JULES BEMPORAD, M.D.

ADDITIONAL REMARKS ON THE RELATION BETWEEN COGNITION AND DEPRESSION

Severe and Mild Depression

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e-Book 2015 International Psychotherapy Institute

From *Severe and Mild Depression* by Silvano Arieti & Jules Bemporad

Created in the United States of America

www.freepsychotherapybooks.org
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Jules Bemporad

For decades the role of cognition in psychopathology was uniformly ignored by classical psychoanalysts. Some cognitive concepts or transformations were implied in psychoanalytic theory, such as the processes of symbolization and dream distortion, or the particular patterns of thought in schizophrenia. However, the major emphasis centered on instincts and affects, the primary motivational forces of behavior, rather than on the structural aspects of thought or the consideration of more elaborate and evolved determinants of behavior. The contributions of academic psychology to motivation were perceived by psychoanalysts as too superficial to assess the primitive forces that were thought to underlie human activity. The classical psychoanalytic position was, and largely still is, a frankly reductionistic one, in which all behavior is traced back to semibiological drives. When cognitive structures are considered, they

are seen only as complex representations of more fundamental and instinctual strivings.

The philosophical reasons for the reduction of high-level psychological functions to instinctual forces already have been presented by others in detailed studies of the historical roots of Freud's thought. These authors view the early psychoanalytic formulations as representive of the particular Zeitgeist of the Victorian era and as bound by a mechanistic, deterministic, and reductionistic philosophical bias which is no longer tenable. I frankly believe that this view of man does not do justice to the creative, aesthetic, altruistic, or social aspects of human existence. I am not necessarily implying a return to a vitalistic or mystical view of man; these higher functions may still be encompassed by a scientific point of view that acknowledges man as partially rooted in biology. The difficulty with traditional psychoanalysis is that it has paid too much heed to the biological causes of human behavior and too little heed to the cognitive and volitional aspects of man. Actually, in more recent years psychoanalysts have tried to deal with the cognitive aspects of man, but only while still clinging to a reductionist, biological position. For example, the recent ego psychologists have considered cognitive

structures in the development of the ego, but mainly in the conflict-free spheres and not as potent motivators of behavior—including neurotic conflicts. As such, cognition again has been relegated to a secondary role in everyday life problems. In the works of other psychoanalysts such as Klein and the object-relations school, cognitive constructs have been liberally implicated in psychic conflicts but never identified as such.

Arieti has been one of the first psychoanalysts to recognize the significance of cognitive factors in psychopathology and to repeatedly indicate that illness may result from conflicts between ideas, which are not reducible to more primitive or fundamental biological drives. While he does not reject the significant contributions of Freud in regard to primal urges or unconscious forces (as may be the case with some neo-Freudian or culturalist schools), Arieti considers that the more evolved aspects of man also markedly contribute to both pathology and normality. This comprehensive point of view has been called the cognitive-volitional school (Arieti, 1974) in that it underscores the importance of the highest aspects of human evolution, such as thought and will. The remainder of this chapter interprets the phenomenon of depression from this point of view, recapitulating in a

highly condensed form much of the theoretical material of this book.

Unconscious Determinants in Depression

Since the inception of the psychoanalytic movement, the concept of the unconscious has been one of the central constructs of psychoanalytic explanation and one of the most important contributions to personality theory. Yet over the course of the evolution of psychoanalytic thought, the concept of what the unconscious actually encompasses has gone through many transformations. The unconscious originally was considered to be the interface between mind and body, the area where the biological instincts assumed psychic representations and affected behavior. It was thought that the unconscious consisted of primal forces, called the instincts. This was the legacy of Darwin who, through his popularizer Spencer, stressed the primacy of force—of driving biological instincts—as the major determinant of behavior.

Later Freud included not only urges and their representations in the unconscious, but also the objects that had been introjected during early childhood. These early incorporations (or identifications)

continued to exert their effect well into adult life without the knowledge of the individual. This aspect of psychoanalytic theory became the nucleus of the Kleinian school. According to the Kleinians, psychological conflicts are only the representations of battles waged between good and bad internalized objects. With this innovation, it may be appreciated how the notions of the unconscious have become more cognitive and structural. The Kleinians have gone even further: they postulate the existence of highly complex, unconscious fantasies which underlie manifest behavior but are not privy to conscious awareness. These fantasies, which are proposed to constitute much of the individual's inner life, are sophisticated cognitive systems; yet this aspect of their structure has been essentially ignored. These fantasies are treated as simple force vectors which influence behavior in much the manner of the biological instincts that theoretically preceded them.

