

BENJAMIN WOLMAN, PhD

DEPRESSION THE PSYCHOSOCIAL THEORY

DEPRESSIVE DISORDERS

Depression: The Psychosocial Theory

BENJAMIN B. WOLMAN, PhD

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Table of Contents

CONCEPTUAL FRAMEWORK

THE CONCEPT OF POWER AND THE “LUST FOR LIFE”

EROS AND ARES

NOSOLOGY

PSYCHOSOCIOGENIC DETERMINANTS

CATHEXIS

GENETIC PREDISPOSITION

THE LEVELS OF DISORDERS

ETIOLOGY

ECOSOMATOGENIC DEPRESSION

GENETIC FACTORS IN PSYCHOSOCIOGENIC DEPRESSION

THE IMMUNE SYSTEM

FEAR OF DEATH

SOCIOECONOMIC FACTORS

PARENT-CHILD RELATIONSHIP

[PERSONALITY DYNAMICS](#)

[THE DYSMUTUAL-DEPRESSIVE DISORDER](#)

[THE SUPEREGO](#)

[ANTIDEPRESSIVE REACTIONS](#)

[DEFENSE MECHANISMS](#)

[THE ID](#)

[WE-EGO AND VECTOR-EGO](#)

[PROTOCONSCIOUS](#)

[SYMPTOMATOLOGY](#)

[SUMMARY](#)

[REFERENCES](#)

Depression: The Psychosocial Theory

BENJAMIN B. WOLMAN, PhD

CONCEPTUAL FRAMEWORK

DEFINING DEPRESSION

The word *depression* has been used in several different ways, to describe somewhat different issues. Since it usually relates to affects, it belongs to the class of *Affective Disorders* in DSM-III (American Psychiatric Association, 1980). Depressed individuals undergo mood changes, thus depression is included in DSM-III-R (American Psychiatric Association, 1987) in the class of *Mood Disorders*. In daily use, depression connotes a variety of negative feelings, such as disappointment, frustration, defeat, sadness, despair, weakness, helplessness, hopelessness, and so on. Apparently no scientific research could put all these feelings into one nosological class, and scientists have tried to offer a more precise and concise definition.

Abraham (1927) and Freud (1917/1956) stressed self-criticism and self-hatred. Bibring (1953), Seligman (1975), and others pointed to the feelings of defeat and helplessness. Beck (1967) and his followers emphasized a pessimistic

outlook on life and a feeling of one's own hopelessness. Nemiah (1985) pointed to feelings of loneliness and sadness.

The *Random House Dictionary* has several definitions of depression. Depression in psychiatry and psychology is defined as "emotional dejection greater and more prolonged than that warranted by any objective reason." Other definitions are: "a low state of vital powers or functional activity," or "dejection, sadness, gloom."

Wolman's *Dictionary of Behavioral Science* (1989) gives the following definition: "**Depression**, as opposed to other negative feelings, such as sadness, unhappiness, frustration, sorrow or grief, is a *feeling of helplessness and blaming oneself for being helpless*. Depression is self directed hatred usually associated with hatred directed toward others. Depression is *endogenous* when it comes from within; it is *exogenous* when it is a reaction to misfortunes."

This definition limits depression to the combination of a feeling of helplessness and self-directed accusation; it excludes other negative feelings.

Exogenous Depression

Every human being is exposed to stressful events; some events are exceedingly stressful and cause *exogenous* depression (Dohrenwend & Dohrenwend, 1974).

Exogenous depression is normal provided it is, like all other normal human emotions, appropriate, proportionate, controllable, and adjustable. Achievement and victory produce elation; frustration and defeat cause depression. When depression corresponds to what has really taken place, it does not indicate poor mental health, but feeling unhappy in victory and enjoying defeat are morbid emotional reactions. Usually joy and sorrow correspond to the magnitude of fortunate and unfortunate events. When one is ecstatically happy at irrelevant achievements and reacts with feelings of despair to mild frustrations, the reactions are pathological.

Endogenous Depression

Quite often my patients say, "I feel miserable. I have no reason to feel unhappy. I have nothing to complain about, but why do I feel so miserable?" Apparently, the depression comes from within; it is *endogenous*. A decrease in self-esteem and a low estimate of one's power form the common denominator of depressive states. The less realistic one's estimate is of one's ability to cope with hardships, the more severe is the depression. No human being can always be successful in dealing with his or her problems, and every human life represents a chain of successes and failures. Endogenous depression reflects one's disbelief in oneself and in one's ability to cope with difficulties. It is a feeling of being weak and unable to withstand hardship, of helplessness and resentment for being helpless.

THE CONCEPT OF POWER AND THE “LUST FOR LIFE”

The behavior of all living organisms has an immanent and universal goal, *survival*. All living organisms fight for survival; all of them eat to live and defend themselves against being eaten or destroyed.

The process of life is a process of oxidation, digestion, metabolism, and so on. The higher the species stands on the evolutionary ladder, the more complex are its life processes. The behavior of all organisms is an aggressive-defensive process, for each organism either devours others or protects itself, by fight or flight, against being devoured.

The entire biological process can be presented as a continuous struggle aimed at the destruction of the prey by the predator or of the predator by the prey. An organism can be forceful, full of energy, capable of providing food for itself, and well prepared for self-defense. Or it may be sick, declining, and dwindling to nothing. When the vital energies become exhausted and vitality reaches the zero point, the organism dies.

I define the *drive for survival* as follows:

All living matter is endowed with biochemical energy derived from the universal energy. At a certain evolutionary level this biochemical energy is transformed into mental energy. Mental energy serves survival. The apparatus of discharge, the instinctual force, reflects the universal urge to fight for survival. It is the “Lust for Life,” the craving of all living matter to *stay alive*.

Pavlov (1928) introduced the term “instinct of life.” According to Pavlov, “All life is nothing other than the realization of one purpose, viz., the preservation of life itself, the tireless labor which may be called the general instinct of life.”

Survival depends on the amount of power that enables the organism to cope with hardships and dangers. I have defined power as “the ability to satisfy needs,” and survival is the arch-need and the prerequisite of all other needs. Further on, “The amount of power the individual possesses indicates how well he or she can protect life and satisfy [his or her] own and others’ needs. Omnipotence is the summit of power, death is the zero point” (Wolman, 1989, p. 258).

The awareness of one’s ability to defend oneself is tantamount to the feeling of power. When people believe in their own power they feel strong, elated, and happy. When people perceive themselves as being weak, they feel unhappy and are depressed. Depression is, primarily, a feeling of weakness, inferiority, helplessness, and inability to cope with adverse situations, plus self-directed resentment for being weak. Whatever the origins of the feelings of weakness and helplessness, most often they are associated with blaming oneself (Abramson & Sackeim, 1977; Beck, 1967; Peterson & Seligman, 1983).

Some human beings give up the fight. In such cases of “learned helplessness,” the lack of self-confidence reduces the ability of the immune system to fight diseases. The decline in “lust for life” can make the organism defenseless

(Ader & Cohen, 1984; Seligman, 1975; Simonton & Simonton, 1978).

EROS AND ARES

Vital energies can be used in two directions, to fight or to help. These two directions can be symbolically represented by two gods of ancient Greek mythology.

