hunger which drives them to try and obtain what has been missing. Whether this is actually true or not, this explanation helps me to understand the kind of patient I have been attempting to describe. He or she is driven to demand from the therapist the total acceptance, protection, care and love which mothers give their new-born infants at the stage when nothing can be expected from the infant in return.

The therapist cannot, of course, fulfil such an unrealistic expectation. Even if he were to abandon all his other work, and take up residence with the patient, be available at any hour of the day, minister to the patient's slightest requirement, he still could not make up for the past nor wholly fill the aching void which the patient carries inside. Such patients have to come to terms with the fact that, although the therapist may have been able to help them to make a new and better kind of relationship with the people they encounter, he cannot wholly replace what has been missing in early childhood. To accept this is exactly like coming to terms with a physical disability. If one has lost a leg, one has to make do with an artificial substitute. If the patient can accept this, the compulsive demands cease, and the patient comes to look at other people in a new and more realistic light. It is, perhaps, a matter of being able to allow oneself to be depressed; to mourn for the ideal mother who never was, rather than continue to hope to find her in someone else.

In my view, hysteria is best regarded in the light of a defence against depression. In trying to avoid pain the patient makes things worse rather than better. It is only when the therapist has an appreciation of what lies behind the hysterical façade that he can help such patients.

Reference

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10

The Depressive Personality

Depression is probably the commonest symptom which brings a patient to see a psychiatrist. It may range in severity from a temporary state of low morale which anyone is likely to experience in the face of commonplace setbacks, to a tormenting condition of melancholic hopelessness which may result in suicide. In the past, psychiatrists were wont to divide depression into 'neurotic' and 'psychotic' varieties. The former was often called 'reactive'; a term which implied that the patient's state was clearly a response, though perhaps an excessive response, to definable events like bereavement, a broken love affair, failure in an examination, loss of a job or a financial reverse. Cases of 'reactive' depression were sometimes treated with drugs or ECT; or might be referred to the psychotherapist, especially if other neurotic symptoms accompanied the depression. Psychotic varieties of depression, on the other hand, were referred to as 'endogenous'; that is, as taking origin from the patient's personality without reference to external events. Such cases of depression were more likely to be accompanied by insomnia, loss of appetite and consequent loss of weight, and other physiological manifestations of disorder. Faced with a patient of this kind, most psychiatrists were, and are, content to prescribe anti-depressant drugs or electrically-induced convulsions without feeling it their duty to investigate the patient's personal psychology or social circumstances in any detail.

Although it remains true that the more profound varieties of

depression are best treated with drugs or ECT, this is because those who are suffering from very severe depression are incapable of that minimum degree of rapport and co-operation without which the psychotherapist is helpless. It is almost certainly not because their disorder is of a different kind from that milder variety which is labelled 'neurotic' or 'reactive'. There does not seem to be any clear division between the two. Instead, depression, like pain, seems to vary along a scale of intensity. The difference between the varieties of depression is not intrinsic, but a matter of degree.

Moreover, research has shown that social factors play a far greater part in determining whether or not a commonplace 'traumatic' event produces clinically definable depression or not. Research carried out by Professor George Brown and his associates has demonstrated that depression seldom comes out of the blue without any precipitant, and women who react to traumatic events with depression are generally contending with a variety of difficulties which render this response more probable. Thus, women who are struggling with an unsatisfactory marriage or with poor housing are more likely to become depressed. So are women who lost their mother before the age of eleven. Other factors which render them more vulnerable are having three or more children under the age of fourteen at home; having no other adult in whom to confide; and having no employment outside the home. Working-class women are four times as likely to become depressed in response to precipitating events as are their middle-class counterparts.[1] Those who have to cope with chronic physical ill-health are also more vulnerable to depression; and in underdeveloped countries, chronic depression is common as the result of malnutrition, disease, and infestation with parasites. In our own culture, certain infections, for example glandular fever and influenza, are notorious for leaving the sufferer depressed, as are the biochemical changes which follow upon the end of pregnancy, or which occur at the menopause. Pre-menstrual tension and depression are sometimes associated.

It is, therefore, extremely important that the psychiatrist takes into account all the circumstances of the patient's life, both past and present, if he is to understand the condition. In addition, he must, I believe, learn to understand the personality

of those who are particularly liable to depression, even if he believes that this liability is primarily caused by genetic factors rather than by adverse circumstances.

