WHAT CAN PSYCHOANALYSIS TELL US ABOUT DEPRESSION?

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ABSTRACT
Early psychoanalytic investigations of depression in *Civilisation and its Discontents* (Freud, 1929) and in much of the work of Karl Abraham offer a framework for understanding depression which may be applicable to modern model of the disease. The emphases on modern living and interpersonal relationships are especially fruitful. The current paper details psychoanalytic approaches to depression and reviews how they may be applicable to current understanding and treatments of the causes and symptoms of depression.

INTRODUCTION
What is the meaning of life? The all-encompassing and perhaps melodramatic question has been the subject of universal debate from mankind’s beginnings. Freud, in *Civilization and its Discontents* (1929), argues that the question itself is context-dependant. In his view, religion is the only institution that attempts to account for a meaning behind everyday life. Freud asks, instead, what it is that mankind actually wants, and the answer appears to be simple – happiness. It seems, therefore, more appropriate to ask where happiness comes from. In psychoanalytic work, the mechanism that dominates the mental apparatus and is the source of all happiness is the pleasure principle. Says Freud, “[what] we call happiness in the strictest sense comes from the (preferably sudden) satisfaction of needs which have been dammed up to a high degree” (1929, p. 264). However, in our modern society, depression rates are rising. According to the World Health Organisation, depression affects about 121 million people globally and is among the leading causes of disability worldwide (WHO, 2010). The search for happiness, clearly, is not proving to be fruitful.
Psychoanalytic theory of melancholia, referred to nowadays as depression, began mainly with the work of Karl Abraham and Sigmund Freud in the early 1900’s. The seminal work in this area was Freud’s *Mourning and Melancholia*, published in 1917, in which he draws on clinical experience in order to explain the state of melancholia. He draws parallels between this and the natural state of mourning, and uses this comparison to explore the psychic mechanisms of depression. Abraham (1927) also looks at the melancholic condition and details some factors necessary for its psychogenesis. Since its beginnings in the work of these early theorists, psychoanalytic models of depression have been expanded and refined to offer insights into the cause, symptoms and treatment of depression.

**CAUSES**
Freudian theory offers two possible explanations for the apparent general unhappiness of the global population: the surplus of pleasure in our society, and the state of civilization itself. The first of these – the surplus of pleasure – is again linked to the pleasure principle, and the possibility of over-exposure, meaning that “[when] any situation that is desired by the pleasure principle is prolonged, it only produces a feeling of mild contentment” (Freud, 1929, p. 264). In a developed Western society such as ours, for the majority of people, every need or desire can be satisfied with minimal effort. As Goethe tells us - and Freud quotes - “nothing is harder to bear than a succession of fair days”. Modern life has become a succession of “fair days”, with standards of living rising in Western countries along with rates of depression. According to the WHO’s 2004 report on the Global Burden of Disease, “depression makes a large contribution to the burden of disease, being at … eighth place in low-income countries, but at first place in middle- and high-income countries” (WHO, p.5). Freud’s concept of overexposure, based on the pleasure principle, can offer one explanation for the prevalence of depression in developed countries. According to this theory, pleasure is, on one hand, omnipresent, and on the other, unattainable, as we have become almost deadened to the experience.

Freud’s second explanation for the universal feeling of *malaise* involves looking at society itself and its effect on the individual. In *Civilization and its Discontents* (1929), he states that there are three
sources of suffering for a human being. The first is the suffering that is inflicted by the body itself, which is inevitably subject to disease and aging and is prone to feelings of pain and anxiety. The second is the suffering provided by the natural world and external influences. And the third, and most painful, is the hurt that comes from relationships with other human beings. The first two of these sources, in Freud’s opinion, are unchangeable and must be accepted. However, the hurt caused by social relationships, he argues, comes about as a result of the state of civilization. He believes that civilization places restrictions on our basic instincts. This is related to Freud’s three part construction of the unconscious: the id, which is comprised of our basic and most primal desires; the ego, which controls the desires of the id and translates them into behaviours that are expressible in the real world; and finally, the superego, which internalizes the moral and cultural rules of the society we live in. With the development of the superego, and the cultural norms that we are forced to follow, we are not free to satisfy the primal drives of the id, as we have accepted the rules of society as binding, and to go against them is to risk expulsion from this society. Primal pleasure has been exchanged for the security and stability that living in a civilized society offers us. In a way, it is as if satisfying the id would be to fight for a large slice of a small cake, while obeying the superego offers us a smaller slice of a larger cake. Being a part of a society ensures that our needs can be satisfied on a regular basis.