Ares, the ancient Greek god of war, is the symbol of aggression and destructiveness. *Eros*, the ancient Greek god of love is the symbol of caring, protecting, and loving. *Libido* is the name of the emotional energy of *Eros*, *destrudo* is the name of the emotional energy for *Ares*.

People can protect themselves by fight and/or by associating with others. In the phylogenetic history of organic life, *Ares*, or hostile behavior, is definitely older than *Eros*, which is cooperative, loving behavior. Only after a long evolutionary process have animals become capable of helping and caring for each other. Even procreation was initially void of sex, and certainly void of love (Wolman, in press).

To love means to give, to do everything for whomever one loves. Weaklings have nothing to give, but strong individuals can give, and one needs much more power to create than to destroy. Scores of skilled workers build a house, but one half-wit can destroy it by setting it on fire. Parents, educators, and doctors help an infant to grow up, but one stray bullet can kill the human being they have nurtured.

Power is the main determinant of survival; thus, being strong makes one elated, being weak makes one depressed. Victory over obstacles makes one feel happy; defeat makes one feel miserable.

NOSOLOGY

One can develop several classificatory systems of any group of people on the basis of gender, age, race, religion, income, or any other characteristic. Every classificatory system is rational, as long as no one belongs to two categories and no case is left out.

DSM-III-R (American Psychiatric Association, 1987) introduced the following nosological system for affective disorders, changing their name to Mood Disorders. This classificatory system divides mood disorders into four groups: (a) manic disorders, (b) bipolar disorders, (c) major depressive episodes, and (d) depressive disorders. Symptomatological consideration seems to be the rationale of the system developed by the American Psychiatric Association in both DSM-III and DSM-III-R.

My nosological system (Krauss & Krauss, 1977; Wolman, 1973) is based on etiologic considerations of cause and effect. All mental disorders, including depression, are either inherited or acquired. Mental disorders caused by genetic factors are *Genosomatogenic*. Mental disorders caused by interaction with the physical or chemical environment are *Ecosomatogenic* (*Ecos* means environment). Mental disorders caused by psychological environment are *Psychosociogenic*. Interaction among the three types of factors is a frequent phenomenon; thus, clinical diagnosis is a difficult and highly responsible task (Wolman, 1978a).

PSYCHOSOCIOGENIC DETERMINANTS

Since Freud, human relations have been perceived in a broad context of growth and development, fixation, and regression. All human beings are born both lovers and haters, and the interaction in early childhood greatly influences the balance of intraindividual and interindividual cathexes of libido and destrudo.

I have introduced a division of human relationships into three types: instrumental (I), mutual (M), and vectorial (V). The instrumental, taking attitude implies concern with satisfying one's own needs; infants are takers and their psychosocial attitudes are *instrumental*. Through growth and learning they may acquire the *mutual* attitude of giving and taking; in mature sexual relations and good marriages the participants are mutual. When one becomes more mature, one may become capable of giving without taking; mature parents display a giving, *vectorial* attitude to their children (Wolman, 1973).

Observing mental patients in hospitals and in private offices, one can't help noticing three distinct patterns of behavior. Some patients are sociopathic-*hyperinstrumental* types; they care only for themselves and tend to exploit others. On the other extreme, there are the *hypervectorial* schizo-type patients, who care for others even at their own expense. The third category are the depressive *dysmutuals*, who swing from one extreme to another. The hyperinstrumental sociopaths are extremely selfish and overinvolved with themselves, the hypervectorial schizophrenics tend to be underinvolved with themselves, and the

dysmutual depressives go from one extreme to the other. The hypervectorial schizo-type patients care too much for others and very little love is left for themselves. Sometimes they hate themselves for not loving enough. The depressive dysmutuals swing from being very friendly to being very hostile to themselves and to others.

The depressive dysmutuals tend to exaggerate and to advertise their feelings. They may take signs of friendliness as evidence of great love. They often imagine that other people are in love with them or hate them. A repeated pattern of these feelings often assumes the dimensions of paranoia (Kraepelin, 1921; Schwartz, 1964; Waelder, 1951; Wolman, 1973).

In 1911 Karl Abraham was the first psychoanalyst to interpret the manic-depressive disorder. Abraham proposed a most valuable

hypothesis that unfortunately failed to attract much attention. At that time, Freud maintained that repressed sexuality leads to anxiety; Abraham hypothesized that repressed hostility leads to depression. Abraham's essay, with its emphasis on hostility, has influenced my thoughts (Abraham, 1927).

CATHEXIS

In psychoanalysis, cathexis means charging or investing an object or an idea with emotional energy. I have introduced the concepts of *interindividual cathexis*, which is the balance of emotional energy of libido or destrudo cathected, that is invested, in an interaction between two or more individuals; and *intraindividual cathexis*, which is the balance of destrudo or libido individuals invest in themselves, and/or in various parts of their own body. Thus, when A loves B, A invests (cathects) some of his or her libido into B, the love object. B is the receiver of these *interindividual* cathexes. Because B, as the receiver of cathexes, may feel loved and cared for, his or her *intraindividual* balance of libido cathexes is increased.

I know of no clear-cut neurophysiological interpretation of the increase of the inner emotional balance, but one can easily observe improved self-esteem, courage, and activity in people, especially children, who receive the interindividual cathexes. Most probably, the issue of cathexis is related to the neuropsychological reactions of the immune system (Ader, 1981; Ader & Cohen, 1984). The resilience in fighting diseases is determined by the immune system, its genetic predisposition, and psychosomatic reactions. Being a recipient of interindividual cathexes of libido improves the intraindividual cathexes and strengthens the immune system.

A child who does not receive adequate loads of interindividual libido

cathexes feels deprived and rejected. The child's intraindividual balance of cathexes becomes inadequate, and, emotionally undernourished, the child craves love. Such children have "hungry libidos" and, as Fenichel (1945) pointed out, they become depressed "love addicts." Quite often, their need to receive love leads to a regressive behavior and to a compensatory intake of enormous quantities of food. Depression is frequently associated with obesity (Wolman, 1982a).

GENETIC PREDISPOSITION

The above described three types of psychosocial mental disorders do not include disorders caused by genetic factors such as, for instance, Down's syndrome, nor disorders caused by physical, chemical, prenatal, natal, and postnatal factors. It must be mentioned that even the three types of psychosociogenic mental disorders could be related to genetic *predisposition*, but they are not genetically transmitted (Beckham & Leber, 1985; Howells, 1980; Wolman, 1987). More about genetics in the following section.

THE LEVELS OF DISORDERS

There are distinct degrees of severity in mental disorders, but the traditional distinction between neurosis and psychosis is today a controversial issue. Pinsker and Spitzer (1977) reported that, in DSM-III, *psychoses* and *neuroses* are not used as principles of classification.

According to Pinsker and Spitzer, the term *psychotic* is used as an adjective to describe certain aspects of severity of illness. Neurosis is referred to as a speculative etiologic concept. Probably, the concept of psychoses as a group of conditions was rooted in mental hospitals at a time when no one was identified as a mentally ill person unless psychotic. But if the term psychotic describes a certain degree of impairment of reality testing, disruption of thinking process, disorganization of behavior, or inability to function, the disorder (or disorders) which causes the psychotic impairment must have been present in mild form before the psychotic level of impairment was reached.