People who are particularly liable to become depressed are said to have 'depressive personalities', or to exhibit 'depressive psychopathology'. Patients of this kind make up a considerable part of any psychotherapeutic practice. The picture is complicated by the fact that depressive personalities are not all of one kind. There is reason to believe that the so-called 'bipolar' manic-depressive, who tends to swing in mood from one extreme to the other, has fewer neurotic traits than those people who suffer only from depression. Some of those who are temperamentally inclined toward depression are, except when actually suffering from the condition, robust, aggressive personalities who, most of the time, cope successfully with their underlying tendency by being overactive. Balzac and Winston Churchill were both examples of this type. However, most of the depressives who come the way of the psychotherapist belong to a more passive, dependent group; and it is this variety of person whom I shall discuss in most detail.

In the face of adversity, people with this kind of personality tend to feel both helpless and hopeless. Instead of imagining that, by their own efforts, they can improve their condition, they believe themselves to be at the mercy of events. On the surface, they may display not only misery, but hopeless resignation, affirming that whatever adverse circumstance is making them depressed was not only to be expected, but also, in some way, their own fault. Their resignation is more apparent than real; for, like the rest of mankind, they not only suffer, but also resent what has caused their suffering, However, instead of their resentment being mobilised to make an effective 'aggressive' response, it is repressed and turned inward, showing itself only in self-blame and self-depreciation.

Depressives, therefore, present themselves as far more ineffective and inadequate than in fact they are; and the psychotherapist's task is not only to reinforce the glimmer of hope which has brought the patient to seek help, but also to disinter the active, aggressive aspect of his personality which, being largely repressed, is unavailable to him.

Depressives of this variety often obtain considerable benefit

from psychotherapy. Although modern anti-depressant drugs have brought relief to many of those suffering from severe attacks of depression, there is no doubt that, at the time of writing, these drugs are grossly over-prescribed, and may also have had the effect of deterring some of those who would benefit from psychotherapy from seeking it. Learning to cope more effectively with life and with one's own temperament will not be brought about by drugs; and although temporary alleviation of depression can be effected by their prescription, continued long-term use is seldom justified, and may actually be harmful, since it tends to blunt the patient's sensibilities, and prevent him from coming to terms with reality.

I do not claim, as some analysts tend to, that the tendency to become depressed in response to adversity can, in all cases, be entirely abolished; but rather to affirm that particular episodes of depression can be alleviated, and that the patient can be helped to deal better with depression should it recur.

In my view, the most striking characteristic of depressives is a negative one; an absence of built-in self-esteem. When a person is actually suffering from depression, it is usual for him to feel, and to refer to himself as, worthless, no good, hopeless, not worth bothering with, a failure and so on. Such expressions are of course determined by internal, rather than external factors. Although the patient's depression may have been initiated by one of the events already referred to above (bereavement, a broken love affair etc.), his feelings of hopelessness and his self-castigation seem to the observer to be out of proportion to the event which sparked them off. The respiratory tract of an asthmatic is unduly sensitive to certain allergens which cause a degree of bronchial spasm and outpouring of mucus comparable to that induced in a normal person by poison gas. The psyche of the depressive is unduly sensitive to events which lower self-esteem, reacting profoundly to reverses which, to the normal person, seem trivial. Thus, a quarrel with someone emotionally important which, to the ordinary person, seems no more than a passing episode, seems to the depressive to be the end of the world. Failure in an examination which, to most schoolchildren or undergraduates, would involve no more than a transient annoyance at having to repeat some work may, in the depressive, spark off a reaction involving feelings of total

worthlessness. Depressives often take the view that, in their periods of depression, they have greater insight into the true nature of things than when they are cheerful. They sometimes opine that periods of freedom from depression are no more than mirages which obscure reality. Most psychiatrists take the opposite view, believing that the patient's depressed mood distorts his vision. However, there is a sense in which the patient is right. As we shall see, a great part of the depressive person's life is determined by his efforts to avoid depression; to establish defences against this dread condition by overactivity, gaining esteem from external sources, or any other manoeuvre which will prevent descent into the abyss. It seems that the state of depression is a constant which underlies all the fronts which he may present to the world in rather the same way that a house may be in a sad state of decay though presenting a brightly-painted exterior. Although the depressive's protestations of his own worthlessness may seem exaggerated, he is right when he affirms that his state of depression is more real, more truly reflective of his essential self, than his state of mind at other times: it is so for him, however it may seem to anyone else.

