DEPRESSION IN THE LIGHT OF INDIVIDUAL PSYCHOLOGY[1]

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Psychiatry, today, is confronted with the same urgency in the treatment of depression, as it was when Adolf Meyer (19, p. 43) substituted the term "depression" for "melancholia" in 1904. Despite the introduction of anti-depressive drugs and electro-convulsive therapy, the therapist is faced with the same pressures and emergencies, and patients and their families with nearly the same amount of suffering as before. Most schools of psychiatry have not attempted to develop a theory of depression, and most of the theories which have been set forth contain questionable formulations. It therefore seems important to consider the nature of depression, its development and its therapy in the light of a comprehensive theory. It is the purpose of this paper to show how Alfred Adler's theory of personality accounts for the facts of depression, and supplies ways for treating it.

Depression as Safeguarding Device

According to Adler's theory most problems confronting the individual are problems of relations with others. All problems in life are answered by the individual with his tested methods, attitudes, and symptoms, and all his responses are in the service of his goals for self-enhancement. Depending on the degree of his developed social interest and courage, he will tend to face the problems of his social reality, and attempt to solve them as best he can, or tend to evade them, seeking detours and distance from the expectations of the community, in order to escape a real evaluation of himself, which looms as a threat to his self-ideal.

Whenever the feelings of inferiority are great, the goals of superiority are correspondingly high, in compensation. Then their achievement becomes increasingly difficult, and the individual becomes increasingly discouraged. If at the same time he has not learned to cooperate as a method of gaining satisfaction in life, and, instead, exploits others, he will soon experience increasing opposition once he steps beyond his more tolerant family circle. The outside world will, therefore, seem to consist of enemies who frustrate his desires, and thus threaten his hopes to achieve his goals. The individual then adopts alibis and evasions to safeguard his self-esteem. Adler called

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these "safeguarding devices;" others later called them "defense mechanisms." Adler says, neuroses and psychoses have "the ultimate purpose of safeguarding a person from a clash with his life tasks, that is with reality, and of sparing him the danger of having the dark secret of his inferiority revealed. . . . What appear as discrete disease entities, are only different symptoms which indicate how one or the other individual considers that he would dream himself into life without losing the feeling of his personal value" (6, pp. 299-300).

The special safeguarding device or symptom called depression has, of course, specific characteristics. To be sure, most cases encountered in practice will not show the clear-cut picture which will be described here. Together with depression, the patients employ other defenses, such as hysterical, phobic, compulsive, or schizoid reactions which modify, each in their own way, the picture of the pure depression.

Exploitation. One prominent characteristic is that the patient's goal of superiority is not readily detected. To all appearances he depreciates himself, accuses himself of being the greatest failure, and expresses guilt for all sorts of evil doings and happenings, local or family calamities, or even world catastrophies. Where then, is the goal of superiority?

Actually, the patient exploits the greater social feeling and empathy of others; he forces them into his service, extorts the greatest sacrifices from them, compels them to express their devotion and love for him and to worry about him constantly. All this serves his hidden goal of superiority for it places him in the center of attention, underlines his importance, gives him license to do whatever he wants, and relieves him of all obligations. Only in fairy tales can a prince or princess command such a privileged position.

Since he is, of course, unable to acknowledge that this is his secret purpose, he expresses guilt feelings about exploiting others and being such a burden to them. Such guilt feelings were already recognized as "mere wickedness" by Nietzsche (6, p. 272). Adler explained their purpose and function as a device for appearing to oneself and others as noble and socially minded, while persisting in exploitative actions. Nevertheless, these guilt feelings are still often considered as basic and honest by the general public and many psychiatrists.

Depression, with its unique superiority ideal, has, like all adult behavior, its prototype in childhood. It is not devised on the spur of the moment, just when some exogenous factor seems to threaten the

individual's prestige and self-ideal. Adler says: "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" (6, p. 288). The patient tries "to approximate the well-tested picture of a helpless, weak, needy child, for he discovered from personal experience that it possesses a great and most compelling force" (2, p. 243).