Thus, I am using the terms neurosis and psychosis as *levels* of mental disorders, and as a link between the various degrees of endogenous depression, viewed as a nosological entity, on a continuum of neurotic symptoms (hysterias, etc.) through hysteroid character neuroses, latent psychosis, and full-blown psychotic depression. The moods of elation and depression are reflections of shifts in the balance of libidinal cathexes from self-love to object love, from self-hate to object hate, from love to hate, and vice versa.

In my nosological system, hysteria and conversions belong to the class of neuroses. They are clusters of symptoms of the basic dysmutual-depressive pathology, to be described later on. When these symptoms become fortified by rigid defense mechanisms, such as rationalization and denial, the neurosis turns into character neurosis. When the defenses prove to be inadequate, and the individual faces psychotic breakdown, but somehow desperately holds on to whatever was left from the defenses, it is latent depressive psychosis. When the defenses fail, a manifest depressive psychosis develops.

I avoid the terms *unipolar* and *bipolar*, because every manifest psychotic depression can develop depressive and manic symptoms. I also avoid the term *manic-depressive psychosis*, for there are five possible clusters of symptoms in manifest psychotic depression, to be described later on.

ETIOLOGY

Quite often, similar symptoms are caused by different causes. For instance, high body temperature is definitely a sign of disease, but it may be a sign of various diseases. Many symptoms or clusters of symptoms, such as indigestion, chest pains, headaches, and so on are not necessarily indicative of a particular disease.

Years ago, in a study of infantile autism, I arrived at the conclusion that the two theories of its organic or psychologic origin deal with two different disorders. Infantile autism type A is a neurological disorder, whereas infantile autism type B is a subtype of childhood schizophrenia, a psychosocial disorder caused by an extreme case of maternal rejection (Wolman, 1970).

One should draw a distinction between the ecosomatogenic depression caused by physical and chemical factors and the psychosociogenic depression caused by social and psychological factors. It seems in both types of depression there is a certain degree of genetic predisposition (Bertelsen, 1985; Depue & Iacomo, 1989; Gershon, 1987). It is possible that depressive disorders are a product of interaction between the genetic predisposition and environmental, psychosocial factors (Cadoret, O'Gorman, Heywood, & Troughton, 1985; Cole, Schatzberg, & Frazier, 1978). Despite a good deal of research, there is no conclusive evidence that depression is carried by genes, however. On the other side, recent immunological studies support the role of genetic predisposition.

ECOSOMATOGENIC DEPRESSION

The subject of this chapter is psychosociogenic depression, but here are a few words about ecosomatogenic depression. This depression can be caused by a variety of neurochemical factors, such as dopamine, acetylcholine, norepinephrine, serotonin, and other neurobiological processes (Thase, Frank, & Kupfer, 1985). Several research works reported by Depue (1988), Post and Ballinger (1984), and others pointed to the role of dopamine. Janowsky, Risch, and Gillin (1983) and several others studied the role of acetylcholine in depression, and more research is currently going on.

GENETIC FACTORS IN PSYCHOSOCIOGENIC DEPRESSION

Despite significant research, there is no conclusive evidence that the ecosomatogenic and psychosociogenic depressions are carried by genes. However, according to Winokur and Crowe (1983), in the population identified as having bipolar depression there was an equal number of males and females, whereas among those having unipolar depression, the number of females was much higher than males. Mendlewicz (1977) suggested the hypothesis of genetic heterogeneity, and according to Farber (1982), children of bipolar depressive individuals tend to be depressed and display hyperactive, impatient, and explosive personality traits. Research by Radke-Yarrow, Cummings, Kuczynski, and Chapman (1985), of interaction between mothers who had a history of depression and their young children, showed that the children were initially anxious and, after a four-year follow-up study, exhibited a low level of social competence. Apparently, the children were somewhat affected by their depressed mothers, but it is not sure that there were genetic causal relations.

As mentioned above, the issue of genetic origin of depression is still a controversial one. Bertelsen (1985), in a research of monozygotic and dizygotic twins, supported the genetic hypothesis, whereas Tsuang, Bucher, Fleming, and Faraone (1985) did not. Apparently, although there is no final evidence concerning the genetic origin of depression, genetic predisposition to depression is a strong possibility, supported by immunological research (Loehlin, Willerman,

& Horn, 1988).

THE IMMUNE SYSTEM

The immune system is involved in biochemical, endocrinological, neurological, and psychological processes. It resembles a set of interconnected bridges that link several areas of living organisms and coordinate several vital functions. When a dysfunction of the immune system causes depression, the depression is ecosomatogenic, and when the dysfunction of the immune system is caused by psychosociogenic depression, the dysfunction of the immune system is psychosomatic (Wolman, 1988).

The immune system plays a significant role in the etiology of mental disorders (Ader, 1981; Ader & Cohen, 1984; Solomon & Amkraut, 1981), possibly somewhat similar to its role in bodily diseases. The immune system may or may not react to antigens, that is, it can be immunocompetent or immunotolerant. It is my hypothesis that cancer is an autoimmune disease, whereas AIDS is an antiautoimmune disease. Both cancer and AIDS are caused by antigens, but the reaction of the immune system determines whether the organism will or will not succumb to the disease (Wolman, 1988). The responsiveness of the immune system, its strength or deficiency, cannot be unrelated to genetic factors.

Researchers are facing even more complex issues in regard to psychological aspects of the functions of the immune system. Depression, stress, mourning, severe frustration, and despair can reduce the responsiveness of the immune system and adversely affect the organism's resilience to diseases (Lipowski,

1985). According to Lipowski, psychosomatic research should take into consideration both genetic and environmental factors. The basic resilience of the immune system is, most probably, genetically determined, but overstimulation and stress may cause “excessive autonomic and cortical arousal leading to cognitive and/or motor performance. . . . Such repeated and sustained arousal may lead to physiological changes as well as behavior, enhancing the subject’s general *susceptibility* to illness” (Lipowski, 1985, pp. 38-39).

FEAR OF DEATH

There are universal human emotions that are contributing factors to feeling helpless and hopeless and resenting these depressive feelings. The *fear of death*, common to all human beings, is the arch-source of depression. The fear of death inspires people to accumulate possessions, to erect monuments, and to believe in a “life after death.” Religions offer a highly important consolation by promising an immortal Hereafter.

All religions link the hope for a happy life after death to what one does when one is alive. The moral principles are linked to a reward and punishment system. Ancient Greeks believed that the souls of deceased people were ferried by Charon, the gods’ oarsman, and brought to the goddess of justice. The goddess of justice held a sword in one hand to make sure that justice had power, and a scale in the other hand to weigh people’s sins and virtues. The sinners were sent to Hades for eternal punishment, and the virtuous individuals were sent to the peaceful Fields of Elysium. Every human being is exposed to the feeling of being weak and judged by divine powers (Schwab, 1946).

The Judeo-Christian tradition promises punishment and forgiveness for past sins. The ancient Jews were expelled from their land and “cried on the rivers of Babylonia.”