Further elaboration of the unconscious came with the revision of psychoanalysis brought about by the structural theory. With the tripartite division of the psyche into the familiar id, ego, and superego, it was postulated that the unconscious encompassed not only the instinctual forces of the id and the internalized values of the superego, but also some of the highly complex functions of the ego. In some of his

last works and especially in those regarding fetishism (1927, 1938), Freud seems to have been considering a division of the psyche into two opposing world views, one conscious and the other unconscious, with both aspects being highly evolved and cognitively complex.

Thus, without directly acknowledging this trend, the psychoanalytic concept of the unconscious has become increasingly cognitive and elaborate. It becomes more and more necessary for traditional psychoanalysts to include sophisticated mental constructs among material that is considered to be repressed or denied. Yet there appears to be a strenuous effort to avoid this conclusion among classical psychoanalysts. It is to this point that Arieti's work has been innovative and allowed a more comprehensive view of motivation. Arieti agrees that man is partially driven by biological forces and primitive forms of cognition are to be found in some mental activities such as dreams or psychotic states. However, not all behavior can be reduced to mere elemental states. The unconscious also consists of highly evolved cognitive concepts which, just like more primitive strivings, are contrary to our conscious desires and so become repressed. Psychic conflicts thus may result from two opposing views of the self or others, each view equally well-formulated and structured.

These repressed constructs exert a powerful effect on overt behavior, both directly and in the individual's defensive maneuvers against these constructs. Despite these motivational considerations, the essential point is that the unconscious constructs can be described as being fundamentally cognitive phenomena.

Arieti's general term for these internalized systems of ideas is "inner reality," which he defined elsewhere (1974) as follows:

> Inner reality is the result of a continuous reelaboration of past and present experiences. Its development is never completed throughout the life of man, although its greatest rate of growth occurs in childhood and adolescence. It is based on the fact that perceptions, thoughts, feelings, actions, and other psychological functions do not cease completely to exist once the neuronal mechanisms that mediated their occurrence have taken place .... Although they cannot be retained as they were experienced, their effects are retained as various components of the psyche (P. 879).

Therefore the unconscious—or in its broader sense, inner reality—is the accretion of past experience, which is constantly evolving and being modified by experience. Yet certain ideas or beliefs that were laid down early in life seem to resist change and to appear almost

impervious to novel experiences. What often seems to occur is that experiences which might alter the childhood cognitive structures are actually distorted by the individual so as to conform to these early prejudices. These childhood misapprehensions of the self and others persist, and their distorting qualities account for the individual's seemingly inappropriate behavior, which is labelled as psychopathological.

In *Meditations* Kafka described holding on to past, outmoded ideas in a highly poetic and yet accurate way. Kafka wrote, "All these so-called diseases, pitiful as they look, are beliefs, the attempt of a human being to cast anchor in some mother soil." Unfortunately this mother soil, this bedrock of security, is all too often based on the misapprehensions and distortions of primitive cognitions of childhood. Even when these early beliefs may originally have accurately reflected the surrounding environment, the ideological system in which the future depressive was raised was so prejudiced and erroneous that it supplied a biased foundation for adult functioning. The depressive, in the same way as other psychologically maladjusted individuals, continues to process experience in a specifically pathological manner, without being aware that he is

reshaping current experience to childhood beliefs. In this sense, depression as well as other psychiatric disorders may be seen as a pattern of basically pathological modes of cognition.

The individual usually continues to act out his unknown beliefs without realizing the sources of his resulting attitudes and feelings, which actually have been engendered by these systems of ideas. At other times an individual may gain a dim awareness of these beliefs about himself and others. However, these realizations are painful and at odds with the individual's expectations for himself, so he does not allow himself to formulate these beliefs accurately in consciousness. Rather, these embarrassing beliefs are repressed or defended against by more superficial sets of beliefs. These superficial concepts are never really successful, either in reassuring the patient or in directing his behavior. From a distance, it may appear that an individual is acting in accordance with mature cognitive ideation, but if his intimate relationships are scrutinized or his private thoughts divulged, the older patterns rapidly become apparent. These compensatory cognitive structures may be seen as analogous to the concept of defense or resistance in traditional psychoanalysis. In contrast to the classical view, both the defense and the unconscious content are

considered to be cognitive phenomena. As such, the problem of the depressive can be understood as the perpetuation of an inaccurate mode of cognitively processing experience that was formulated in childhood and crystallized in adult life.