Many psychiatrists see in this employment of methods that were used in childhood, something that they call "regression." But this betrays a rather mechanical view of the functioning of the human mind. In the first place, as Adler says, "We can never speak of regression in the Freudian sense; otherwise every psychic act would be a regression, since it is always based on experiences from the past" (5, p. 73). A second point which contradicts "regression" is that all symptoms and methods of action are directed towards some goal; they are therefore relentlessly *forward-* pressing, and never directed backward.

The history of the depressed patient shows that he has depended since childhood on the efforts and aid of others, to an excessive degree, and that he does not recoil from stressing and exaggerating his weaknesses, illnesses and inadequacies. He does this in order to force others to compliance with his wishes, and to extort sympathy and active help from them, as well as to spur them on, often to unheard of sacrifices. He will use his power ruthlessly where and when he can, often adorning his actions with ethical postulates, only to turn around and point to his needs and his weakness, when he can not prevail with his will alone.

Depreciation. In his depression-free days, the patient's thwarted but exaggerated ambition urges him to chase after glory and after successes which can be attained without much effort and risk of failure. As soon as failure seems to threaten, however, he shrinks from the task, and stresses that he has failed again as he always has. Indirectly he blames this on the wrong-doing of relatives or friends, on his upbringing, on an unlucky star under which he was born, or, as a last resort, on his sickness, his depression. He ascribes his depression to heredity or other unknown causes, while laboriously—though largely unconsciously—generating this depression within himself. He anticipates a dire fate, from which he cannot save himself or be saved by others, despite all their strenuous efforts.

Thus he frustrates all efforts to help him and thereby depreciates others. This is one of his methods for feeling superior. The therapist, I may add, is of course, frequently one of the patient's chief targets. Characteristically, the depressed patient will say, "Now it's too late," or find some other spurious reason for rejecting the very thing he had

complained had been denied him. We are reminded of the child who, after much fussing and crying, is finally offered what he wants and responds, "Now I don't want it."

Certifying the sickness. To demonstrate to himself and all others that he is really sick, the depressed patient is ready to go to any length and to pay all costs. He can sit for hours painting in his mind the evils that will befall him, and then act as if they had already happened. He thereby produces a shock effect with the utilization of all his emotional potentialities—primarily fear and anxiety, and always rage against someone near him. He neglects himself and his outward appearance; he disturbs his bodily functions, his sleep and his nourishment; he presents a pitiable condition, always stressing his grief-stricken state. Adler remarks: "We want to stress especially that toxins are released by the endocrine glands through the affect of rage and grief by way of the vegetative nervous system" (4, p. 173*n*). In such a condition, then, social relations, and with it, all obligations, are safely excluded, and the patient's proof of sickness, irresponsibility, and need for those who will serve him are firmly established.

This, then, is the relentless effort of the depressed: to prevail with his will over others, to extort from them sacrifices, to frustrate all of their efforts to help him, to blame them—overtly or secretly—for his plight, and to be free of all social obligations and cooperations, by certifying to his sickness.

Suicide threat. If the patient is still dissatisfied with the effect his illness has on some significant person in his entourage, a threat of suicide will usually terrorize his environment into compliance with his wishes. If this, too, fails, he may in his rage and in revenge go so far as to attempt or commit suicide. He expects the particular person involved to be shattered by this act, and suffer guilt for not having acceded to his wishes. In addition he indulges in a romantic delusion, a beau geste, designed to point up the worthlessness of others, and to absolve himself of all criticism: *De mortuis nil, nisi bene.* He will no longer have to carry on the Sisyphus work of covering up his own responsibility for his failures, which he feels is in danger of being exposed, and of upholding his illusory superiority ideal, in the service of his vanity.