The Catholic religion elaborates on hell and heaven and demands confession

of—and penance for—sins. All Christian denominations have developed intricate systems describing the dependence of human beings on the promise of mercy from an all-powerful, omnipotent source.

SOCIOECONOMIC FACTORS

Freud's patients complained mainly about sexual problems; today the main problems facing patients are insecurity and depression. At the present time, economic and political insecurity greatly contribute to widespread depressive feelings. Living in the aftermath of the Great Depression, World War II, and the Holocaust, and now coping with the current proliferation of nuclear weapons and with the rampant and chaotic violence that permeates every level of humanity can hardly be expected to foster a society of secure, well-adjusted adults. Depression is a feeling of weakness, helplessness, and hopelessness associated with resenting and blaming oneself for being weak. Small wonder that depressed individuals tend to turn to alcohol and drugs, and many of them join various cults that relieve depression and give the illusion of power and control (Akiskal, Hirschfeld, & Yerevanian, 1983; Fox, 1967; Rounsaville, Weissman, Crits-Christoph, Wilber, & Kleber, 1982).

Present-day fluctuations in economic life, with the inevitable phenomena of inflation, depression, and recession, do not provide much security to the vast majority of people. Many people have no job security, and many face unemployment and poverty. But even middle- and upper-class individuals cannot be very secure because changes in the economic climate of this society may seriously affect their income and possessions. A loss of income can cause exogenous depression, but quite a few people will also blame themselves for their

real or imagined inabilities in coping with their financial problems, and will develop endogenous depression as well.

PARENT-CHILD RELATIONSHIP

The feeling of security depends on one's estimate of one's own power and of the power and loyalty of one's allies. Since no human being can be omnipotent, every human being needs allies. Isolation and loneliness cause exogenous depression. When an individual believes in being lonely, it causes endogenous depression, whether or not the belief is realistic. Children cannot survive unless taken care of by adults, and children's most severe fear is the fear of abandonment (Bowlby, 1980; Joffe & Vaughn, 1982; Wolman, 1978b). An early separation from parents may cause severe depression with a host of psychosomatic symptoms such as enuresis, school phobia, asthma, and many others (Kimball, 1978). The earlier the separation, the more severe the depression (Hamburg, Hamburg, & Barchas, 1975; Levinger & Moles, 1979; Spitz, 1946a, 1946b; 1960).

The lack of maternal love causes "affect hunger." The rejected child may try to win love by intentional suffering and may escape into illness. "The discouraged child who finds that he can tyrannize best by tears will be a cry-baby, and a direct line of development leads from the cry-baby to the adult depressed patient," wrote Kurt Adler (1967, p. 332).

Many severely depressive patients come from families where no one was genuinely interested in the child's welfare. As a result of the lack of a true and meaningful relationship in childhood, the depressive individuals suffer from feelings of insecurity and rejection (Cartwell & Carlson, 1983).

Most depressive patients are exposed in childhood to a sort of emotional seesaw of acceptance and rejection. The mothers of severely depressed patients did not like their children; however, when the children were in serious trouble or gravely ill, the mothers turned around and showered them with affection. These emotional swings were conducive to a self-defeating attitude in the offspring; getting sick became the only way to win love (Kashami & Carlson, 1985; Schaffer, 1977).

In most cases, adequate maternal care is given to the infant in the first few months of life; the rejection comes somewhat later. Thus, depressed patients have a tendency to regress to infancy. Regression goes back not to the point of frustration or rejection, but before that point, to the true or imaginary era of the “lost paradise” of safety and love. In milder, neurotic cases of hysteria and depressive neurosis, the regression is usually to the oral stage in an intentional, albeit unconscious hope to win love.

Parental rejection need not be associated with pathological hostility; infants may feel rejected when the mother is sick and unable to take care of them, or when she is pregnant with another child, or when she is too busy working or is overburdened with a large family (Earle & Earle, 1961; Goldstein, 1988).

In some instances, the future depressed patient had to compete unsuccessfully against a more privileged sibling. Many depressive patients were a

kind of Cinderella in their family, which was usually composed of a hostile mother, an uninterested or hostile father, and favored siblings. Some mothers preferred another child; the child who became severely depressed was the forgotten child, the “ugly duckling.” In some instances the mother, father, and siblings joined in rejecting the child, telling the child how ugly and stupid he or she was.

The child who has become a depressed patient was usually the unwanted, unloved, and forgotten member of the family, treated like a burden and handicap (Hodges & Siegel, 1985; Kashami & Carlson, 1985).

As previously mentioned, the regressive process in depression goes back *not* to the *point* of frustration or rejection but *before* that point, to the true or imaginary era of the lost paradise of safety and love.

PERSONALITY DYNAMICS

Several authors have tried to relate depression to personality types, using various frames of reference; among them are Akiskal, Hirschfeld, and Yerevanian (1983), Arieti and Bemporad (1980), Becker (1977), Millon (1981), Paykel, Klerman, & Prusoff (1976), Winokur (1983), and others.

In the following description of personality dynamics I am applying a modified psychoanalytic model (Abraham, 1927; Freud, 1933,1949; Wolman, 1984a). As described earlier, I rejected Freud's concept of Thanatos, and I introduced the dual concept of Eros (love), associated with libido, and Ares (hate), associated with destrudo. I also added the concept of interindividual cathexis, revised Freud's structural theory, and added the concepts of *we-ego* and *vector-ego*. I modified the psychoanalytic topographic conscious, preconscious, and unconscious theory: I rejected Freud's preconscious concept and introduced the concept of *protoconscious* (Wolman & Ullman, 1986).

THE DYSMUTUAL-DEPRESSIVE DISORDER

One of the outstanding features of depression is an imbalance of libido and destrudo cathexes. Maternal gratification of the infant's needs helps in the development of a proper balance of cathexes. However, when milk is withheld from a hungry child or when it is given in an unfriendly manner, the infant is unable to develop the proper balance between inter- and intracathexes of libido and destrudo. Total rejection leads to an increased intracathexis of libido and increased intercathexes of destrudo, that is, more self-love and more hatred of others—which leads to a sociopathic personality (Wolman, 1987). When a child is expected to give more love than it receives, and the parents are overdemanding and expect the child to compensate them for their true or imaginary misfortunes, the child's libido becomes hypercathected in the parents and inadequately intracathected in itself. The child, forced to over-control his or her resentment, follows the hypervectorial path to schizophrenia. In hypervectorial, schizophrenic patients, the repressed destrudo breaks through and leads to outbursts directed against oneself and others (Wolman, 1966a, 1966b, 1970).

Well-adjusted individuals have a reasonable balance between love and hate; they love themselves and their allies and hate their enemies. Their libido is *intrapersonally* cathected in themselves and *interpersonally* cathected in other people. Their destrudo is cathected *interpersonally* in others who represent a threat to them.

The libido of depressed individuals is inadequately self-catheted; they love themselves only when others love them. They are “love hungry,” as Fenichel (1945) put it.

In depressive disorders the destrudo is abundantly intra- and intercatheted. Most of the time, depressive patients hate themselves. A depressed patient told me, “No one cares for me because I am a worthless person, and I hate myself for being a worthless person. I hate myself because no one loves me, but how can anyone care for me if I myself don’t care for myself, and how can I care for myself if no one cares for me?”