From what source is self-esteem derived, and why is it that the depressive has so little of it? No-one knows the complete answer to either of these questions, but it is possible to give a partial explanation which is an approximation to the truth in many instances.

The human infant is born into the world in a peculiarly helpless and dependent state, and remains at least partially helpless and dependent for a period which, in comparison with his total life-span, is longer than that of any other animal. It is reasonable to assume that the human infant has, at first, but little notion of his own capabilities or lack of them. As he matures, however, he becomes increasingly aware of his dependency and helplessness relative to adults. If he is brought up in a home in which he is welcomed, played with, cuddled, and generally 'made much of', the likelihood is that he will come to feel himself sufficiently a worthwhile person to counteract his realisation of his own inevitable inadequacy compared with adults. One could equally well say, in the jargon of psychologists, that repeated positive reinforcement has conditioned him to favourable self-appraisal; or in Kleinian ter-

minology, that he has introjected his parents as 'good objects'. Loved children are generally praised for every new accomplishment; for every word learned, for the beginnings of manual skills, for all kinds of achievements which, only a year or two later, will be taken for granted. And the more that parents are irrationally adoring, the more is a child likely to grow up thinking well of himself, even if his actual achievements are extremely modest. In the sentence above, I put the words 'made much of' into inverted commas deliberately to draw attention to the fact that loving parents habitually, and rightly, overvalue everything that their infants do. Because his parents value him so highly, the child comes to have a good opinion of himself. Whereas his self-esteem originally depended upon repeated affirmations of his worth from outside sources, it eventually comes to depend upon something within himself which has become 'built-in' as part of his own personality. The process is similar to that of the formulation of conscience, in which prohibitions originally promulgated by parents become the person's own conscience or super-ego.

Contact with the mother may be interrupted by her illness or death. Research into the development of subhuman primates has confirmed the hypothesis that some forms of depression may be related to severance of the mother-child tie in infancy. Monkey infants brought up in isolation for six months are fearful and insecure when introduced to their peers; are unable to play; and, later, are unable to mate. Infant monkeys which are separated from their mothers for short periods even when they have already become somewhat independent not only become depressed at the time, but show after-effects which persist for years, for example, less social play and greater fear of strange objects. Suppose, however, that something in the parent-child relation goes wrong. Parents may not proffer enough irrational adoration; or may tend to keep the child over-dependent, thus depriving him of any sense of his own achievement. A child may be born with a physical disability, or may suffer so much ill-health that he continues to feel inadequate compared with his peers. Or the parents may set such high standards that the child comes to feel that he will inevitably fail to live up to them. Depressives do not feel disregarded, as do the hysterics we discussed in the previous chapter, but

rather that they have been scrupulously regarded, weighed in the balance, and found wanting.

The absence of an inner sense of worth has a number of consequences. First, such a person has a proclivity to be more than usually dependent upon the good opinion of his fellows. It is impossible for the depressive to be indifferent to what others think of him, since repeated assurance of their good opinion is as necessary to his psychic health as are repeated feeds of milk to the physical well-being of infants. Whether or not one subscribes to Freudian theory in regarding depressive personalities as being fixated at the 'oral' stage (and there is some evidence to support such an assertion; see Fisher and Greenberg[2]), there is no doubt that such personalities are 'hungry' for approval, and need recurrent proofs of their acceptability in the shape of repeated reassurance from others, recurrent successes, or other bolstering devices to prevent them relapsing into the underlying sense of despair against which they have to protect themselves. Being so dependent upon the good opinion of others and so vulnerable to criticism often has the consequence that the depressive is less than normally assertive with other people, and overanxious to please them. Whereas the hysteric, who is also overanxious to please, tends to do so in ways which are designed to elicit attention, and which are sometimes exaggerated or irritating, the depressive tends to be less obtrusively demanding. Some depressives become expert at identifying themselves with others, and are exceedingly sensitive to what the other person is feeling. Because they are so anxious to avoid blame, and to obtain approval, they develop antennae which tell them what might upset, and what might please, those with whom they are associated. This kind of sensitivity is not unlike that demanded of their secretaries by overburdened executives, who expect that they shall know, without being told, exactly in what mood the boss may be, and treat him accordingly.