The symptom of suicide also has its prototype in childhood where it has been tested out as a method. There are all sorts of ways for children to hurt themselves, in order to hurt others. Essentially we find this in the child who says: "It serves my mother right, if I break

my leg." The implication is always: "Then she will be sorry and suffer." Similarly the adult suicide says: "See what you have driven me to do; now you will suffer the rest of your life for it and, missing me, realize what a rare and sensitive person I was."

Delusion and mania. The delusional and hallucinatory constructions in the psychotic types of depression, depend on a more total identification with the pessimistic predictions and anticipations by the patient, his greater devaluation of reality, and his more complete denial of logic and common sense. This occurs when his inferiority feelings are so great and his compensatory illusory goals so high that their protection is possible only in unreality. Dissociation thus becomes a necessity; the hostile outside world of people is used for the personification of his difficulties in achieving his grandiose goals. In schizophrenia the process is similar. Thus many psychiatrists classify psychotic depressions, as well as the manic-depressive psychoses, with schizophrenia.

Mania is a frantic effort by the patient to force a success in the service of his goal of superiority. He is so strongly identified with this in his overcompensation of his inferiority feelings that he appears to take literally the "all" in the "all or nothing" proposition so typical of the neurotic. He intoxicates himself with false courage. This is not unlike alcoholic intoxication, which is also often resorted to, to overcome depression. The effort usually fails, as does the gambler's, when he puts all his money on one horse, in a desperate effort to recoup his losses. Occasionally it may succeed, and such patients achieve notable feats; usually, however, mania gives way to a deep depression.

Manic-depressive psychosis also has its prototype in childhood. It may be seen in the child who begins everything with great enthusiasm and progresses very rapidly, only to give the whole thing up, just as quickly, when brilliant success does not immediately follow his efforts. The same children use persuasion to a dramatic degree, but give way to tantrums and crying when their efforts fail. To call their behavior contradictory and to attribute it to ambivalence, is, of course, to overlook totally the underlying singleness of purpose.

Both the manic and the depressed never really believe in themselves, do not appreciate others, and are always eager to exploit others for their own purposes. Both negate reality by the use of a delusion about their prophetic gift: one, by foreseeing that everything will be wonderful and that he can do anything, the other, that everything will be dismal and that he can do nothing.

The depressive suffering. The manic, in his false overoptimism, identified with the proposition that life is designed to bring him success, shows tremendous buoyancy and gives the appearance of great enjoyment of life, despite his enormous tensions. As for the depressed, does he enjoy his symptoms? Since he is firmly dedicated to the proposition that life is designed to bring him suffering, and since his suffering is the most formidable weapon in his battle against his opponents, he cannot possibly enjoy his depression; that would annul all his efforts. The patient does endure the most severe agonies. But we should never forget that he is largely not aware of the fact that he creates them, and for what purpose he does so. Sly and secret smiles of triumph are, however, frequently encountered among patients when they report the sacrifices others are obliged to make as a result of their depression, or when they report how they frustrated others. Evidently the patient's secret enjoyment of depression was recognized a long time ago. The very insightful Viennese playwright Nestroy has, according to Fenichel, a character say: "If I could not annoy other people with my melancholia, I wouldn't enjoy it at all" (9, p. 392).

CRITIQUE OF OTHER THEORIES

The proponents of the libido theory have had a particularly difficult problem in the interpretation of depression. According to Jones (15, pp. 279-280), Freud failed in his first attempt to explain the genesis of depression.

Abraham recognized the superiority feeling and contempt for people in the depressed, but failed to see in them, and even denied, any basic inferiority. In fact, he believed that they have genuine self-appreciation (1, p. 455). Together with Freud (11), he constructed a system, wherein the libido, loosened from its attachment to a love object (after its loss), was repressed, and reappeared in the form of depression.

Rado, according the Fenichel (9, p. 411), gave the final touch to this theory by having the libido break in two, in its agony over the loss of its love object. One half becomes repressed as latent aggression, while the other half is turned like a boomerang against the self, in the form of depression. He also added fear of retribution as cause of self-punishment, and finally that all depression contains a fear of starvation, originated in infancy (18).