And so the vicious cycle of depression goes on. Depression is self-perpetuating, but it can be interrupted by a true or imaginary sign of affection or admiration coming from without. Some depressed persons may indulge in an elated mood, whereas some others may reject the friendly person, thinking that there must be something wrong with that person if she or he cares for them.

Depressed individuals are exceedingly sensitive to the slightest sign of rejection or disrespect. Their self-love (self-catheted libido) is inconsistent. They tend to believe that they are good-looking and smart only when they are told so by another person, or when they are in a state of manic bliss.

Being overly dependent on the opinions of others, depressed people cannot be consistent in their self-conception. As one patient put it, “My mother, my father,

my brother, my teachers, everyone hated me. So I realized that I am an ugly, stupid little boy.”

Dr. Jekyll and Mr. Hyde

The feeling of being rejected is a constant feeling in depressive neurotics and psychotics. Friends and relatives of depressive patients often compare the rapidly changing attitudes to the turning off and on of hot and cold water faucets. The soft-spoken, kind, affectionate Dr. Jekyll turns into a Mr. Hyde whenever his loving attitude is not fully appreciated and repaid with high interest.

When in a loving mood, the volatile depressed individuals make exaggerated promises about great love and unlimited desire to be of help, but at the slightest disappointment, they forget what they said a short while before. Depressed patients are not calculated liars; they exaggerate in mutuality (hence the name “dysmutual”), wanting too much and giving too much. They are easily carried away by momentary feelings; they say things that bear witness to their poor sense of reality, making promises they cannot possibly fulfill.

THE SUPEREGO

The superego of depressed individuals incorporates the parental rejecting figures. The superego of the depressive dysmutuals is highly inconsistent, full of hate yet ready to embrace the ego when it is in great trouble; at such moments, depression turns into elation.

A depressed individual can be an idealist and a swindler, cruel and sentimental, religious and atheistic at the same time. Depressed individuals easily shift their moral or political identifications; they have no steady conviction, no persistent philosophy. One day they are determined to adhere strictly to the rules of religion; the next day may find them preaching the opposite.

In psychosociogenic depressions, the superego is almost continuously attacking one's ego. Guilt feeling is an outstanding feature of depression, but the content of the self-accusations has little to do with reality. In their depressed moods, patients recall events that happened a long time ago and magnify their importance.

ANTIDEPRESSIVE REACTIONS

There are several possible reactions to depression. In the peculiar imbalance of cathexes a small supply of libidinal cathexis (affection) from without may terminate the depression. Depression may be interrupted by an intake of food or fluid, by rest or play, by praise or achievement. Depressive moods come and go, and their inconsistency is one of the chief characteristics of depressive disorders.

DEFENSE MECHANISMS

The neurotic defenses against depression are the ego-protective symptoms, which include denial, dissociation, fatigue, reaction formation, and a galaxy of psychosomatic symptoms, such as headaches, gastrointestinal troubles, and so on. The ego-deficiency or psychotic symptoms include the manic state, paranoid projections, aggressive-defensive moods, and severe regression.

The term *manic-depressive disorder* is misleading: the manic mood is one of a number of possible reactions to depression. The so-called manic-depressive patients are *depressed*, that is, torn by the attacks of the superego. The manic state is an effort to deny depression and to ward it off. In a manic state, the patients display a flood of words and actions in a desperate effort to escape the feelings of guilt and depression; but even at the peak of elation the depressed feelings never completely disappear.

Manic episodes may come as a blissful reaction to profound, bottom feelings of loss and defeat; they can also be triggered by achievement or by a sign of affection from without. Mania is not a happy mood; it is a state of tension accompanied by a feeling of *power*. A patient in a manic mood acts indiscriminately, making friends with whomever he or she meets. However, the slightest opposition to these overtures may trigger depression and hostile feelings.

THE ID

The id is a carrier of impulses. In well-adjusted individuals the ego holds on to reality and restrains both the id and the superego.

In depressive states the ego is weak and subservient to the whims of the superego. Depressed patients are inattentive and lack self-discipline. Quite often, unable to withstand superego pressure, their ego merges with the id. Their contact with reality is tenuous, even on a neurotic level. Depressed patients show little perseverance, and even when endowed with excellent intellectual abilities, they are often underachievers.

The degree of their reality testing corresponds to the level of disorder. A neurotic's ego tries to ward off superego pressures by developing defense mechanisms such as rationalizations, reaction-formation, and denial. Unlike schizophrenics, depressive patients rarely lose all contact with reality. Even on the psychotic level, the depressive patients still preserve some contact with reality. However, inattention, forgetting, oblivion, distortion of truth to please people or to impress them, exaggeration, omission of detail, and lack of understanding for the feelings of others are typical of depressive patients.

One of the outstanding features of depressives is the shifting self-image. At one moment they perceive themselves as being helpless, and a while later they may feel powerful.

WE-EGO AND VECTOR-EGO

The development of we-ego and vector-ego undergoes substantial changes in depressive disorders. Normally, the we-ego develops in adolescence as a function of group identification (Wolman, 1982b). Depressed children and adolescents tend to overdo or underdo in interpersonal relations; they are either overinvolved with their peers up to the point of denying their own identity or, feeling rejected, they withdraw from social relations, or shift from one extreme to the other (Pearce, 1977). The development of the vector-ego is associated with attainment of intellectual and moral development. The depressed individuals are overdependent on approval by others, and they rarely attain the level of vector-ego (Wolman, 1982b).

PROTOCONSCIOUS

I believe that Freud's (1938/1949) topographic theory that divides the mental strata into conscious, preconscious, and unconscious layers should be revised, for there is hardly any significant distinction between the conscious and preconscious layers. The term *conscious* indicates what one is aware of at the present moment; preconscious implies what is in one's mind, but not *on* one's mind at the present moment. Obviously, preconscious is the storage room of the conscious.

One may revise the psychoanalytic topographic theory by analyzing phenomena that were almost unheard of in Freud's era. Sensory deprivation, biofeedback, and autogenic therapy were rather unknown at that time, and transcendental meditation, certain imagery processes, and parapsychological phenomena of telepathy and psychokinesis were not yet scrutinized by rigorous scientific research.

The above mentioned phenomena are neither entirely conscious nor entirely unconscious. They are not conscious because there is no reality testing, yet the individual who experiences transcendental meditation or telepathy is aware that he or she does experience these phenomena. Psychomotor epileptics who attack innocent bystanders are both aware and unaware of what they are doing; they are neither unconscious nor conscious. Their state of mind is somewhere between—it is *protoconscious*. The dichotomy between sleep and wakefulness has been

undermined by the so-called *lucid dreams theory*. Lucid dreamers are asleep; thus they cannot be conscious. They are, however, aware that they are dreaming and therefore, they are not unconscious. In a lucid dream the dreamers are able to reason, remember, and act volitionally while being sound asleep and dreaming (LaBerge & Gackenbach, 1986). They are neither conscious nor unconscious; they are *protoconscious* (Wolman, 1986; Wetzell, 1984).