In response to this acceptance of the rules of civilization, some psychoanalysts see depression as a form of protest against society, a way of saying “no” to what we are meant to be (Leader, 2009). Taking civilization as the cause of a universal feeling of discontent, it is not surprising that, in our modern society, in which individuals depend largely on social relationships and a sense of community, depression has become more and more prevalent.

Although these theories offer an explanation for depression in the general population, Freud and Abraham also suggest some theories for the psychogenesis of depression in a specific individual. Freud (1917) notes the similarities between the states of mourning and melancholia. He describes mourning as a response to an actual loss of a love-object, such as a person, or even an ideal. On the other hand, in melancholia, the patient cannot consciously grasp what he or she has lost, or else knows what it is, but not
what it is about the object that they have lost. Abraham (1927) also offers some possible causes for depression, based on his clinical work. He sets out four factors that are necessary for the psychogenesis of depression. The first is linked to the five stages of psychosexual development, which are oral, anal, phallic, latency and finally, genital. A child must successfully pass through each of these stages in order to become a psychologically healthy adult, while fixation at any stage can persist into later life and result in adult neurosis. Abraham believed that the melancholic patient is fixated on the oral stage, and thus overemphasises oral eroticism in later life. Secondly, the patient will also have experienced early and repeated childhood disappointments in love. Thirdly, the first of these disappointments is likely to have occurred before the Oedipal wishes – wherein the id of the child desires to do away with the father and reunite with the mother, but is constrained from doing so by the realism of the ego – have been resolved. Finally, a repetition of this primary disappointment in love is also likely to have occurred later in the life of a melancholic patient.

These early psychoanalytic concepts draw on the clinical work of both Freud and Abraham in order to attempt to find exactly what causes melancholia. These theories work on both a societal and individual level and offer some explanations for the prevalence and causation of depression.

**Symptoms**
The symptoms of depression are well known and are often found to varying degrees in everyday life, but the pathological state has been defined diagnostically, originally by Freud and in modern times by the DSM. Freud, in *Mourning and Melancholia* (1917) describes the state of depression as “mentally characterized by a profoundly painful depression, a loss of interest in the outside world, the loss of the ability to love, the inhibition of any kind of performance and a reduction in the sense of self, expressed in self-recrimination and self-directed insults, intensifying into the delusory expectation of punishment” (p. 204). The modern diagnostic criteria for depression (as detailed in the DSM) draws on similar elements and describes the symptoms as follows: sadness, loss of interest in the outside world, under or over-eating, under or over-sleeping, loss of energy, feelings of worthlessness, and recurrent thoughts of death (APA, 2000).
Taking a psychoanalytic approach to some of these symptoms can offer an insight into their causation.

As has been noted, Freud believes that mourning and melancholia are both a response to a loss, whether it is a conscious or unconscious one. The apathy found in both states is due to the exclusive devotion to mourning that leaves no room for interest in the outside world. Both of these conditions result in inhibition and loss of interest, as the ego is absorbed in the work of mourning. This absorption of the ego also accounts for the sleeplessness commonly associated with depression, which is due to “the impossibility of effecting the general drawing-in of catexes necessary for sleep ... It can easily prove resistant to the ego’s wish to sleep” (Freud, 1917, p. 205).

The most distinguishing symptom of melancholia is the loss of self-esteem that is characteristic of depressive moods. The mechanism behind this loss of self-esteem is explored in depth by Freud. In the course of normal life, an individual’s unconscious makes a choice of love-object, and a bond is formed between the individual’s libido and this object. If something should occur between the two, such as a slight or disappointment, this bond is subject to a shock. In a normal, non-melancholic state, this shock would result in the withdrawal of the libido from the love-object and its transference to a new object. However, in the pathological state of depression, this extension of the libido is instead drawn back into the ego. This results in the identification of the ego with the hated and abandoned object. Thus, the ego, in seeing itself as comparable to the hated object, begins to equally revile itself, resulting in the self-reproach that is commonly observed. In this manner, Freud argues, all self-reproaches felt by the melancholic patient are, in fact, accusations against a love-object that have been transferred onto the patient’s own ego. Every negative feeling the patient feels towards themselves was originally aimed at another person. If this was not the case, the patient, who claims to feel unworthy and inferior, would undoubtedly act in a humble and submissive manner to those around them, which has consistently not been observed.

Abraham (1923) argues for the emphasising of the sadistic element of melancholia as being the source of self-reproach. He, like Freud, believes that the depressive state comes from repressed hostile feelings towards the love-object. The subject constantly attempts to gain possession of the
love-object, and is hypersensitive to its every slight. The subject then believes whole-heartedly in his or her own omnipotence, in that they have caused pain and suffering to their love object. As a result, the subject allows him or herself to be tormented by this love-object. According to Abraham, it is this process that is at the heart of melancholic self-punishment. The feeling of being the worst person in the world, therefore, comes from two sources – the melancholic’s identification with the hated love-object, and the inner perception of being a source of great suffering to this love-object (Perelberg, 2005).

