Psychodynamic theories of depression: A review of three different models

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1. INTRODUCTION

Perhaps there is as much disagreement on the aetiological issue of depression as on the question of its nosological status. This may be partly because aetiological inferences were made on the basis of inadequate or arbitraty nosological classifications and vice versa. Another reason that may explain this long dispute is the imprecise definition or meaning of the term depression. Indeed, the term depression denotes different things to clinicians and researchers of different theoretical persuasions. For those in the psychoanalytic tradition, depression refers more to an affect than to a clinical condition; for those with an organic orientation, depression is more than an affect – it refers to a clinical syndrome involving a wide spectrum of symptoms including affective, cognitive, behavioral, and somatic symptoms. Besides the semantic confusion which surrounds this area of affective disorders, there is a lack of consensus on the research strategies that might be adopted in the study of depressive disorders. There are, as Akiskal and McKinney (1975) rightly point out, those who:

> *"favour 'understanding' depression over objective description of observable signs and symptoms",* (p. 286),

and there are those who over-emphasize clinical descriptions at the expense of theoretical understanding. These differences in both theoretical orientation and empirical consideration gave rise to divergent views about the aetiology or causation of depressive illness. Those who adhere to a psychogenic view of depression, emphasize the aetiological significance of psychological factors; those who subscribe to a biological view, in contrast, trace the depressive symptomatology and manifestations to organic or biological events. Although recently reconciled and integrated into a comprehensive psychobiological model (Akiskal, 1980; Akiskal and McKinney, 1975), these two contrasting conceptions of the origin and aetiology of depression still dominate the literature of affective disorders.

A substantial number of psychological hypotheses and theories have been advanced to account for both subjective and clinical manifestations of the depressive

illness. As might be expected, theories rooted in the psychoanalytic tradition explain the psychopathology of depression in terms of personality or psychodynamic factors and development events. Although mainly formulated in id psychology terms (libidinal stages), these theories still exert a considerable influence on contemporary thinking about the phenomenon of depression.

More recent cognitive and behavioral formulations of depression appear to enjoy more popularity in both clinical and academic communities. Unlike traditional psychoanalytical theories, the more recent ones are less speculative and more importantly lend themselves easily to experimental and empirical verification or evaluation. But despite this relative superiority, both cognitive and behavioural theories suffer from serious conceptual inadequacies.

Because of similarities in emphasis and conceptualisation, only the main psychoanalytic theories will be reviewed and evaluated.
To do them more justice they will be reviewed in the 'historical' context in which they have evolved.

2. MAIN AETIOLOGICAL FORMULATIONS

Depsite its substantial achievements in the nosological domain of mental disorders, clinical psychiatry remained a 'pseudoscience', at least until the birth of psychoanalysis. The emergence of this now different discipline gave psychiatry a new breath. The originality of psychoanalytical theory lies, as Bomporad (1980) pointed out, in:

> *"its insistence that mental illness was not simply the outward manifestation of cerebral pathology, but that its symptoms were psychological in origin and had meaning."* (p. 15).

Until the birth of psychoanalysis, providing an adequate nosological classification of psychiatric disorders appeared to be the main RAISON D'ÊTRE of most, if not all, psychiatric investigators. Freud, in contrast, devised an analytic technique the aim of which was not only to describe or classify symptoms and syndromes but also, and more importantly, to uncover their causes and meanings. For Freud and his followers, symptoms are more than manifestations of an underlying pathology, they are symbolic representations of latent unconscious conflicts.

The important claim by Freud that mental disturbances could be understood in terms of unconscious mental processes led to criticism and eventually to the rejection of the widely adopted descriptive psychopathology. Accordingly, Freud's extensive theoretical formulations of anxiety, hysteria, ego defences and unconscious shifted away attention from nosological pre-occupations to more important questions regarding the aetiology and the nature of psychiatric disorders. The subsequent psychoanalytical investigations of unconscious processes and motives resulted in aetiological formulations that facilitated both the understanding and management of psychiatric disorders.