This kind of adaptation to others carries with it obvious disadvantages. If a person is frightened of asserting his own opinion for fear of offending, it is not likely that he will be an effective executive or leader. The habit of deferring goes hand-in-hand with a kind of passivity which, though it may earn commendation for 'niceness', does not command respect. It can be looked upon as a prolongation of one aspect of childhood.

Children defer to their parents because they need to in order to keep their parents' approval; and also because, for many years during which they are growing up, the parents do in fact 'know better' because of their longer experience. Depressives often defer to persons who, in reality, are their inferiors; and this habitual mode of behaviour has the effect of reinforcing their sense of their own worthlessness.

Moreover, habitually to be so orientated to what the other person is feeling often has the effect of making the depressive uncertain of his own feelings; of dissociating him from his own 'inner self'. Since he is always guided by the opinions of others, he ends up by having no identifiable opinions of his own. Since he is always adapting to the emotional state of others, he becomes progressively less conscious of what he himself is feeling.

Because of their habitual suppression or repression of the independent, executive aspect of their personalities, depressives feel themselves to be, and sometimes are, more helpless than the average person, and turn to others to tell them what to do in any situation in life requiring decision. An underlying conviction that whatever choice they themselves make is likely to be wrong, and a desire to avoid blame if things in fact turn out badly, supports this tendency; with the consequence that depressives not only feel themselves helpless, but often are so in reality.

Recent work has emphasised the role of helplessness in depression. Experiment has shown that dogs, faced with unpredictable, repeated traumas in the shape of electric shocks which they cannot avoid, give up trying to escape or do anything, and simply lie down and whine.[3] Helplessness and hopelessness march hand in hand. Depressives feel themselves to be powerless to affect the course of events, and therefore 'give up' and adopt a passive role. In the histories of depressive patients, it sometimes emerges that the individual did far less well at school or university than his intellectual gifts would warrant. This is generally because, at some point in his development, he became convinced that his own efforts would be useless. Gifted persons of depressive temperament often do well when all that is required is an effortlessly clever response to material which is fed to them. They do less well when effort is required to master

a subject; since they have no confidence that anything which they have to do themselves by effort is likely to be successful.

Later in life, when experience has taught them that some measure of success does in fact follow from their own efforts, they may substitute ceaseless striving for passivity. This is why achievement of a goal is often succeeded by depression. The writer who completes a book, the business man who brings off a deal, the person who is given promotion, may all find that depression rather than euphoria follows their success. This is because the aftermath of success is 'relaxation' and inactivity; to the normal person, a chance to 'recharge batteries'; to the depressive, a relapse into the conviction of his own ineffectiveness. If one has been striving very hard to achieve a particular end, completion of the task actually involves a loss; a loss of the endeavour to which so much energy has been devoted, and which, during the effort, may have contributed to self-esteem by making the individual feel effective or important. Normal people feel the need of a holiday on completion of a demanding task; depressives often find that holidays precipitate depression.

We have seen that, in their personal relationships, depressives tend to suppress their own opinions, defer to the other person, and identify with the other in order to fit in with his attitudes. This lack of assertiveness involves considerable repression of what may be called the aggressive side of the depressive's personality.

As I have pointed out elsewhere (*Human Aggression*[4] and *Human Destructiveness*[5]) it is impossible entirely to separate the violent, destructive, hostile aspect of aggression from the constructive, effective, assertive aspect, without which no decisions would be taken, no leadership proffered, no action to alter events embarked upon. Without a certain assertion of his own personality, a person ceases to exist as definably distinct. In fact, when we loosely affirm that a man or woman has 'a lot of personality', what we usually mean is that he or she is notably assertive. In his relationships with others, the depressive personality generally feels defeated. What he is usually quite unaware of is that there is another side to his masochistic submission of self; a violent, hostile and destructive side of which he is usually so frightened that he has erected formidable defences to make sure that it does not emerge. No human being

can experience repeated defeats at the hands of others without resenting them. What the depressive has done, albeit automatically and without conscious intent, is to throw the baby out with the bath-water. By repressing his destructive hostility, he has at the same time deprived himself of those positive features of aggression which would allow him to assert himself when necessary, stand up to other people, initiate effective action, 'attack' difficult problems, and make his mark upon the world. I said that helplessness and hopelessness march hand in hand: let us add hostility to make a triad of 'h's.