The dreams of depressed individuals are sometimes more rational than their waking cognitive processes. Quite often, even when they are quite depressed they have lucid dreams, and in these dreams their repressed ego presents a realistic solution to their problems and calls for rational actions.

The lucid dream enables them to experience protoconscious phenomena. Some depressive patients also have parapsychological experiences, and report extrasensory and premonition phenomena. Possibly, the lack of emotional balance contributes to the ability to regress to protoconscious and unconscious levels (Wolman, 1986).

Elated moods of depressed patients are usually protoconscious. The patients are somewhat aware of their excited mood, but they are unable to test reality or to control themselves. In a manic mood they tend to do immediately whatever they feel like doing; there is no delay, no reconsideration, no self-discipline.

SYMPTOMATOLOGY

INCONSISTENCY

One of the outstanding features of depressive disorders is *inconsistency* in practically all aspects of behavior. Depressed individuals can easily turn love into hate and vice versa; they tend to be happy and unhappy, sociable and seclusive, full of energy and passive, sleepy and unable to sleep, and so on.

Depressed individuals are highly inconsistent in their plans and actions. They may enthusiastically choose an occupation and, after a while, be thoroughly disappointed. The proverbial “other pastures are always greener” applies to depressive disorders. Depressed individuals are in a never ending search to compensate for their feelings of inadequacy. They rarely check the availability of things they wish to possess or the accessibility of things they want to accomplish. They often start a great many projects at the same time and abandon all of them in no time. They are often hypomanic to cover up their frustrations, and are critical of themselves for not having accomplished the impossible tasks. They are often irritable and angry at themselves and others.

Their decision-making processes and analysis of what they have to face, as well as other cognitive functions, vary greatly, depending on their moods (Bower, 1981; Davis & Unruh, 1981; Teasdale, 1983; Wetzel, 1984).

“LOVE ADDICTS”

Depressive patients either exude overflowing love and kindness or are irritable and hateful. They are at their best behavior when loved and admired. It is easy for them to be kind and friendly to strangers whom they expect to win over, but the same person who is a kind Dr. Jekyll for strangers may be the rude Mr. Hyde for his or her family members. Their libido and destrudo are frequently shifting. Deeply depressed psychotics are in a state of almost continual hatred toward those who reject them and toward themselves for failing to win love. Their destrudo is very active and resists sublimation, neutralization, and aim-inhibition (Abraham, 1927; Arieti, 1974; Bibring, 1953; Mendelson, 1960; Wolman, 1973, 1984b).

LEARNED HELPLESSNESS

When depressed individuals feel they cannot win love by being strong, they try to win it by being weak. Many of them can work hard toward a goal, but when they come close to a victory, they defeat themselves. They seem to recapitulate their childhood; they tried to win parental love by being successful, but this did not work. The self-defeating and self-hurting tendency of depressed patients is deeply rooted in their unconscious belief that maternal love can be won only through misery. Many depressed patients, whether on a neurotic or psychotic level, have the masochistic wish to suffer, and hope to gain love by suffering.

Depressed people often fear success, and after trying hard they somehow manage to prevent it. They practice “learned helplessness” (Leites, 1979; Seligman, 1975).

Depressive moods last long and are painful, yet the patients seem to do very little to overcome their depressive feelings. They are accident-prone and often act against their own interests. They are quite sensitive to criticism coming from without, but they blame themselves for what their discreditors blame them for, as if hoping to win sympathy by willingly accepting punishment.

SEXUALITY

Depressed individuals may not be able to resolve their Oedipal complex through identification with the parent of the same sex. In most instances, maternal rejection prevents normal resolution of the family drama, and overdependency on and incestuous attachments to the parents may continue all through their life. The defense mechanism of reaction-formation makes them feel hostile toward the parent they are attracted to the most, and they are usually attracted to the more forceful, more aggressive, and more rejecting parent.

Depressed females try to attract as many men as they can in order to satisfy their desire to be loved by everyone, but they tend to lose interest in men who love them.

The combination of an absent or weak father and an aggressive mother is

conducive to a tendency toward *homosexuality* in male offspring.

Depressed male patients cannot renounce their mother as a love object, nor identify with their father. Depressed males tend to perceive all women as potential lovers. They fall in and fall out of love, always in search of the loving mother. Many depressed males are impotent; they tend to boast about their victories, while actually fearing intercourse. They often pursue women they cannot win over, but as soon as they win, they run away.

OBESITY

Depressed patients are unable to love unless loved. The less love they receive, the more they need. The feelings of being loved are usually short-lived; sooner or later, these patients experience the pangs of emotional and of physical hunger. Small wonder that they may overeat constantly, as if trying to fill the emotional void. They also overeat to make themselves less attractive, less capable of an active life, less successful, and less healthy. Overeating serves to deepen their self-defeat, to prove to themselves that they are weak and unable to control their weight and behavior; in the back of their minds looms the unconscious hope of gaining love by self-destructive behavior (Wolman, 1982a).

PSYCHOSOMATIC DISORDERS

According to Katon, Kleinman, and Rosen (1982), at least 26 percent of

patients who come to physicians complaining about physical disease are depressed, and their depression has led to the development of psychosomatic symptoms. Apparently, a great many psychosomatic conversion symptoms are related to underlying depressive disorders (Beckham & Leber, 1985). Exposure to stressors alone is almost never a sufficient explanation for illness, just as genetic studies have shown that biological factors alone do not cause mental disorders. According to Kurt Adler (1967), the rejected child may try to win love by intentional suffering and escape into illness. "The discouraged child who finds that he can tyrannize best by tears will be a cry-baby, and a direct line of development leads from the cry-baby to the adult depressed patient." Quite often, psychosomatic disorders represent a willful, albeit unconscious, escape into illness.

Several psychosomatic symptoms in depressive disorders are related to the immune system. According to Zegans (1982, p. 149), "Any stressful process that alters the normal physiology of hormones will naturally have an impact on immunological behavior."

Mason (1975) found that depression and mental stress can affect endocrine glands and thus disturb the functions of the immune system and reduce the organism's resilience.

Depression also reduces the organism's overall ability to fight disease.

Depressed individuals are prone to develop a variety of diseases and disabilities, and many of them suffer from angina pectoris, myocardial infarction, and other cardiac diseases (Herd, 1984; Howells, 1980; Wolman, 1988).

SUICIDAL ATTEMPTS

Depressive-psychotics usually fall asleep easily and wake up very early. There is nothing to do in the wee hours, and there is no one who cares. At such moments, depressed psychotics often act under the desire to punish themselves and those who do not love them. Some of them imagine themselves dead, listening to the sobbings of their relatives, as if believing that death would win the love they failed to receive in life. Some patients imagine themselves being alive, lying in their coffin, and smiling to themselves with a feeling of victory.

Unfortunately, their suicidal attempts are all too often successful. Any sign of rejection may motivate a depressive patient to attempt suicide. Quite often, they did not want to die, but desired to be nurtured (Brown & Sheran, 1982; Hankoff & Einsidler, 1979; Miller, 1980; Pokorny, 1983; Shneidman, 1980; Wolman & Krauss, 1976).