Although depression was not at the top of the list of psychological disorders investigated psychoanalysts, it has nevertheless received considerable attention in the psychoanalytic literature. Early psychoanalytic writers such as Abraham, regarded depression as an affect resulting mainly from excessive repression of libido.

Just like in other disorders (e.g. neurosis) the emphasis was put on libidinal stages. Unlike the traditional libidinal orientation which, as already pointed out, attached great importance to libidinal strivings, the ego psychology orientation emphasised the ego's awareness of its sense of helplessness and its perceived inability to fulfil its narcissic aspirations. Psychoanalysts with ego psychology orientation conceptualise depression as an ego state characterised by its feelings of powerlessness, helplessness, and low self-esteem.

Despite the apparent theoretical attractions of both traditional and more recent or contemporary psychoanalytical formulations of depression, clinicians remained sceptical as to the possibility of these theories fitting the complicated clinical picture of the depressive condition, and explaining or accounting for the wide spectrum of depressive symptomatology.

2.1. THE HOSTILITY TURNED-INWARD MODEL

An initial attempt at providing a psychoanalytic formulation of the aetiology of depression was made, not by Freud as some believe, but by Abraham in 1911. In this first psychoanalytic paper on depression, Abraham used two key concepts, borrowed from Freud, to explain the nature and the origin of this affective disorder: the concept of libido and that of repression. In accordance with Freud's theoretical formulations of psychosexual development, Abraham conceptualised depression as a chronic fixation of the libido at an archaic or early developmental stage. More specifically, Abraham regarded depression as an affect resulting mainly from an excessive repression of libidinal desires and instincts. The depressive person is seen in this model as excessively dependent on others and the environment for love, happiness and security.

Although theoretically sound, Abraham's view on depression was not shared by his colleagues. In fact, he was openly criticised by Freud for putting too much emphasis on libidinal stages. Following the publication of Freud's influential paper, 'Mourning and Melancholia' in 1917, Abraham revised and expanded his theoretical propositions vis a vis depression.

Abraham's subsequent work reflected the strong and profound influence that Freud's formulations on melancholia had exerted on him. Accordingly, depression was no more conceived as a state of retarded or blocked libido, but as an affective state due to the introjection of hostility originally destined to the ambivalently loved object. This is how Abraham described the process leading to the redirection of hostility and anger against the ego:

> *"When melancholic persons suffer an unbearable disappointment from their love-object they tend to expel that object as though it were feces and to destroy it. They thereupon accomplish the act of introjecting and devouring it – an act which is a specifically melancholic form of narcissitic identification. Their sadistic thirst for vengeance now finds its satisfaction in tormenting the ego"* (Abraham, 1924).

Amongst Abraham's other contributions to the theoretical understanding of depression, were his important propositions concerning the predisposing factors the onset of depression. Abraham viewed oral dependency, a sort of thirst for love, as the characteristic feature of the depressive personality. he postulated that 'primal

parathymia', traumatic experiences in childhood, plays an aetiological in the pathogenesis of depression. He maintained that the reactivation of childhood losses later in life is the critical factor in the development of depressive illness:

In the last resort melancholic depression is derived from disagreeable experiences in the childhood of the patient". (Abraham, 1924).

The depressogenic effects of object loss have also been recognized by Freud. He insisted that the loss need not have happened in childhood, and the lost object need not have died for depression to develop and emerge:

"In melancholia the occasions which give rise to the illness extended for the most part beyond the clear case of loss by death, and include all those situations of being slighted, neglected and disappointed which can impart opposed feelings of love and hate into the relationship or reinforce an already existing ambivalence". (Freud, 1917).

The importance of object loss both as a predisposing and precipitating factor to the development of depression has been stressed in Freud's 'Mourning and Melancholia' his major piece of work on the origin and the nature of depressive disorders. In this classic paper, Freud drew a sharp parallel between the state of mourning and the clinical condition of melancholia. He found similarities not only in antecedent conditions but also in affective or emotional manifestations. A common feature to both mourning and melancholia is that they both develop and emerge as a reaction to a sudden loss of a loved object. More common to both states, are the sorrow and the sadness triggered by loss, the pathological self-reproaches and criticism, the loss of energy, and the lack of interactions and interest in outside world. However, the critical difference, according to Freud, is that in mourning the loss is external, whereas in melancholia the loss is internal (unconscious):

"In grief the world becomes poor and empty; in melancholia it is the ego itself".