Childhood Cognitive Patterns in Adult Depressives

The basic beliefs that predispose one to depressive episodes concern evaluations of the self and of others important to the individual. As a result of childhood training, the depressive comes to rely to an inordinate degree on the nurturance of others in order to maintain a favorable sense of self. A dominant other or dominant goal become the individual's *raison d'etre*, without which he senses himself to be devoid of meaning. Self-evaluation is not an internal capability: it is left to the whims of external events. It is just this reliance on external agencies for self-worth that predisposes the individual to repeated episodes of depression. Other people are inordinately utilized as a barometer of the individual's self-worth.

The depression-prone individual thus has a distorted cognitive view of himself and of others. He unrealistically believes himself to be

basically unworthy, helpless, even malevolent, while the dominant other is greatly inflated in importance. Obtaining the nurturance of the dominant other becomes the road to redemption or gratification for some individuals, and the achievement of some spectacular goal becomes the salvation for others. Without an active pursuit of these accomplishments, the individual feels himself to be in a painful state of deprivation, having lost all meaning and self-worth.

The depressive has maintained a belief of the self and others that is typical of childhood. Indeed, the depressive persists in parentifying others and devaluing the self. This system of self-regard was so firmly entrenched in childhood that it has prevented other more realistic experiences, which might have proved corrective, from penetrating into the basic belief systems. However, adult depression represents more than the resurgence of childhood cognitive beliefs. The individual continues to elaborate these encapsulated cognitions and to magnify their contents. The self becomes more demeaned and the other becomes even more powerful, or the goal more crucial. In order to stick to accustomed life patterns and to defend against threatening alternate cognitive options, some individuals grossly exaggerate the memory of the original relationship, further perpetuating the

characterological pathology within themselves. The patient's childhood recollections or transference manifestations may suggest truly horrible experiences at the hands of brutal parents. This is not always an accurate representation of the individual's past: these data contain a large kernel of truth, but this truth has been contaminated by reelaborations and exaggerations, the result of decades of psychic reworking and consolidation of early cognitive structures. As stated, this often grotesque caricature of the parents and of the self has been gradually created to insure the continuation of a maladaptive career path in the face of reality's temptations.

From this basic system of ideas, in which the self is devalued without the ministrations of a dominant other or the accomplishment of some overriding goal, secondary cognitive structures are logically derived. One such structure concerns the need to control the gratifying other somehow in order to make sure that the needed nurturance will be forthcoming. The devious maneuvers that are developed in order to maintain the needed relationship are behaviorally seen as the familiar manipulations of the depressive. These annoying and yet pathetic attempts at control of others are motivated by the more basic, inferior estimation of self.

Another aspect of the depressive personality that derives from this fundamental system of ideas is the fear of autonomous gratification. As mentioned throughout this work, the depressive eschews any chance of independent pleasure or meaning, and often he derides such activities as childish or silly. This is a perpetuation of the parental sanction against any activities which might have deterred the patient from his pursuit of the parental goal or which might have allowed the patient to have loyalties outside the household. The significance of this self-inhibition for later depression is that some patients become depressed as a result of this sterile, ascetic life pattern. Other individuals who respond to an environmental event with depression are prevented from overcoming their despair partially because of this inhibition. In either case, the individual cannot allow himself to find new avenues of meaning. He sticks to his habitual pattern of self-denial and dependence on others, so that a transient frustration or loss provokes a clinical episode of depression. These sets of beliefs regarding one's restriction of the possibility of autonomous pleasure underlie the clinical symptom of helplessness. The depressive is helpless in finding meaning in life because all of his prior meaningful activities have been sabotaged by guilt and shame.

He cannot see alternate modes of meaning and therefore he feels himself to be empty and hopelessly deprived. He can only desperately seek out others to give him direction, that is, to reinstate his traditional childhood role and to confirm all of the ideas of self and others implicit in this role.

