parallels between clinical and social contexts.

My underlying concept is that depression, rather than being an affliction, is a practice—a distorted way of relating to other people. It is a way of interpersonal functioning which unavoidably results in misery. It is misery for the depressive and also for those closely associated with him or her. Every depressive, although conforming in some degree to a certain pattern of living, has both achieved such a pattern and expresses it in a wholly idiosyncratic way, and this uniqueness needs to be explored fully in each case. While, for instance, the genesis of the depressive personality is always associated with deprivation in childhood of non-obligating solicitude, the deprivation may take extremely different forms. For a brief example, and with immediate sharp contrast, idiosyncrasy of deprivation of genuine affectual nurture may for one child take the form of unmitigated, tyrannical, harsh or savage criticism. For another, the deprivation may be expressed in the style of pressuring praise, a "benign" coercion to live up to superior standards of performance. Myriad subtle variations and combinations of obligatory behavior to evoke "love, " or its denial under almost any circumstances, characterize the genetic milieus of the hosts of depressives.

Despite the uniqueness of each life, the concept of the depressive personality can be generalized in terms of six cardinal elements. Enumerative presentation carries the hazards of rigidity and reductionism. What follows will, I believe, nevertheless, offer the opportunity for an authentic grasp of the basic problems. The elements are: despair, manipulateness, aversion to influence, unwillingness to enhance others, anxiety, and an affective core of anger (Bonime 1976).

Extracts from a letter sent me by a stranger many years ago offer some of the central aspects of the way of life to which I refer. The letter, from a self-designated depressive, by itself gives rich opportunity for speculation and demonstration. The writer identifies himself as a Ph.D. and otherwise indicates a presumably high level of achievement. "I have never had therapy, " the communication begins.

*I have been having severe depressions ... I can't love. My marriage [after a few years] has collapsed ... largely my fault. I'm extremely autocratic and exploitive. These characteristics (formed in my childhood) I've not been able to modify. Every relationship I have is essentially one-sided because I won't give ... my favorite game is to withdraw to punish people for not loving me ... nothing affords me happiness. I believed [my occupation] might be my means to happiness. But this is not the case. I've lost contact with my feelings—my emotions—and I want to recapture them.*

This letter is a very sad one to read. It reflects much about the first of the above noted elements of depression: *despair*. A vital quality of depressive despair is the *sense of being trapped* in a way of living that is anguishing and can't be changed. The man writes, referring to his self-styled autocracy and exploitiveness: "These characteristics (formed in my childhood) *I've not been able to modify*." [italics mine] There was much more formed in his childhood than he designates and of which he's probably not aware, even if it's an essential part of the entrapment. This childhood heritage unquestionably includes many forms of *manipulativeness* which he is remote from delineating as subtle variants of the gross controls and uses of people which he easily specifies as "autocratic and exploitive." The subtle dominations and utilizations of others may be, when unsuccessful, constant subliminal sources of a variety of painful feelings. These are feelings of frustration, failure, rejection, even being the object of hostility when the behavior of others is transmuted by paranoid misinterpretation (Bonime 1979). This subliminal current of responses would add continually to the patently painful consequences of acknowledged autocracy and exploitativeness.

Thus, alongside despair, the depressive personality involves *manipulativeness* as one of its pivotal elements. These people, always ones who have been deprived of affectual nurture in childhood, develop techniques of eliciting by multiple methods a sort of compensatory care from others. Some of the compensatory care comes from what this man denoted as his "autocratic" and "exploitive" practices which he describes as having been "formed in my childhood." Characteristics of this kind do not evolve in a childhood milieu of sufficient and appropriate solicitude. Autocracy and exploitativeness and their less easily recognizable manipulative variations, such as seductive charm or pseudohelplessness, also do not become by themselves part of a developing personality. Like speech and other forms of interpersonal behavior, they require stimulus and tutelage. The depressive, in childhood, has been overcontrolled and exploited for parental purposes (Fromm-Reichmann 1959). Much of the psychotherapy of these people involves a focus on the open or covert control by which they were manipulated and on the exploitation they suffered. However, while examining how they suffered from it during their developmental years, it is important for them also to explore in psychotherapy how well they simultaneously learned two important categories of functioning. (1) they learned *how* to manipulate and exploit; and (2) they learned techniques of *evading* coercion, exploitation and whatever else, no matter how distortedly interpreted, gave them the *feeling* of being exploited and coerced.