DEPRESSIVE NEUROSIS

As mentioned in the section on nosology, I believe that there are five levels of mental disorders: neurosis, character neurosis, latent psychosis, manifest

psychosis, and the total collapse of personality structure (Krauss & Krauss, 1977). Depressive neurotics are usually absent-minded, forgetful, and careless. In elated moods they are hyperactive and full of enthusiastic plans, ignoring or underestimating difficulties. Their thinking lacks precision, and they tend to confuse wish and reality. They may sound self-assured, but the slightest disappointment can put an end to their cheerful mood and make them depressed. In depressed moods they procrastinate, and they are sluggish and apathetic. They refrain from taking the initiative or engaging in active behavior, always expecting defeat and preaching gloom.

There are three main neurotic syndromes: *depressive*, *dissociative*, and *conversion* (i.e., conversion-hysteria) *reaction*. The neurotic depressive syndrome is associated with anxiety states and feelings of inadequacy. Neurotic-depressive patients tend to blame themselves for noncommitted errors. They are accident-prone in an unconscious wish for self-punishment.

Amnesia and the so-called “split personality” are typical symptoms of the dissociative syndrome. Instead of facing difficulties, patients deny them. In extreme cases of dissociation, patients tend to forget their own name and past experiences. Fugue, split personality, loss of memory, and loss of identity help them to escape self-blame.

In the conversion-hysteria syndrome, the patients develop a galaxy of

psychosomatic symptoms that can imitate almost every possible physical disease. Hysterical symptoms can be quite frequent, even in psychotic-depressive patients in their prepsychotic years, but as long as the hysterical psychosomatic symptoms prevail, the patients are not psychotic yet (Anthony & Benedek, 1975; Gold, Pottash, Extein, & Sweeney, 1981; Herd, 1984).

DEPRESSIVE CHARACTER NEUROSIS

Rationalization is the choice defense mechanism of depressive character neurotics. They tend to give to themselves and others shallow advice, such as “Keep smiling,” “Don’t worry,” “Let’s face it,” “Everyone does it,” “Never too late,” and so on. Depressive character neurotics tend to be hyperactive and gregarious. Quite often, they comment on their true or imaginary hardships, blaming the world and defending themselves. They often say, “Crooks and thieves are successful, and honest people have no chance.” A patient who failed in business made himself believe that he “sacrificed himself for his family, and never gave up,” and that the business failure was caused by “enemies” who hated his great virtues.

DEPRESSIVE PSYCHOSIS

In most cases, the transition from neurosis to psychosis is an erosion rather than a catastrophic event. Most often, latent depressive psychotics feel that they are failures, that they have never done anything sensible, that their lives have

been a waste, and that no one likes them; at the same time they will quite often try to give the impression that they are happy and successful individuals. Mild euphoric moods prevail, but depressed moods, occurring in the early morning hours, are distinct signs of deterioration. Their moods usually improve at evening, but their sleep is often quite disturbed (Luce, 1970).

Depressive latent psychotics often act as if in a frenzy, undertaking a great many activities aimed at warding off the oncoming depression. One patient of mine, a musician, decided to become a physicist, a mathematician, a philosopher, a historian of art, and an anthropologist in addition to being a composer, a conductor, and an impresario. A female patient was “collecting men,” by letting herself become involved with casual acquaintances and total strangers. Another patient started half a dozen projects, contacted scores of people, made hundreds of appointments, and kept dreaming up new, grandiose, and never-to-be-concluded projects.

The term *vacationing ego* describes the mentality of latent depressive psychotics. It seems as if all functions of the ego shrink to one task: the warding off of the superego’s hostility. Latent depressive psychotics tend to accept commitments they cannot meet, alternate exaggerated friendliness with isolation, undersell or oversell their services, underspend or overspend their money, and act in a thoughtless way whenever their wish to impress others is at stake.

THE FIVE SYNDROMES OF MANIFEST DEPRESSIVE PSYCHOSIS

There are five clinical syndromes in the manifest depressive psychosis. These syndromes are descriptive categories related to observable symptoms and personality structure. Occasional transitions from one clinical pattern to another have been observed (American Psychiatric Association, 1987; Grinker, Miller, Sabshin, Nunn, & Nunnally, 1961; Kaplan & Sadock, 1985; Wolman, 1973).

In the first syndrome, *major depression*, the ego has lost its control over the id and the superego. The patients are at the mercy of their irrational impulses and are unable to follow a rational path of behavior. They torture themselves with guilt feelings for true or imaginary transgressions.

The second syndrome is *mania*, a frantic and hyperoptimistic frame of mind that aims at covering up the deep and torturous depression.

The third syndrome is *paranoia*. When the ego, battered by the superego, resorts to projection and externalizes superego pressure, the patient perceives the world as a rejecting and punishing mother who some day will be forced to accept her suffering child.

The fourth syndrome is *agitated depression*. When the weak ego is unable to withstand the assaults of the superego and can't control the demanding id, the patient is continuously irritable, hates oneself and the whole world, and is in the

throes of depression. Agitated depression often leads to suicidal attempts.

The last syndrome is *simple deterioration*, when both the ego and the superego are defeated and the primitive, uninhibited impulses of the id take over.

Major Depression

The first syndrome is the so-called *major depression* (American Psychiatric Association, 1980, 1987). The symptoms of the major depression include passivity and helplessness associated with irritability and anger directed toward oneself (Krauss & Krauss, 1977; Mendelson, 1960).

Major depression is a psychotic syndrome; the ego has lost whatever control it had over the id impulses and is unable to restrain the superego's hostile attitudes. Major-depression (i.e., psychotic) patients may cross streets on red lights, eat in an unrestrained manner, or refuse to eat. Their biological rhythm is disrupted, and their sleeping patterns are disorganized. Quite often, they refuse to get up in the mornings and may, unless prodded, spend their days in bed in total passivity.

Depressed psychotics lose concern for their personal hygiene and appearance. They don't mind wearing dirty and torn garments, and are unable to relate to other people although they wish to be taken care of. Their cognitive functions oscillate from total incoherence to an almost normal way of thinking

(Leight & Ellis, 1981; Teasdale, 1983; Usdin, 1977; Wetzel, 1984).

Their pervading feeling of guilt may lead to suicidal attempts. Some of their self-accusations are remotely related to reality, but some are of a hallucinogenic nature (Nelson & Charney, 1981; Winokur, Clayton, & Reich, 1969; Winokur & Crowe, 1983).

The Manic Syndrome

Manic moods can start when patients experience a severe blow to their self-esteem and/or feelings of security. They may lose a close relative or friend, a job, status, prestige, property, or money. Quite often, the manic moods are precipitated by a sudden and severe failure of efforts.

Introjection of the image of the rejecting parent is typical for all depressive disorders. The introjected image is usually hostile, but only up to a certain point. The patient reactivates his or her childhood experiences as if invoking the superego to do what the mother did: "I see how unhappy you are. Now I will take care of you and reward you for your misfortunes." The superego, as it were, embraces the failing ego and acts the way the rejecting mother acted when she felt sorry for her suffering child.

There is no reality principle in a manic mood, no self-discipline, and no self-control. Manic patients do whatever they feel like doing. If they are sexually

aroused, they may proposition the first person they meet. Psychotic depressed patients regress to a stage they experienced before they felt rejected and depressed. They regress to the “lost-paradise stage,” to early childhood and infantile bliss (Arieti, 1974).