*Mourning and Melancholia* emphasises the oral fixations of the melancholic, who has regressed to this stage of libidinal development. Regarding the love-object, the “ego wants to incorporate this object into itself, and, in accordance with the oral or cannibalistic phase of libidinal development in which it is, it wants to do so by devouring it” (1917, p. 249). Freud links this cannibalistic tendency of the ego to the rejection of food that so often accompanies melancholia. Abraham (1916) also supports this interpretation of this symptom. He believed that the patient refuses food as he or she is attempting to refrain from carrying out repressed impulses of symbolic cannibalism.

The strangest and most interesting characteristic of melancholia is, for Freud, the suicidal tendencies that often accompany it. This appears to be in opposition to the strongest drive present in all living creatures: the drive towards pleasure, and, in effect, towards life itself. It is the self-love of the ego that creates in us the overwhelming drive to live, and it is the primal state from which instinctual life proceeds. In order to explain this, Freud explores the possibility of a second set of instincts that are in constant opposition to the libido. The initial dichotomy between the id and the ego was unable to account for some of his clinical experiences, such as patients with melancholia and post-war soldiers who constantly related their unpleasant experiences both while awake and in their dreams. Freud was puzzled by this apparent opposition to the pleasure principle, and was driven to reflect on the mysterious masochistic trends of the ego (Freud, 1920). He then proposed a “death instinct”, also known as *Thanatos*, suggesting that all instincts strive to return to the restoration of an earlier stage, that is, death. In his view, sadism is a death instinct that has been turned on the subject’s own ego.
It is through the ego’s sadism that the suicidal urges characteristic of depression occur, the “indubitably pleasurable self-torment of melancholia” (Freud, 1917, p.211). Only by recognising the displacement of any negativity towards the love-object onto the patient’s own ego, and the sadism involved in this, can we understand how the ego could possibly overcome the most primal of drives and seek to kill itself.

TREATMENT
Treatment for depression in psychoanalytic work was initially of a pessimistic nature and involved making the patient aware of his or her repressed impulses (Mendelson, 1974). Abraham (1924) believed that treatment should alleviate symptoms, but also protect against other attacks by getting rid of the patient’s regressive libidinal urges. However, Jacobson (1954) states that for some patients, it is not possible to carry the analysis to the point where their pre-Oedipal fantasies and impulses can be produced and interpreted. She believes that patients will inevitably undergo the phenomenon of transference, wherein the feelings and desires that were directed onto one person will inevitably be transferred to another. In this way, she believes that the depressed patient will make the therapist their central love-object and the focus of their pathological demands.

Therapy for melancholic patients is understandably demanding. Fenichel (1945) summarized the difficulties that must be overcome in the therapeutic treatment of depression. The first is the oral fixation of the patient, which must be analysed through crucial infantile experiences. The second is the ambivalence of the transference of unconscious feelings to the therapist. The third is the inaccessibility, both emotional and communicative, of the depressed patient.

Traditional psychoanalytic therapy for depression was an extended process which looked to reveal unconscious emotional material using free association techniques. The focus nowadays is on emotional catharsis in the context of a stable, long-term, and well defined patient/therapist relationship (Mays & Croake, 1997). However, if a treatment’s value is to be assessed in terms of its clinical use, then psychoanalytic therapy for depression must be found to be lacking, as its use as a stand-alone treatment is no longer common (DePaulo & Horvitz, 2002).
CONCLUSIONS
Psychoanalytic theory can offer some insights into the causes, symptoms and treatment of depression. However, there are some gaps in the literature that remain to be filled. Mendelson (1974), for example, notes that more modern literature largely ignores the treatment of depression by psychopharmalogical means. Psychoanalytic treatment overlooks the effectiveness of medication, which, although not a solution in itself, does raise some theoretical issues regarding the psychogenesis and symptomatology of depression. Another possible critique of the psychoanalytic treatment of melancholia is the oversimplification of its causes. Depression that has no apparent motivation is becoming more and more common and it is not plausible that each and every one of these sufferers has been subject to a loss or slight from their love-object. However, the rising numbers of sufferers could be attributed to the state of our modern society rather than to a specific object-loss. On the whole, psychoanalytic theory can offer at least some valuable insights into the causation, symptomatology and treatment of depression, but its use should not be relied upon to the exclusion of other methods of investigation.
REFERENCES