The latter observation has introduced another element of depressive character and practice: *aversion to influence*. The depressive, with our assistance, can usefully seek to recognize his or her intense resentment, avoidance and also misinterpretation of being controlled. Depressives are underachievers (Capponi 1973). They experience responsibility itself as coercion. Can this perhaps be an implication in the letter: "I've lost interest in my [occupation]"? They fulfill responsibility in desperation, in fear of the consequences of delinquency. Part of the above letter alluded to this: "Though I've been functioning, it is only under extreme pressure."

A fourth central element of the depressive personality was characterized as an *unwillingness to enhance the lives of other people*. The stranger's letter expresses this eloquently: "Every relationship I have is essentially one-sided because I won't give." The unwillingness to give is the basis of much of their suffering. Because there was a genuine deprivation of affectual nurture in childhood, there is a constant search for the non-obligating solicitude that (with the exception of physical and mental handicap) is appropriate exclusively to the state of childhood. When individuals grow up being controlled and exploited for the benefits of parents or parental substitutes and adjuncts instead of receiving care for fulfillment of their own genuine needs, they grow up with a sense of an essential lack. A *need* of the child is to be cared for simply because of the value he or she has in existing as a human being. Too often he or she is helped, groomed, rewarded for functioning well in the ways he or she is trained for the convenience or greater glory of those responsible for the child's development. The evolved depressive's constant manipulation, exploitation, demand, and lack of reciprocation are manifestations of a constant search for that free, valuing, non-obligating care. The older one grows, however, the less appropriate these wishes become. Growth, maturity, involve reciprocation and responsibility. Therefore nothing offered the depressive is ever fulfilling, because it cannot arrive with that unrequired reciprocity of which the individual was earlier deprived. It can never include that childhood quality, and not only because other people expect an exchange within relationships, a reciprocal valuing; that is not the major barrier. An absolutely insurmountable barrier is that what is offered cannot ever include the precious lost quality—and it cannot because the recipient is no longer a child, can no longer experience whatever is offered, with the feeling of a child. Thus the most generous of friendship, love, concern is never enough—it always arrives with a quality of inadequacy. Thereby, whatever the richness of any offering, it insinuates into the patient's life another increment of *not enough*. The depressive lives in a cumulative context of deprivation, being owed so much and increasingly more, because of his or her own rejecting what is offered and what is always not enough. Others never adequately fulfill the depressive's "needs"; in such a context of growing deficit *the depressive becomes increasingly unwilling to enhance others*. He or she does not even show genuine gratitude for what is received. The empty, poor, deprived one has nothing spare to give—it is unfair for the world to expect, let alone demand. The letter writer says, "I won't give."

Difficult, painful and *frightening* consequences flow from this and the other distortions. A fifth cardinal element of the depressive personality and the practice of depression is *anxiety*. The depressive suffers recurrent, often intense anxiety. He or she fearfully, mostly unawarely, wonders how much longer those who seek to help will persist in their efforts to allay the suffering, change the insupportable life. How much will those helpers endure of a mostly false, grudging or absent gratitude, or even the simple pleasure of observing a meaningful follow through? How much risk of the consequences of unfinished responsibility is threatened by procrastination?<sup>2</sup> How many promising contacts can be sabotaged and still be replaced? What is a safe estimate of what traffic will bear? When will complete, final rejection descend? The depressive lives in this constant ambience of threat.

Apart from the ambient practical risks of occupational, social, often conjugal loss, there is another deep subjective threat. The depressive's *sense of self* derives to some extent from successful manipulation. When this practice, manipulation, is faced with failure, it is a threat not just to a technique of living, but to the feeling of *me* that is the sensate-cognitive-affective accompaniment of an individual's functioning effectively (Bonime 1981). How long, how constantly, can the depressive maintain or restore the sense of self he or she achieves through effective manipulation? How close is collapse of the self? When will the strain of threatened self-dissolution from his or her cumulative failures, repetitious losses of sense of self, become insupportable? Is there, besides, a danger that the sense of inescapable entrapment in this miserable way of life may lead to suicide, or self-injury, or losing one's mind? The recurrent and long enduring low mood of the depressive has this often subliminal, almost constant accompaniment of anxiety.