This is not a feature of the depressive's personality which impresses itself upon the uninformed observer. To him, many depressive people appear as particularly 'nice', largely because, as we have seen, they are expert at reinforcing the personality of the other at the expense of their own. After an encounter with such a person, the other party may feel that he does not know much about the depressive person, or that he is something of an enigma or a pleasant nonentity. But most people are so pleased to have their own opinions listened to, their own views acceded respect, and their own wishes anticipated, that their feeling of warmth toward the depressive outweighs any doubts they may have about what he may 'really' be like. This is, of course, exactly what the depressive is, unconsciously, aiming at. Having abandoned hope of being effective or being thought to be so, he has fallen back on being thought 'nice' as the only way in which he can maintain his self-esteem. This niceness masks considerable hostility.

I once worked in a house in Harley Street in which the door was opened, and appointments made, by a butler of an old-fashioned variety seldom encountered today. As befitted his office, he was extremely polite, attentive, and, on occasion, even embarrassingly subservient. Patients often commented upon how 'nice' he was. However, I was aware of a very different side of his personality. My room was above his living quarters; and, after he had gone off duty, the sounds of his angry quarrels with his wife came through the floorboards. No doubt he was taking out on her the feelings of resentment toward the people to whom during his working day, he was compelled to be subservient. His 'niceness' masked considerable vindictiveness.

I have written at some length about the passive, dependent type of depressive personality because this is the type which the psychotherapist is most likely to encounter. If the view of the depressive's psychopathology which I have outlined is accepted, it is possible to outline what the therapist is aiming at with such a person, and also to suggest how positive results may be achieved. First, the fact that the therapist is willing to continue to see a depressive patient over a period of time reinforces hope and counteracts despair. Second, the therapist's acceptance and understanding of the patient tends to counteract the latter's negative view of himself, and may, if the period of therapy continues for long enough, become 'built-in' in the way described in the chapter on transference. The patient, because he comes to feel that there is at least one person in the world who genuinely appreciates him, may alter his attitude towards others, assuming, for example, that they are more likely to be friendly than critical. Third, the therapist may be able to counteract the depressive's negative view of his own accomplishments and effectiveness by drawing attention to the many occasions on which he has behaved intelligently and competently. Fourth, the therapist will try to uncover and mobilise the aggressive side of the patient's personality in order that he may be able to 'attack' life more successfully.

The psychotherapist who undertakes the treatment of persons with an underlying depressive psychopathology may find it helpful to bear in mind the following considerations. First, nearly all episodes of depression resolve themselves 'spontaneously'. I put the word 'spontaneously' into inverted commas, because close examination of such recoveries usually discloses psychological factors of a more or less subtle kind which have prompted recovery, just as close examination discloses precipitants of the attack. These factors seem to be of three kinds. First, the patient, especially if he is managing to remain at work, may find that his self-esteem is partially restored by discovering that he can be effective at it. Most jobs require repeated actions of some kind which do not demand weighty decisions or new initiatives; and the fact that a depressed person finds to his surprise that he can continue to function effectively at this level may convince him that he is not entirely useless. This is why I seldom reinforce a depressed person's desire to

'give up' and retire to bed or to hospital unless he is exhibiting clear-cut psychotic symptoms, is dangerously suicidal, or is so depressed that he cannot co-operate.

Second, a depressed person may recover because he has been able to re-establish a loving relationship with a person who is emotionally important to him. Vulnerable depressives, as I have already mentioned, may be thrown into a state of profound despair by the kind of transient quarrel which we all may have with people who love us and whom we love. The depressive has no certitude that he is worthy of love or that love will last. Its temporary disappearance is, to him, a confirmation of his pessimistic convictions. However, if a tactful spouse or other loved person manages to convince him that he is still loved, or if, more importantly, he manages to admit that he too was angry, his depression will often lift. Recovery of this kind is likely to be short-lived, and to be misinterpreted by the psychotherapist, who may flatter himself that it is the consequence of his ministrations when, in truth, it may have very little to do with them. It also may mean that the patient breaks off treatment prematurely, before the therapist has had time to do as much as he could for him. For reasons already discussed, I do not urge therapy upon those who do not want it, but I do sometimes point out that whilst recovery from depression is usual, what we want to achieve is that relapses shall be less frequent or less severe; and that learning how to deal with such episodes more effectively takes time and patience.