The Clinical Episode

This internal cognitive structure predisposes the individual to both repeated experiences of depression and the inability to adequately fend off this painful affect. When deprived of external supports which have maintained a satisfactory view of the self (being needed by others, pursuing some goal, or following some superior hyper-moral life pattern), the individual is faced with the painful realization that he has lost his crucial source of meaning and self-esteem. He now views himself as eternally deprived of a state of well-being. It is this realization (whether realistically justified or not) that culminates in the consciously felt emotion of depression. This affective state automatically arises as the result of an alteration in the assessment of the self in its relation to the environment. The loathed concept of the childhood self, which had been repressed, reemerges—

and with it, the overwhelming sense of despair and hopelessness.

The role of self-assessment in contributing to depression was clearly observed by Freud and by Kierkegaard before him. Freud described a critical difference between mourning and depression, which centered on the locus of the loss. In the former condition, the environment is impoverished; but in depression, the self itself becomes barren and empty. It appears that without the necessary environmental props, the satisfactory image of the self cannot be maintained and a painful transformation of the self-concept occurs, leading to depression. Kierkegaard described this process in more detail. As previously quoted, he illustrates this self-transformation by reporting a vignette of a girl who has lost her lover: "A young girl is in despair over love, and so she despairs over her lover, because he died, or because he is unfaithful to her. This is not a declared despair; no, she is in despair over herself. This self of hers, which if it had become 'his' beloved, she would have been rid of in the most blissful way, or would have lost, this self is now a torment to her when it has to be a self without 'him'" (1954, p. 153). The now tormented self is perceived as being unworthy and alone, as empty and forever doomed. This alteration of the view of one's own self brings about depression.

Thus stated, depression results from a cognitive transformation. However, this is a highly sophisticated cognitive process; it involves systems of ideas about self-worth and life's meaning. Depression can be categorized as a high-order emotion in contrast to fear or rage. As described by Arieti (1967), the affect of depression necessitates the capability of assessing the self and its worth. In addition, a sense of the future appears necessary. However, the cognitive structures that predispose and underlie the experience of depression are not available to consciousness. They are the conditions for, and the forms of, this particular type of distorted awareness, but the individual is unaware of them.

Such unconscious systems of ideas in fact prolong and intensify the experience of depression. The relatively healthy individual may utilize an initial feeling of depression to mobilize his resources and alter his life so as to alleviate the causes of this painful affect. All of us are prone to momentary experiences of depression after a loss or frustration. However, as indicated by Sandler and Joffe (1965), this psychobiological reaction does not necessarily escalate into a clinical depressive episode. Most individuals can fight against depression by detaching psychic importance from the lost object or frustrated

aspiration and by substituting alternate objects or goals. In time, the depression lifts because the individual can create other satisfying relationships and activities; he did not depend on the lost external agency for his total sense of worth.

The depression-prone individual, however, cannot alter his existing cognitive set and successfully defend against depression. He cannot avail himself of alternate cognitive possibilities which could lead to new sources of meaning or gratification. In an appropriate metaphor suggested by Becker (1964), the depressive is like an actor who knows a specific set of lines which are to be delivered only before a particular audience. He cannot vary his situation either in terms of what he says or to whom he speaks. He is fixed in an undeviating course in his search for meaning, and even if this course is blocked, he clings to it without flexibility. In such individuals the depressive affect increases because: (1) The loss or frustration which elicited the depression was desperately needed to fulfill a neurotic sense of self. (2) The individual cannot alter his cognitive patterns to find substitute sources of meaning. (3) The depressive continues to use learned, yet inappropriate modes of coping, such as turning to others to relieve his pain or publicly bemoaning his fate.

If the depressive episode continues unchecked, there is a coalescence of this affect so that it creates new cognitive patterns. It is at this stage that the individual may exhibit the conscious cognitive constructs described by Beck (1967). The depressed individual thinks negatively about himself, his environment, and his future. This cognitive triad may be the result of a prolonged depression which has not been relieved by either internal choices or external support. These constructs accurately represent how the individual sees his situation after becoming depressed. These negativistic attitudes serve to further increase the depth of the depression; by their pessimistic content, they prevent activity that might alleviate the sense of despair. Such beliefs are also used to justify the feeling of depression, and it becomes a self-perpetuating and self-enclosed system.