Psychotic delusions and hallucinations are often associated with *delusions of martyrdom*, of being lost and found, of being a Cinderella saved by a Prince Charming or a slave led by the Messiah to the lost paradise. Psychotic depressed patients often dream of a disaster that will force the mother to love them (Bibring, 1953; Hodges & Siegel, 1985). However, even in a manic mood, patients seem to be protoconsciously aware of the underlying depressed feelings. Their thoughts shift from one issue to another and from one grandiose plan to another. In manic moods they dream of a great many actions; but they refrain from the practical steps that could bring disappointment.

Paranoia

One of the psychotic reactions against depression is paranoia, a projection mechanism in which the patient is saying to himself or herself: “I do not hate myself. They hate me.”

This projective-paranoid mechanism is used by the ego in many disorders. It occurs whenever the ego, attacked by the superego, has not given up, but is unable to test reality and uses projection.

The same mechanism takes place in schizophrenia, when the ego is exposed to intolerable accusations from the superego (Wolman, 1983). Patients who elicited hate by their hostile behavior deny that they were ever hostile; they believe they are innocent victims of enemies (Wolman, 1987).

In depressive disorders the projections become systematized and reproduce the Cinderella story of the persecuted child who will finally be rewarded. Paranoiacs believe themselves to be martyrs, persecuted by a bad mother or anyone else, but ultimately to be helped by the mother of their dreams.

A man ran away from the Army during World War II because he believed two men in his platoon had been ordered to kill him. All soldiers, he said, were cowards who fought only when forced to, but he was a military genius who could “smash Germany with one big blow.” He went to his colonel with his inventions, but “. . . the envious colonel would not let me become famous” and turned his proposals down. The patient believed that the colonel gave orders to shoot him on the next day and to steal his plans. The patient deserted.

Paranoia represents a combination of elation and of denial of depression. It is the martyr-hero complex—a dramatization of an unfairly persecuted person who eventually will be rewarded for innocence.

Paranoia has been linked to the depressive psychosis by several authors. According to Kanzer (1952), guilt feelings lead to regression, to a magic

omnipotence, and/or to submission to the imaginary prosecutor. Internalization of the rejecting parental figure is the basic psychological mechanism of paranoia. According to Salzman (1960), the paranoid megalomania is an effort to deny one's low self-esteem. Kraepelin (1921) noticed the wish for grandiosity and excessive ambition in depressives; their persecution complex offers a detour of the desire to be admired.

In all cases of paranoia I have seen, paranoia was a reaction against unbearable feelings of depression. All paranoiacs share the wish of the rejected child whose misery will eventually gain the mother's love.

The Agitated-Depressive Syndrome

Not all dysmutual-depressive psychotics are capable of the manic-denial or of the paranoia-projective maneuver. Agitated-depressive patients may, occasionally, be calm, especially when they have the chance to outshine others, but since no one can always be successful, the elated moods are short-lived (Wetzel, 1984; Wolman, 1973).

Agitated-depressive patients are full of gloom and anger. One patient described his mood in the following way: "I feel like jumping out of my skin. You'd better lock me up before I strangle my wife and my child. I cannot stand them; I hate them and hate myself. The best thing would be to put an end to everything." A female patient, tortured by her moods, was hospitalized voluntarily and felt better

on the ward where she “took care of all those crazy characters.” She became very active, a sort of assistant and advisor to the doctors and nurses. After she was discharged from the hospital, she found life bleak, and regressed.

Hate and self-hate are the main symptoms of the agitated-depressive syndrome. The defeated ego does not exercise reality testing; a casual approval by a nurse gave a female patient new enthusiasm for living, but her son’s lack of interest provoked a violent and self-destructive reaction. In agitated-depressive patients the slightest sign of rejection unleashes uncontrollable outbursts of violent behavior directed against themselves and others.

Simple Deterioration Syndrome

In the simple deterioration syndrome in depressive psychosis the patients regress into parasitic life as if hoping that somebody will take care of them. They give up any efforts to live a normal life. One man who held a menial job in a mailroom found a dark corner where he hid and slept. When he was discovered, he was fired. His reaction was, “I knew this was going to happen. They are just unfair! Don’t they understand that life is too hard for me!”

Simple deteriorated psychotics refuse to exert themselves. Their “sleepy ego” merges with the id. There isn’t much reality principle left, and there is no self-discipline. The id’s law of immediate gratification rules their regressive behavior.

Simple deteriorated psychotics of the dysmutual type go down the social ladder. If they have some money, they usually spend it in a senseless manner. Some of them become addicted to drugs or alcohol and some become street bums and beggars.

In the simple deterioration syndrome the patients renounce love for others and the need to be loved by anyone. They accept defeat and give up all effort. They may sleep on a bench on a street or hang around in a public place, begging. They do not care any more for anything. When life gets too difficult, they may turn on the gas and put an end to it all. Defeated, depressed, rejected, and forgotten by all, the simple deterioration depressive psychotic does not care to live any longer (Brown & Sheran, 1982; Hankoff & Einsidler, 1979; Roy, 1982).

SUMMARY

The term *depression* is used to describe a variety of negative feelings, such as frustration, disappointment, mourning, and so on. Depression as a psychopathological term means the *feeling of helplessness associated with blaming oneself for being helpless*. Helpless anger directed against oneself and others and feeling guilty for being weak are the essential elements of depression.

There are two distinct types of depression, albeit their symptoms are quite similar. The distinction is based on etiologic factors. The first type, ecosomatogenic depression, is caused by biochemical factors; the second type, psychosociogenic depression, is caused by psychological factors.

Both types of depression can be caused by inner (endogenous) or outer (exogenous) factors.

There is probably a genetic predisposition to both types of depression.

There are three basic types of interaction with others: instrumental, mutual, and vectorial. Well-adjusted adults interact in an instrumental manner in the breadwinning functions, in a mutual manner in friendship and sexual relations, and in a vectorial manner in the parenting relation. Classification of mental disorders in the nosological system follows the division of three major psychopathological types: sociopathic hyperinstrumentals, depressive

dysmutuals, and schizo-type hypervectorials. Psychosocial depression is dysmutual, that is, related to imbalances and shifts in moods and social relations.

The etiology of depressive-dysmutual disorders is chiefly related to faulty parent-child interaction. The parents of depressive patients show no affection toward nor interest in their children, except when the children are gravely ill or in a desperate situation.

Children exposed to the parental emotional seesaw feel rejected and blame themselves for being rejected. They often wish to suffer, for that was the only way they gained love. In the masochistic streak of depression, depressed individuals hate themselves for not being loved and hate others for not loving them.

One may distinguish five levels of severity in depression: (a) depressive neurosis, (b) depressive character neurosis, (c) latent depressive psychosis, (d) manifest depressive psychosis, and (e) total collapse of personality structure.

There are five possible syndromes in psychotic depression: (a) major depression, (b) mania, (c) paranoia, (d) agitated depression, and (e) simple deterioration. The division into unipolar or bipolar depression seems to be superfluous, for elation is one of the defense mechanisms of escape from depression.

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