In the psychotherapy of depressives, it is important not to be misled by the patient's account of his own lack of effectiveness. Many such patients omit any account of the occasions when they are, or have been effective; and it is valuable to be able to elicit these and to draw attention to them. It is equally important to be able to detect when the patient has given up prematurely because he has an inner conviction that his own efforts are unlikely to bring any reward. Some depressives have a quite unrealistic picture of successful people, believing that they have acquired skills or achieved eminence without needing to apply themselves. This picture is the consequence of the depressive's childhood conviction that he can never 'measure up' to parents or other adults. I once knew a depressive who made a habit of saying of himself, 'Of course, I'm so dim'. Intellectually, he was

far from dim, and in fact performed competently at a fairly high-level job; but his reiteration of his 'dimness' provided him with an excuse for less achievement than might reasonably have been expected of a man of his gifts. After all, he had always told us of it. Because of his dependency, passivity, and anxiety to please, the type of depressive patient who is generally referred for psychotherapy will quickly form a positive transference. Or rather, he will rapidly *appear* to do so, for such patients seem to be more compliant and grateful than actually they are. Psychotherapists are easily deceived into thinking that such a patient has accepted an interpretation when, in fact, he may disagree or have reservations which he does not yet dare to express. It is particularly important for the therapist to be alert to this possibility, and to interpret excessive politeness, deference and over-eager compliance with the therapist's remarks. One lesson which it is vital that the patient should learn is that it is possible to be quite different from other persons and yet retain friendly relations with them. As I said earlier, a certain amount of aggression is required to maintain differentiation of oneself as a separate entity.

The most difficult task which the therapist has with such a patient is to make him aware of his hostility. And yet it is by means of the disinterment and expression of this that recovery comes. Since the depressive adaptation almost certainly began in childhood, it will be particularly difficult to uncover and to help the patient to accept hostile emotions to his parents, whom he is likely to have idealised. A child who is a poor mixer and who cannot stand up for himself is prone to idealisation since he may feel that his parents are the only persons in the world who care for him, and that his very existence depends upon maintaining an image of them as 'perfect'. The persistence of such a belief in adult life impairs the patient's capacity to achieve independence and make new relationships.

One opportunity for disinterring hostility is when the therapist goes on holiday, or unavoidably has to cancel an appointment. The more dependent the patient is, the more will he resent being abandoned. His depression is likely to increase whilst the therapist is absent, and he will probably complain of this whilst carefully refraining from criticising the therapist in any way for leaving him. But his complaints are likely to be

phrased in such a way that criticism of the therapist is implicit, for instance by employing a querulous tone of voice. Or else the patient may fall silent, saying that he has nothing to say, or that therapy is useless. This is a form of 'sulking', and if the patient can be brought to see this, he will be one step on the way to discovering that hostility can be expressed without his relationship with the therapist being terminated.

One patient who had developed techniques of deference, compliance, and an extraordinary capacity for identifying with the other person, had done so early in childhood to avoid upsetting her father, who was a difficult and bad-tempered man whose wrath, she felt, had at all costs to be avoided. Everyone who knew her liked her; and she acted as confidant and sympathiser to nearly all her friends. The consequence was that she became depressed, because she felt that her friends were imposing upon her, swamping her, and depriving her of any chance of asserting her own personality. Her way of dealing with this was to retreat from personal involvement altogether, give up her regular job, at which she was very good, and try to express herself through writing. But writing is a lonely occupation, and her dependent needs soon forced her to enter into relationships again with the consequence that she again began to feel annihilated and depressed. Her depression was really due to her feelings of resentment against those who imposed upon her and exploited her; and her problem was to recognise and express this resentment, whilst at the same time coming to understand how she herself invited exploitation.

It might be said that such a patient was not primarily depressive, but schizoid, in that she presented the typical schizoid dilemma in which closeness to others presents danger, whilst avoidance involves isolation. However, as we shall see, schizoid people lack the capacity for identification with others possessed by depressives; and, although this patient tried to isolate herself for part of the day, she was never so lonely nor so afraid of other people as are most of those whom we label schizoid.