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<sup>2</sup>Procrastination is often a rebellion against the coerciveness mistakenly felt by depressives in the demands of responsibility. Procrastination may also serve to disguise the full measure of the depressive's capacities in order to reduce expectations by others.

Finally, before tackling more fully the psychotherapy of this painful, compulsive way of living, there remains to consider one more crucial element of the practice of depression: it is the *affective core of anger*. Anger constitutes much of the motivation of depressive practice and is one of the most difficult aspects with which to deal psychotherapeutically. It is my forceful speculation, in fact, that the affect designated "depression" is itself a *manifested* anger—not by loud rage, not by lividness or flush, nor by overt stubbornness, not by assaultiveness, nor by hypertension, migraine or intestinal pain. This *anger*, here designated as *despression*, is manifested by a different dysphoric state, one of low mood and low energy. Psychosomatic or conventional anger may accompany or be intermingled with the depression. Psychosomatic manifestations, also violence and other antisocial activity, are among many variations of behavior and feeling often referred to as "masked depression" (Lesse 1974). One patient, after extensive analysis, wrote six months following a long prearranged termination: "I've written many times and then torn up the letters—partly out of anger and partly because I so wanted to be able to handle things myself ... David and I have some real problems, but I suspect they could be handled if I could get my neurotic behavior under control. Since [termination] I've had one psychosomatic problem after another—eyes, bladder, bowel, herpes, migraine ..." (These were recurrences and included profound lethargies.) Sporadic sessions were required, particularly with the added problems of post-analysis marriage. The exacerbations of anger, much of it, as in the past, manifested somatically and directly associated with responsibility, now was conjugally accentuated by increased demands and the bitter need to recognize that, married or single, she'd *never* be released from the necessity personally to carry out her role in life.

During psychotherapy, one must clarify that the anger of depression is punitive to those who either seek to or fail to assist. It is essential also to distinguish depression from sadness, grief, discouragement, all of which may be perfectly appropriate and healthy responses to life situations. It is further necessary to keep in mind that these appropriate emotions may exist along with depression and that they call for a different clinical response, often a simple sympathy without inspection. Likewise it is therapeutically important to distinguish between practice of depression, on the one hand, and the despair that results from the entrapment in depressive practice, a despair which becomes a part of the total syndrome. A depressive collapse—neurotic, psychotic or suicidal—may be simultaneously an angry vindictive attack on the unfulfillers and an act of hopeless, anguished, desperate search for escape. During the protracted contact with the angry (depressive) patient, the psychotherapist must never lose touch with compassion, while at the same time never easing the essential demand for the patient's engagement in the therapeutic process. Nothing the therapist subjectively feels in terms of frustration, impotence, failure, resentment, can begin to approach the intensity of rotten feeling of the person living a depressive's existence. The deepest compassion justifies no relaxation in the demands upon the patient, none that are part of the therapeutic process. On the contrary, compassion engenders in the therapist more intense efforts to engage the patient.

Psychotherapy of the depression prone individual thus requires a constant awareness of the suffering along with a constant exploration of the anger—the anger that is justifiable on the basis of readily or eventually discovered early imposed and later self-induced deprivation. The early deprivation, though often obvious, is not always readily discernible in a family setting outwardly seemingly adequate as recalled. It is an arduous and long task then to achieve recognition of the early established angers, and then that depression is itself a mode of anger. Many of the childhood mopes and listless boredoms were angers. The anger must be pursued in endless contexts, past, present and in the therapy itself. It needs to be delineated in all the protean forms it has later assumed, and connected with the painful consequences of the practices of depression—miserable moping weekends, occupational humiliations, party pooping, sexual anorexia, interminable active and passive assaults with unaccountable unhappy effects. It is crucial to be aware that the very basis of psychotherapy, because it demands a most intense exercise of the patient's personal capacities, is, for that reason, enraging to the patient. The depressive yearns and demands to be relieved of torture by some external force, not to be engaged in an arduous education in how he or she can change the way of living whose agony becomes more and more recognizable as largely self-produced. One patient says: "I'm so depressed—the harder I try to cope, the sicker I get." At another time: "I am so outraged at the finality of having to do all this myself, that collapse is always imminent." This patient was extremely self-sufficient, demonstrated (with secret pride) by admirable handling of *other* peoples' catastrophes, but she was "outraged" over the endless responsibilities of her own everyday life, the relatively simple social and personal requisites and marital obligations. In analysis, despite, or perhaps because of highly productive work with dreams, she showed a great reluctance to bring them in. (Dreams, as might be expected, richly reveal the depressive personality [Bonime 1962], [1980].) A frequent response to insight was a yawn—like pulling the covers over one's head instead of facing another day.