During the depressive episode, conscious cognitive constructs replace the more fundamental childhood systems of ideas that brought about the depression. In structural terms, the process is as follows: an unconscious system of cognitive constructs interacting with an environmental trauma culminate in the production of an affective state and subsequently a cognitive transformation, which in turn creates new cognitive distortions. Beck's cognitive triad disappears with the

amelioration of the clinical episode, but the underlying unconscious attitudes remain, and—without extensive therapeutic intervention—leave the individual vulnerable to repeated depressive attacks.

In some cases, the depression takes on psychotic proportions; it is accepted by the individual, together with its distorted world view. The individual no longer tries to ward off his depression even by inappropriate means, and he becomes overwhelmed by this painful affect. Most cognitive processes may appear to be paralyzed by a massive sense of despair, so that there remains only the perseveration of a few painful thoughts. Other individuals may respond with a general slowing of all cognitive processes so that thinking becomes an extraordinarily laborious task. These severely impaired individuals thus may appear to have a depression without content, that is, without psychological cause. However, if patiently interviewed, the cognitive aspects of depression—both those that preceded and followed the episode—will gradually emerge. Successful therapy may not in fact be possible until the patient begins to recognize the thought processes that underlie and perpetuate his depression (Arieti, 1977).

Implications for Therapy

The conceptualization of certain forms of psychopathology such as depression as the residue of a retention of childhood cognitive distortions into adult life carries with it some implications for change in psychotherapeutic technique. The primary task of the therapist is to alter these distortions and to allow the patient alternate and more appropriate conceptions of himself and others. It is in the treatment situation that these older beliefs become openly manifest, for example, in transference distortions, and thus the patient can become fully aware of the unconscious systems of ideas that have been directing his thoughts and behavior.

The first task of therapy involves the identification and formulation of the patient's unconscious beliefs as derived from dreams, transference, and general comments about other people. In the security and trust of the therapeutic relationship, the patient becomes aware of these underlying cognitive systems and begins to appreciate their effect on his life. Once out in the open, these beliefs are subject to modification and a more accurate and adult interpretation of reality is possible.

Sullivan coined the apt phrase "selective inattention" to describe

the individual's defensive use of denial in order to tune out experiences that would jeopardize self-esteem. Perhaps an equally frequent mechanism is "selective distortion," or the individual's misinterpretation of events to fit into unconscious systems of ideas. These distortions are not generalized to all experiences, but they are selectively used to fulfill archaic needs of which the individual often is not aware. In depression, certain others are invested with magical, grandiose power so that they can become dominant others for the patient, who believes he can only function successfully if he lives in the good graces of such an esteemed figure. At the same time, the patient will act out a life script according to distortions about himself. For example, he will shun independent gratification, block creative potential, and unrealistically limit his life. In so doing, he still is acting in accordance with beliefs instilled in childhood by his parents. These beliefs lead to distorted interpretations of reality in terms of his effectiveness, capacity for pleasure, and often the belief that others are overly concerned with his day-to-day behavior.

These childhood distortions are revived in therapy, as they are in non-therapeutic relationships that have meaning for the patient. In the therapy situation, however, these distortions are reflected back to the

patient so that he can begin to appreciate the systems of ideas which dominate his existence and cause him emotional distress. Therapy should allow the individual the opportunity to alter these childhood systems of ideas so that alternate modes of cognition will be possible.

One of the most significant aspects of this process is for the patient to allow himself to be open to extratherapeutic experiences so that life itself can alter his distortions. Depressives and also many other types of patients cling to their distorted cognitions, continue to misinterpret experience, and never change their fundamental belief systems. Therapy must encourage the patient to act and interact without his previous prejudices so that reality can penetrate to his basic distorted ideas. The recounting of these experiences in the sessions form part of the working-through process in which events are discussed and with the therapists' help are given new meanings that are free from previous misinterpretations. Despite the considerable support given by the therapist (and the analysis of transference distortions), cure is the result of the patient altering his cognition in everyday behavior outside the office. The task of therapy thus is to liberate the individual from his rigid distortions of the past and to make him receptive to the genuine novelty and flexibility of the future.

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