Eventually Freud had to introduce the death instinct in order to explain the tendencies toward self-destruction in depression and other conditions. But the death instinct is rejected by many, among them

Rado (18). Basing his whole understanding on adaptation, Rado regards suicide, for example, as a phenomenon that is still obscure. In our view, suicide is goal-directed behavior toward an illusory goal of personal superiority.

Enlarging on the conception of loss of love object as a factor in depression, Goolker, Schein and Wender (12) concluded recently that the ability to love and appreciate is necessary in a depression, if one assumes a love object the loss of which is bemoaned. Thus, they mistake the wish to dominate, that is so characteristic in the depressed, for love. They also maintain that maturity and a better integrated personality are essential for depression, since it is so rarely seen in children. That is about as logical as saying that echolalia is a sign of maturity, since infants cannot repeat words.

Federn (8, p. 278) feels that mania and depression are due to inability to stand frustration. This seems true, but then he continues: "While the manic seeks comfort too quickly, the depressed deviates by his inability to seek any comfort at all." Now, actually, the depressed seeks comfort constantly, only he cannot acknowledge receiving it, since, as we have seen, inconsolability is his method of battling his environment, of proving that he is sick and therefore not responsible, of depreciating others, and of pressing them even more into his service. When he succeeds in this, it gives him enormous comfort, in that it supplies him with the necessary illusion of his superiority.

There are always, of course, the proponents of constitutional theories of depression. In these theories the impulses range apparently freely, automatically, and independently. The patient as an active creator, coordinating them in the service of his goal, is left out. We see the same serious omission of the patient as a creative agent in environmentalistic theories like that of English and Pearson who state that "The parental attitude of letting children 'cry it out' too often and too long, is bad. . . . , and the baffling lack of emotional response in depression. . . . . is undoubtedly due to this cause" (7, p. 28).

There are also many researchers in the fields of biochemistry, physiology, and endocrinology who, on finding changes in one or another organic constituent in depression, believe to have found its cause. We, like others who stress unity of the personality, with psyche and soma totally integrated, expect physiological changes in any neurosis or psychosis. But we believe that the question of the primacy of these changes has been answered long ago to the effect that neither organic nor psychological symptoms come first; they generate each other. The principle of multiplicity of causes, all of which are inter-

related and influence each other, must be considered basic here, as in any other area. And this holds true equally for organic, environmental, interpersonal, or conditioning schools of thought.

Gutheil (13) has a more serviceable definition of depression, "sadness plus pessimism." While he does not point up the purpose of either the sadness or the pessimism, he does recognize the depressed patient's fear of his own worthlessness. Adler as early as 1914 pointed to the "pessimistic perspective" of the melancholic, together with his godlike, prophetic look into the future, where everything is black (3, p. 250).

Lichtenberg (17), a psychologist leaning toward Lewin (16) and French (10), also comes close to the Adlerian view. His definition of depression emphasizes "the feeling of hopelessness, the feeling of responsibility for the hopelessness, and the context of goal-directed behavior accompanying the hopelessness."

The schools of interpersonal relations, as might be expected, come closest to our views. Sullivan (20, p. 50) states that there is only a superficial similarity between grief and depression, and that in the latter all constructive situations are cut off, while stereotyped destructive ones are maintained. He also sees goal-directedness in the depressed suicide: "Our impulse to live . . . in these people is vanquished entirely by a hateful combination of impulses, which leads to destroying oneself in order to strike at some other person" (20, p. 12). Clara Thompson, too, in criticizing Freud's theory of the death instinct, recognizes that "suicide is usually stimulated by motives other than self-destruction. Spite and punishing the loved one are almost invariably factors." (21, p. 52).