This particular yawning response to demands on the self (all insight has implicit demands) aptly suggests the lethargic mode of expressing anger—it is a possible authentication that depression is a mode of anger. The act is, "Let me alone, " with a yawn instead of a shout. Correlating insight for the patient with the yawn or other response leads eventually to recognition by the patient that these responses are useful signals of insightful target areas. One patient was grateful for the concept regarding depression as anger, grateful over thereby being released from almost daily lying in bed until two PM. But this same person expressed open, conventional rage at the expectation that there was a step beyond getting out of bed. There was then a need to pursue an occupation. The procrastinations, the lethargies, the diffidences are important manifestations of anger as the affective core in the depressive. These are expressions of what was dramatically demonstrated in another depressive as "angry unwillingness" (Bonime 1980, pp. 142–145). It was exemplified in one instance by this man's sudden unwillingness to open an eagerly and long awaited letter that he knew gave him permission to proceed with an essential project; again, responsibility experienced as coercion.

There is a particular point in therapy of the depressive when it is singularly important for the therapist to consider the concept of depression as a mode of anger. It is when a therapist who is keeping alert to his or her own feelings detects in her or himself a tendency to impatience, seemingly excessive discouragement, *boredom*. These responses are conceivably expressions of depression in the psychotherapist, a probable occupational hazard in psychotherapy of depression (Bonime 1957). Many clinical dangers lie here. Among them are the complete abandonment of psychotherapy in favor of pharmaceuticals, electro-convulsive therapy, hospitalization, transfer to a therapist of another sex, an older or younger one. The danger of any of these shifts inheres in the basic fact that the patient can thereby be released from more intensive personal pursuit of his or her problems. He or she can continue, instead, the lifelong pursuit of external sources of relief. Fortunately, from the standpoint of acute misery, *symptomatic relief* is often found via one of these alternate routes. The danger, however, remains in the fact that symptom alleviation does not basically alter personality. The practice of depression, the personality of the depressive, is a relative constant. It has no premorbid health; it is not an intervening illness. The depressive's life is always filled with the already indicated types of interpersonal difficulties. It is suffused with underachievements, diverse intensities of frustration, dissatisfaction, anxiety and unhappy lowered mood. The psychotherapist's own bored, presumptively depressive practice can attenuate the patient's use of his or her own resources for exploring and dealing with problems. By discouraging the psychotherapist, the depressive patient takes the pressure off him or herself and can subtly establish an effective anti-therapeutic manipulation. Variant techniques of discouraging the therapist are frequent latenesses, cancellations, forgetting insights, omitting report of dreams, being silent, having "no feelings, " having the mind be or go "blank, " accusations of empathic or sympathetic inadequacy ("You don't understand"; "You don't care"). Sometimes the depressive even succeeds in provoking vindictiveness from the therapist in the form of verbal attacks—perhaps only by inflection—or well-rationalized retaliatory and competitive silences. One patient, after months of useful insight from a dream, suddenly, one day, repudiated the content of his dream. (That was extremely difficult [!]; fortunately, the value of two years of analysis does not rest upon a single dream or insight.) The central point is that a depressive patient, by putting an effective strain on the psychotherapist, may thereby succeed in deflecting from himself, reducing, the demands of the psychotherapeutic process.