Freud identified further differences in the way the loss is handled in both melancholia and mourning. He insisted that in the latter state, the anger arising from feelings of resentment and desertion is directed toward the lost object (the object actually being a person); in melancholia, however, the anger is directed internally since the lost object is introjected (hence the pathological self-criticisms).

Freud regarded melancholia as a state of pathological mourning. He argued that the libido is the major factor which determines the course that the experience of mourning will take – whether it will be 'healthy' or pathological mourning (melancholia). Freud observed that in normal mourning the free libido (that is the libido previously invested in the lost loved object) is actively re-invested in another subject; in melancholia, however, the free libido is not re-invested in any external object, but introjected or withdrawn into the ego. Freud considered the identification with and the introjection of the lost object as critical to the development and manifestation of depressive disorders. This is how he described the process that eventually provokes depressive illness:

An attachment of the lilbido to a particular person, had at one time existed; then owing to a real slight or disappointment coming from this loved person, the object relationship was shattered... the free libido was not displaced on to another object; it was not employed in any unspecified way, but served to establish an identification of the ego with the abandoned object. Thus, the shadow of

the object fell upon the ego, and the latter could henceforth be judged by a special agency, as though it were an object, a forsaken object. In this way an object loss is transformed into an ego loss nd the conflict between the ego and the critical activity of the ego and the ego as altered by identification". (Freud, 1917).

For Freud, the introjection of the disappointing object and the hostility associated with it breeds depression. Because the hatred and the criticism destined to the love object are now, by means of both mechanisms of identification and projection, directed against the self. This discharge of anger against the self engenders feelings of dysphoria, inadequacy, guilt, sadness, and eventually depression. For Freud, the introjection or retroflexion of anger is the SINE QUA NON of depression.

The hostility-turned-inward model, initiated by Abraham then expanded and refined by Freud, is regarded as the major psychoanalytical contribution to the theoretical understanding of the phenomenon of depression. Although this model enjoys respectability and popularity in some quarters, it has been criticised both on theoretical and empirical grounds. Critics pointed out that Freud failed to say how depression differs from other affects that also result from the introjection of hostility. Perhaps the major weakness of this model lies in its failure to account for all aspects (subjective as well as clinical) of depression. In fact, some argue that Freud's model has little or no relevant relationship to the clinical picture of depression (e.g. Akiskal & McKinney, 1975).

Attempts at externalising or re-directing hostility toward external objects, have not produced any significant improvement or change in the level of depression (e.g., Klerman and Gershon, 1970; Wadsworth and Baker, 1975). A final point that needs to be made about the conceptual 'inadequacy' of this model, is that contrary to Freud's tendency to assimilate depression to hostility turned inward, contemporary research has provided evidence showing that both depression and hostility are distinct affects that can co-exist within the same person. In other words, one can experience hostility without feeling depressed.

2.2. THE LOWERED SELF-ESTEEM MODEL OF DEPRESSION

The lowered self-esteem model of depression abandoned the widely adopted libidinal approach to emphasise the role of the ego in the pathogenesis of depression. In this model, depression is viewed as an affect characterised by the collapse of self-esteem. The self-esteem model was first outlined by Finichel (1945), but it was Bibring (1953) who later developed it and refined it. "Bibring's theory" s as Bomporad so rightly described it (1980), is a "paradigm of simplicity and clarity" (p. 31).

Rather than conceptualising depression as 'a residue of libidinal striving', as was the case with the proponents of id psychology, Bibring conceives of depression as an affect arising out of ego contradicitons. For Bibring, the conflicts giving rise to depressive disorders are not between the ego and the super ego, but within the ego itself.