TWO CASES

I recall one patient, a highly intelligent college girl, who told me that she was always depressed and unhappy, even in childhood. But, she added: "I was actually not as unhappy as I pretended to be; I felt more interesting being unhappy." She also told me how she always used to lie about having pains of all sorts, and never would allow her mother to leave her. She had enuresis until the age of eleven, when, much against her will, she was sent to a boarding school. She admitted not liking anybody, and that any friendship would be a positive danger to her. Her earliest recollection was that, when she was four, a car ran over her toe. She wasn't hurt, but a big fuss was made over it. The patient added: "It was a pride of mine."

You can see in this short description the early childhood preparation for a pattern of life of hurting herself, or at least appearing to hurt herself, in order to gain recognition, have her way, achieve an illusory superiority, dominate others, and never attach herself, really, to anybody except for exploitation. At the same time, there is, of course, a deep-seated feeling of inferiority with its compensatory superhuman ambition as her guiding line. She totally lacks belief in her ability to achieve anything by her own honest efforts; therefore, she feels constantly on the brink of exposure as a sham and a failure. This, in her vanity, her exaggerated self-image can not permit. And so, the tenacious clinging to the safeguarding device of depression, despite the high cost to herself.

Another patient, after prolonged treatment, admitted that she could stop her depression any time she wanted to. But, she added, she could not afford to do so, because her husband would immediately resume treating her like a door mat, as he had done before her depression started; now, she had the upper hand. When she was cautiously asked, if she could not just play-act to her husband, as if she were depressed, but otherwise enjoy her life, she acted offended at the proposition that she be so dishonest. She also constantly bemoaned the fact that she was such a burden on her environment, including her husband. Here, again, one can see the goal-directedness of the depression, the battle for superiority, and the safeguarding of the idealized self-image.

THERAPY

We see constantly patients getting over their depression, with or without treatment. This they do usually, when they have covered up their failures sufficiently by an overwhelming proof of being sick and therefore not responsible, or when they feel they have in some way regained superiority.

This raises the question, why do monoamine oxidase inhibitors, imipramine (Tofranil) and electro-convulsive therapy (ECT) frequently diminish or even dispel depression long before this could normally be expected? Hospitalization by itself, of course, frequently may act to stop a depression without drugs or ECT; this may be due to fortifying the proof of sickness, the absence of responsibilities, and also the patient's removal from his main opponent at home. He may quickly form dependencies on other people in the hospital, who can perhaps be impressed and dominated more easily. In some cases drugs or especially ECT may well constitute the necessary proof of sickness for the patient. But this can not be the explanation in the majority of cases. The chances are much more likely, that these drugs, as well as ECT, cause a break in the constant, intensive preoccupation of the patient with his prestige strivings and morbid delusions. Memory changes have been definitely found to take place in monoamine oxidase inhibitor therapy (14), and the interruption of memory by ECT is well known. Then, a readaptation can take place under the influence of a new environment, giving the patient a chance to try perhaps one of his other methods tested from childhood. Often these are not much more desirable than was the depression, and occasionally they are worse. Schizophrenia is known to have started and severe somatic symptoms such as bleeding ulcers have occurred after depression was lifted.

Therefore drug therapy or ECT alone should never be substituted for psychotherapy in depression. The relationship with the psychotherapist is of extreme importance and may frequently be the one factor that leads the patient to the adoption of more social ways of dealing with life at this point. It is not true that psychotherapy is

useless with a severely depressed patient. Numerous patients have repeated to me word for word what I had spoken to them during their severely depressed period, once they had gotten over their depression or gone into a more manic state. They take it in and evaluate it, though they do not give any sign of having even heard it.

The task for the therapist is well delineated by the facts brought out in Adler's theory of depression: The therapist must introduce the patient into a meaningful relationship and, broadening this, lead him to develop more social feeling. This will serve to anchor the patient more firmly in society and impart to him a feeling of belonging, and therefore give him more courage. In this way he can come closer to common sense, and reality will become less frightening to him. Only thus will he be able to diminish his feelings of inferiority, and reduce his exaggerated goals.