Her attempts to become a writer draw attention to the fact that creative people sometimes have depressive psychopathology, as I have attempted to show in my book *The Dynamics of Creation*[6]. Writing and other creative pursuits may help the depressive in two ways. First, he may gain an increased sense of

his own competence in being able to produce anything at all. Second, if what he produces is published or displayed, and becomes accepted by others, he will receive a boost to his self-esteem which may be repeated each time he produces something new, although, as I pointed out earlier, depression is sometimes an immediate aftermath of completing a piece of work. Depressive personalities are, as one might expect, particularly vulnerable to criticism. All creative people identify themselves to some extent with what they produce, for every piece of work, even if it consists of mathematics or observations requiring maximum scientific detachment, contains part of themselves. Imaginative writers are, as one might expect even more identified with their work than are scientists, and therefore even more sensitive about it. One of the commonest causes of 'creative block', that is, inability to conclude original work which has been embarked upon, is fear of hostile criticism when it is finally exposed. Virginia Woolf is one example of a successful writer who remained intensely vulnerable to criticism throughout her life. She had a number of attacks of depression of psychotic intensity, and finally, realising that another attack was imminent, committed suicide.

The risk that a depressed patient may commit suicide is something which may haunt the psychotherapist, particularly if he is inexperienced. Patients of mine have done so, and I have felt guilty and depressed myself on this account. As after any bereavement, one searches one's mind for occasions where one may have said the wrong thing or failed the dead person in any way. However, I cannot recall any patient of mine taking his or her life whilst actually in regular treatment; and, from discussions with colleagues, I believe this to be rare. That is, when regular psychotherapeutic sessions have been established, and there has been time for some positive rapport to have been achieved, it is uncommon for a patient, however depressed at the end of one particular session, to feel so hopeless that the possibility of relief at the next session is entirely abandoned. The position is different if, as I recall in one example, the patient had had to discontinue treatment because of moving elsewhere; or in cases where the therapist has seen the patient only once or twice and therefore has not had time to establish a relationship. If psychotherapy is to achieve one of its main

objects, that is, that the patient shall become more independent and autonomous, the risk of suicide has sometimes to be taken. At an initial consultation, if the therapist feels that suicide is an imminent possibility, he may decide that he cannot take on the case, and take steps to ensure that the patient is admitted to hospital, or treated by some other means than psychotherapy. But if the patient is coming regularly, and a psychotherapeutic relationship has been established, it is inappropriate and harmful to the patient if the therapist suddenly changes from a person who is encouraging independence and freedom of choice into a doctor with special powers to confine people in mental hospitals, against their will. It is also inadvisable for psychotherapists to prescribe anti-depressant drugs or give electro-convulsive therapy themselves since to do so means adopting a quite different role vis-à-vis the patient, and, if the patient seeks psychotherapy at a later date, when his acute disturbance has subsided, may complicate his relationship with the therapist. If a patient is deeply bent upon suicide, confining him will not necessarily prevent him from doing so. Patients who threaten suicide must be taken seriously. The idea that those who talk about suicide do not commit the act has been proven false. But it is legitimate to try and discover what lies behind the threat in the case of patients in psychotherapy. Some may be blackmailing the therapist into giving them more time, or trying to convince him that their troubles must be taken more seriously. Most such patients belong more to the category of the hysterical personalities discussed in the last chapter than to the group of seriously depressed patients. Some are seeking revenge upon those they feel have not loved them; and it is important to seek out and make conscious the hostile motive in suicide, which is almost always present. Others may be seeking oblivion, which often seems to represent a final wish for complete merging with an idealised mother of the kind portrayed by Swinburne in 'The Garden of Proserpine', where 'Even the weariest river, winds somewhere safe to sea'. It is often appropriate gently to point out that, if the patient really wants to take his own life, no-one can stop him: but that one may wonder why, if he is so determined to make an end of himself, he is bothering to tell the therapist about it or seek treatment for his condition at all. This must be done extremely tactfully, for there is a risk that the

patient will take such an enquiry as a proof that the therapist does not appreciate the seriousness of his condition, and that only a suicidal attempt will bring it home to him. When I was in training, a patient of whom I had been partially in charge took an overdose after telephoning the consultant in charge of her case to ask for an urgent appointment or make some such demand, which was refused with, I believe some lack of tact, since the consultant was a notably difficult and aggressive woman herself. The patient responded by taking the seven three-grain capsules of sodium amytal with which she had been furnished on leaving the ward in the hospital to become an outpatient. This was clearly a gesture rather than a seriously intended attempt at suicide; but she developed pneumonia and died, nevertheless.