There can be much value in delineating such usually unaware manipulations. Acknowledgement of the patient's getting under one's skin is more helpful when accompanied further with acknowledgement of the therapist's own negative contribution, and with decent assurances to watch subjective responses that might hinder progress. The patient can be assured also that the therapist will stay with him or her, that the patient's behavior or attitude will not be more than traffic can bear. It can be valuable when the delineation of the patient's intratherapeutic manipulations—discouraging, angering, boring, making excessive demands upon the therapist—are indicated as comparable to the patient's burdensome and provocative activities outside the therapeutic situation (Bonime 1968). Outside of therapy the sabotaged efforts of friends, relatives, coworkers, to ease the situation eventually provoke toward the patient, impatience, cessation of help and devastating, enraging accusations of "self-pity." A sense of danger of the withdrawal of the helpful efforts of others, even of complete abandonment, may prompt in the patient the tentative use of personal resources to relieve the drain on those concerned. He or she may function companionately, productively, responsibly. The patient may, in comparable fashion, make genuine efforts to take part in the psychotherapeutic process by bringing dreams, offering associations, exposing emotions. These excursions into self-sufficiency, within and outside therapy, are significant in the slow course of change and growth. The lethargies, helplessnesses, unreliabilities and psychosomatic escapes do return, but the patient, during the periods of changed behavior, has been through important sensate-cognitive-affective recognitions and ineradicable new emotional experiences.

With all the difficult negativity, a vital role of the therapist is that of sensing the interweaving in the vast complex of the depressive personality the signs, past and emergent, of genuine assets. It sometimes gives one the sensation one feels while contemplating a difficult psychological figure-and-ground presentation. One patient in such a complexity offers us an opportunity to trace healthy emergent trends. Referring to her husband she said most explicitly: "I know David can only take so much of this and ... I play a kind of brinkmanship with him. ... When I feel I've gone too far, I just suffer in silence. ... I gave a small dinner party ... and it was very pleasant ... the next day I had back pains." She recognized the whole picture and went on with her description. She was not an alcoholic, but took occasional alcoholic fugues: "I also am taking recourse to the old booze—not blackouts, but [drinking] too much. I realize so well the need for oblivion. [This was one patient who used to yawn at the approach of insight.] The reality of it all, the now or never aspect of where I am—the fears, the anger ... If I don't do certain things, I have anxieties. Both before and after ... I attempt my collapses." She was contemplating her functioning, not crying for help. Her immediate association was of an incident when she was developing insight and had a fierce struggle one afternoon to overcome her temptation physically to collapse on the street on the way to her analytic session. As just indicated, it is important in the very midst of serious symptomatology to keep in view positive aspects of the picture, gains that are developing. With this woman, anxious, angry, and collapsing as she felt on the way to my office that afternoon, she didn't cancel her appointment. She came to the office, reached there on time, worked intensively through the whole session. These growth experiences do not transmute the individual nor eliminate the pathology, but slowly contribute to a healthy change of personality.

It is crucial for the psychotherapist not to back away from the patient's severe anxieties (Bonime 1959). The sense of self, as discussed under anxiety as a cardinal element of depression, is an affective-sensate-cognitive almost proprioceptive phenomenon experienced in the course of functioning (Bonime 1981). It is a fearful situation to find one's familiar personality not functioning. As quoted above, "... if I don't do certain things I have anxieties ... and if I do certain things I have anxieties ..." It is as though she were saying in fright, if I cannot force people to sustain me I am not *me*; and if I function with self-sufficiency I am not *me*. The prospect of self-dissolution, of either the physical person or the personality, is a fearful prospect. This concept can be effectively introduced to a depressive, who is in part frightened of the undefined possible consequences of struggling to develop self-sustaining personal resources. It is particularly urgent to focus upon, not withdraw from, the severe anxiety, sometimes associated with depersonalization of various intensities, that may accompany achievement of a major transmutation in a patient's functioning (Bonime 1973). A collaborative depressive patient's dawning comprehension of some of the forces involved in the maintenance of his or her "helplessness" can over time supplant hopelessness with at least ambivalence—a real achievement. With achievement of ambivalence psychotherapy becomes significantly less a polarity between the therapists' efforts and the patient's resistance. Just as experienced by that patient who yearned for but successfully fought off her collapse on the way to a session: with the ambivalence evolved through insight, struggle for change becomes the patient's own.