In the beginning, the therapist must avoid any battle with the patient who is ready for battle, with his back arched. The patient must get the feeling that he has already won, that battle is entirely superfluous. At the same time, the therapist must establish the fact that he is entirely powerless without the patient's help. This usually startles the patient, who is used only to depending on others and to blaming them for not helping him sufficiently. Also, the therapist must make it quite clear to the patient that he does not expect anything from him; that he is free to do or not to do what he wants. This not only makes secret sabotage by the patient impossible, but also makes less pointed his self-accusations of being incapable of doing anything. The therapist must often fortify his approach by taking a definite stand against the relatives who may make demands on the patient.

Like children who cry for something unreasonable, these patients must be treated with the utmost friendliness and distracted from what they are concentrating on, namely, the perpetuation of their depression. These distractions, of course, must be meaningful in that they must serve to re-illuminate the whole of the patient's past, present, and perspective for the future.

With manic-depressives I have found it also extremely valuable during their depression to talk about their manic phase, how they expect to handle it, when it comes, so that it may be less severe. During their manic phase, I focus on the expected depression and prepare them for making it less deep. All the time I explain the unity of both phases as but different means for achieving the same end.

The patient's pessimistic anticipations must be dealt with by con-

vincing him that he produces them for a purpose, what the purpose is, and where optimistic anticipations would lead him, namely, to giving up domination of others, assuming responsibilities and entering into cooperation with others—all ways of life which he never really experienced, because they seemed such a threat to him till now.

Guilt feelings must be dealt with thoroughly and uncovered as a cheap device for putting an undeserved halo upon one's head, by saying: "The spirit is willing, but the flesh is weak." I frequently use the alcoholic and his guilt feelings as an example, pointing out how much more gratifying it must be to the ego to feel like the judge, rather than like the alcoholic. This artificial splitting of oneself into two people, the judge and the offender, is only a device for dissociating oneself from the uncomfortable company of the offender who intends to continue his asocial actions.

In every case the uncovering of the underlying rage against people —especially against certain people in his environment— is of utmost importance, because this denies the patient the possibility to hide behind noble motives and sentiments for his actions. In this connection, the problem of suicide should be dealt with, by uncovering the thought of it and the intention of it, as a definitely insidious and vengeful device, filled with rage. I like to tell my patients that the deviousness of this act has been generally recognized; that people quickly try to forget suicides, shy away from talking about them; and that many religions do not allow suicides even to be buried beside other people. It is important to stress to the patient, that nobody will feel guilty on account of his action. Patients have tested me with the question, how I would feel, if I were to read of their suicide in the newspaper. I answer that it is possible that some reporter hungry for news would pick up such an item from a police blotter. But, the next day, the paper will already be old, and only a dog perhaps may honor their suicide notice by lifting a leg over it in some corner. The prestige value, the beau geste, the attention getting, and the safeguarding of their self-esteem by such an act is dealt a definite blow by such interpretation.

When, through all these phases in treatment, the therapist can show the patient that he esteems the patient despite his negativism, despite his exploitative actions, despite his shabby devices, despite the malevolence he has shown to his relatives *and* to the therapist; when it can be shown that these actions were based on childhood errors that can be corrected in the present, and that there is hope for him to become a social human being; then, and only then, will cooperation with

the therapist begin. This will become a gratifying new experience for the patient, for he will no longer fear, as he had in all other relationships, that he will be humiliated by cooperating.

Undoubtedly the therapist, his social feeling, his devotion to the patient, and his art are most severely taxed by depressed patients. Their styles of life of noncooperation, exploitation and domination, their attempts to arouse the therapist's antagonism, so that they can feel justified in continuing their style of life, make their treatment extremely difficult. But through an understanding of the true nature of depression, together with devotion, hopefulness and empathy, the therapist will often be enabled to overcome all these difficulties successfully.

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