Such cases, fortunately, are rare; and I reiterate that suicide seldom occurs during the course of psychotherapy, provided there has been time for rapport to be established. An inexperienced psychotherapist may feel the need to urge the patient to see a more senior colleague in cases in which he is seriously worried about the possibility of suicide. In this instance, he will be wise to explain to the patient exactly why he advises this course, and leave it to him to follow it or not as he wishes. In most instances, the patient will not want to see somebody else, and will refuse to do so. Since this is an assertion of his independence, his refusal must be accepted. The therapist will discover that, at the next session, much useful material will probably emerge which will be concerned with how genuine is the patient's wish to die, and with how competent or not he believes the therapist to be. A number of people with an underlying depressive psychopathology manage to avoid becoming clinically depressed by over-work or by finding legitimate enemies upon whom to vent their aggression. When such manoeuvres are overdone to the extent to which they become obvious to the layman, it is common for psychiatrists to refer to the patient as employing a 'manic defence'. An example of such a person is Winston Churchill.[7] Churchill became depressed when he was immobilised, as during his brief imprisonment by the Boers; or when confronted by certain failures, as in the case of the campaign which he initiated in the Dardanelles during the 1914–18 War. His background gave ample reason why he should be

vulnerable to what he called his 'Black Dog'. But, during most of his life he was adept at staving off depression. Whilst he was awake he was seldom idle, and when he stopped working he went to bed (albeit at 3 a.m.) rather than 'relaxing'. He had, for much of his life, the sustaining influence of holding great office. When he was out of office, he turned to painting, a creative activity which he himself describes in notably aggressive terms. He was at his best during the 1939–45 War in which Hitler was so legitimate an enemy that few people doubted the necessity of defeating him. Churchill admirably dealt with his underlying psychopathology until old age and arteriosclerosis undermined his will and he relapsed into what appears to have been a kind of depressive stupor during his closing years. No-one could be less like the passive, dependent type of depressive; nor more improbably a psychiatric patient than Churchill. But the psychotherapist will have referred to him a number of people, including politicians, whose defences against depression are of similar type, and who are far from being dependent or passive.

John Stuart Mill provides a good example of a man who suffered a severe attack of depression in adult life whose upbringing clearly predisposed him to this happening. As many people will remember, John Stuart Mill was remarkable in his intellectual precocity. His father, James Mill, himself undertook his education, with the consequence that Mill started to learn Greek at three years old, and, by the time he was eight, he had read the whole of Herodotus, Xenophon's *Cyropaedia*, the first six dialogues of Plato, and much else besides. He records that it was 'totally impossible' that he should have understood the Theaetetus of Plato. 'But my father, in all his teaching, demanded of me not only the utmost that I could do, but much that I could by no possibility have done.' Although Mill, by his own reckoning, started with an advantage of a quarter of a century over his contemporaries because of his father's rigorous educational methods, he was so kept from mixing with them that he had no idea, until he was over fourteen, that his achievements were in any way remarkable. Measuring himself against his father, he had always found himself to be wanting. Moreover, since he had been so carefully segregated and had not participated in games or in the ordinary pursuits of boys, his physical skills were minimal, and he remained 'inexpert in

anything requiring manual dexterity'. Far ahead in intellectual matters, 'The deficiences in my education were principally in the things which boys learn from being turned out to shift for themselves, and from being brought together in large numbers'. Moreover, Mill's father was a man of exceptional energy and decision, and, as Mill observed: 'The children of energetic parents frequently grow up unenergetic, because they lean on their parents, and the parents are energetic for them'.

This is not the place to describe the depression which so deeply afflicted Mill when he was twenty years old, though every psychiatrist ought to read his own account of it. It must suffice to mention that the first ray of light broke in upon his gloom when he was reading some memoirs in which the author relates his father's death, 'the distressed position of the family, and the sudden inspiration by which he, then a mere boy, felt and made them feel that he would be everything to them – would supply the place of all that they had lost'. Mill records that he wept at this affecting account; and clearly believes that it was because the book made him able to feel emotion again that he started to improve in spirits. Another interpretation would be that this passage made him aware that sons can sometimes aspire to replace, or even surpass, their fathers; and it was this realisation which made him feel less inadequate.[8]

However this may be, Mill's upbringing clearly demonstrates that a child may receive the most devoted attention from his parents but fail to acquire a proper sense of his own value. And both Churchill's life and Mill's demonstrate that great achievements, of entirely different varieties, may in part come about because an individual who, in early life, believed himself to be inadequate, is driven to make especial efforts to prove the contrary.

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