A major problem in working with the depression prone patient is the exceedingly slow pace. There are many reversals, negative therapeutic reactions, many difficulties in engaging and reengaging the patient in the psychotherapeutic process (Bonime 1969), (1978). The depressive wants relief and comfort, but not by working for it. For the depressive, the problem is the deep and perpetual feeling that relief is owed, is due. The continuing underlying feeling of deprivation is a steady stimulus to keep up all the idiosyncratic techniques devised to tap the resources of others instead of developing one's own. That underlying sense of deprivation of value, experienced sometimes as being exploited, fortifies the defenses against influence which, along with responsibility, is misinterpreted, mis-felt as coercion. It is a major barrier to change.

The fight against coercion has been and is reinforced by the profoundly competitive milieu in which we all, each in our special way, develop our personalities (Bonime 1966). One patient, after considerable progress, was able to delineate and communicate a definite counter-therapeutic feeling with the statement: "... Even if things worked out better for me, I have occasionally felt I wouldn't want to admit it—it would be like being bested in an argument." Many depressive people have managed considerable life accomplishment, as did the person whose letter was quoted at the start of this paper, the man who had a Ph.D. and a high position in his field and had expected his occupation to be his source of happiness. There was the woman who tended to collapse at the prospect of carrying the responsibilities of her own life: she was regarded as a "magnificent" performer at times of voluntary crisis intervention in other peoples' lives. Over time it is essential gradually to call attention to the substantial demonstrated capabilities of the "helpless" depressive; but it is necessary at the same time not to batter a patient with inventories of his or her evident personal capacities. The depressive is not altered by aggressive documentation, will not be "bested in an argument." Furthermore, any attempt to base a change of functioning on argumentation will achieve nothing productive psychotherapeutically, but on the contrary

is more likely to foster a reinforcement of the patient's feeling of being competed with and coerced, even of being the object of contempt. It may, at times of pseudo-helplessness in the patient, be hard for the therapist to avoid a perfect repudiation of claimed incapacity. The circumstances of patently fragile claims of helplessness are much harder to deal with for the patient than for the therapist. A nearly universal problem for the patient in psychotherapy is shifting from the personality formed in our culture's competitive interpersonal milieu to a personality modified by clinically essential collaboration. It is particularly hard because the patient must continue to function outside of therapy in that same competitive milieu in which much of the competitive personality distortion developed. Therefore a fundamental element of psychotherapy is the therapist's need to keep a constant assessment of the therapeutic milieu and do all possible to avoid making "points" against the patient, avoiding all tendencies toward a dyadic polarity. Probably much of the current focus in the literature, on countertransference, is a growing recognition of the range of influences, many hindering, polarizing influences, of the psychotherapist's personality in the clinical situation. The increasing focus on countertransference is one of the prognostically healthy trends in psychoanalysis and other modes of psychotherapy (Epstein and Feiner 1979), (Langs 1980).

A final psychotherapeutic concern is helping the patient in sensing, delineating and communicating emotion during psychotherapy. The depressive to a large extent feels confined to a few negative emotions—hopelessness, lack of enjoyment, boredom, despair. To various degrees, life seems empty; the depressive often appears to himself or herself to be out of touch with feeling. But the feelings are there. The depressive does not have affective poverty, does not have to believe he or she is fundamentally so hollow, flabby, unresponsive, inert. The range of actually experienced feeling is wide and can eventually subjectively register, be acknowledged. With any patient, the emotion can tell or suggest a great deal about each personality by the nature and the combinations, variety and alterations of emotional responses in various contexts. The woman who affectively experienced acknowledgement of an insight about "being bested in an argument" if she got better, was also sometimes experiencing the feeling that it was better to be competitively ahead of her analyst than to have her life work out better with a change of personality. In retrospect, the same context that made her feel victorious, later made her feel foolish and restricted. How much had she missed in life, how much had she slowed up analysis because of competitive false pride? How much painful extra hopelessness had she brought upon herself? How much new freedom did she gain by finally sensing, delineating and communicating her feelings?

The man who wrote the letter quoted at the start of this paper stated as his last sentence: "I've lost contact with my feelings—my emotions—and I want to recapture them." Despite his declared "lost contact with ... feelings," his very brief communication reflects, at very least, ten distinguishable emotions. The term "recapture" is an interesting implicit recognition of a potential capacity for affect. To start with, the whole letter exudes misery. He then alludes to gratification when he speaks of his "favorite game." That game is to "withdraw to punish people," which is a declaration of vindictive affect, vindictive gratification. (It is important to distinguish between gratification and happiness. The depressive is miserable but has, nevertheless, gratification from every successful manipulation of people, every vindictive punishment. The recognition of gratification as different from happiness is an important distinction and can help a depressive to see how much depressive practice can be indulged in for gratifications that make happiness impossible.) This man of the letter also suffers shame; he's "tired of this sick game of self-deception" and he confesses his "autocracy" and "exploitiveness" and unwillingness to give. All these self-searching revelations we must also recognize as at least in part engendered by healthy pride in honesty, as likely reflecting an internal current of self-respect. He also expresses fear: "I fear to give." And he suffers boredom, does not even enjoy the occupation in which he is deeply involved and which he thought would bring him happiness. He reveals also a grandiosity in a statement that "For many years I believed myself to be a strong person capable of dealing with all my problems." And finally he feels bankrupt, helpless, about changing his condition: "These characteristics I've not been able to modify." The purpose of this inventory of emotions from somebody who writes, "I've lost contact with my feelings," is to indicate the broad spectrum of affect an individual may have without awareness of being a feeling person. This also suggests how potentially valuable a continual pursuit of feeling could be—a search in every context for the personality-defining emotions associated with varieties of functioning. Through this pursuit of affect there is a constant possibility of recognizing the relationship of what one seeks, revenge by withdrawing; and also the nature of the consequences, the misery of being unloved. The depressive, exploring affect, can begin to see himself or herself as playing some role in the production of an anguished existence instead of appearing to himself or herself as essentially a victim.

Some final and summarizing thoughts. It is an exceedingly difficult undertaking for a depressive to give up depressive practice. He or she has spent a lifetime trying in complex, idiosyncratic ways to be recompensed for an initial loss. Much of the depressive's personality is based on a premise of something due without reciprocal obligation. Much of this expectation is lived as a demand. Much correction of the "unfairness" is sought by individually constructed forms of manipulation and punitiveness. The mass of what is due has, for each in specially sensed ways, increased with the patient's lifelong rejection of what has never been enough; the frustration, anger, and vindictiveness has intensified and made the possibility of satisfaction in life increasingly remote. The practice of depression is of such a nature that fulfillment in life is precluded. The psychotherapeutic process itself implies involvement in all the elements of living that depressive practice seeks to elude. The necessary change of function is itself sensed as being coerced, as well as defeated and humiliated. Significant alteration of the personality brings awareness of an unwillingly granted enhancement of the therapist and of everyone else in contact with the patient's life. Change to self-sufficiency is a struggle entailing intensified anxiety. The anxiety is in part engendered by a loss of "helpless" manipulative control of others. This is not a simple competitive defeat, but a frightening dissolution of the self, the *me*. That *me* has always subjectively been alive in the effective function of acting helpless and commandeering, controlling others. Anger tends to increase in the very process of psychotherapy, which is entered into for relief from the burden of making a life for oneself: Psychotherapy moves toward and ends with the excruciating need to cancel life's accumulated debt, a harrowing write-off, and accepting the need of having forever to go on making a life for oneself.

The great gain in psychotherapy of the depressive is that the despair of permanent entrapment in the practice of depression may be significantly dissolved. The depressive may become free to pursue many new options toward self-fulfillment, affectively, interpersonally, occupationally, recreationally, and experience new, rewarding qualities of living. These results become the stimulus for the patient to struggle against tendencies toward recurrence of any of the elements of depressive practice. Successful struggle remains difficult but possible.

With all this in mind the psychotherapist working with a depressive may feel moved toward persistence in the complex, long, fluctuating experience. It may be necessary after termination to remain available for occasional consultation. A basically successful termination of dynamic therapy with a depressive patient can bring to the psychotherapist a sense of increase in clinical courage and stamina and increased compassion.

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