Although previous psychoanalytic writers mentioned self-esteem in relation to depression, they failed to recognise its importance in both the aetiology an development of depressive illness. Although Bibring recognises the importance

object loss and developmental events emphasised by both Abraham (1926) and Klein (1948), he maintains that depression is mainly a reaction to a loss or a blow to self-esteem:

> *"Depression can be defined as the emotional expression of a state of helplessness and powerlessness of the ego, irrespective of what may have caused the breakdown of the mechanisms which established self-esteem".* (1953).

Central to this theory is the ego's awareness of its helplessness and powerlessness, he must, according to Bibring, perceive a discrepancy between his actual situation and his narcissic aspirations. The perceived inability to achieve or attain aspirations is apparently the mechanism which activates the fall of self-esteem and triggers depression.

Unlike other psychoanalytic theories of depression, the present one has been favourably reviewed by most clinicians and researchers. Part of the reason is that the self-esteem model is much closer to clinical reality in general and to the clinical picture of depression in particular. Another reason as to why Bibring's model was more acceptable is because its conceptual formulation is consistent with contemporary theorising and thinking about the phenomenon of depression. For instance, low self-esteem has been described as a characteristic feature of depressive illness in most clinical observations and reports. Similarly, the component of helplessness is central to one of the most recent and perhaps successful theories of depression (Seligman, 1974; Abramson et al, 1978). Another reason why Bibring's theory has had more success than traditional psychoanalytical formulations, is because it is less speculative and provides more acceptable descriptions and explanations of depressive syndrome.

But despite the apparent adequacy of the lowered self-esteem model of depression, questions arise as to its ability to explain or account for all aspects of the clinical syndrome of depression. Low self-esteem could perhaps account for the subjective component of depression, but is unlikely to do so for the behavioural and somatic symptoms of this syndrome. In fact, recent theories of depression such as Beck's cognitive model (1967) and Seligman's learned helplessness theory (1974), regarded loss or low self-esteem as an epiphenomenon or a symptom of depression but not as its cause.

It appears after all that the construct of self-esteem is important but perhaps not sufficient to account for the wide range of depressive symptoms and disorders.

2.3. OBJECT LOSS, STRESS, AND DEPRESSION

There has been a widespread conviction that object loss plays an aetiological role in depressive illness. However, such belief and enthusiasm is hardly matched or justified by the existing empirical findings. The studies carried out so far in this line of research offer little or no support for the hypothesised causal connection between object loss and depression. Attempts at determining the nature of the relationship between these two variables have often been undermined by various methodological problems and constraints (see Tennant et al, 1981, for a detailed discussion of these problems)

Psychoanalysts are, perhaps, unanimous in regarding object loss as an antecedent of depressive complaints. The importance of developmental object loss in the pathogenesis of depression has been emphasised by both Abraham (1926) and Freud (1917).

In fact, they both postulated a causal link between childhood loss and

depression later in life. They regarded depression as an affective reaction to childhood losses.

The initial attempt at assessing the consequences of childhood loss on psychomotor functioning of human infants was made by Rene Spitz in 1945. Spitz reported to have thoroughly examined the reaction of a group of human infants that were separated from their mothers in the second half of the first year of life. The infants' reaction to the separation event, later termed 'anaclitic depression', was found to have similar features to that of a depressive reaction. Specifically, the infants' reaction was characterised by crying, psychomotor retardation, withdrawal, insomnia, anorexia, and weight loss. Although this finding may be regarded as a firm evidence of the depressogenic effects of object loss, some have challenged this interpretation. It was argued that the infants' morbid reaction reflected nothing but the consequences of an abrupt institutionalisation.

Although this may be true for the Spitz study, the syndrome that was soon after described by Robertson and Bowlby (1952) in older children, cannot be accounted for by the sole phenomenon of 'hospitalism' or institutionalisation. The separation syndrome reported by these authors consisted of three phases: Protest Phase – protest is believed to be the initial reaction with which the children respond to the loss of an important attachment bond (mother). In this stage the child is described as restless, agitated, and anxiously searching for his mother. Despair stage – in this stage the child is described as withdrawn, helpless, and sinking into despair. Detachment stage – in this stage the child loses interest in the outside world; the rejection of the mother is imminent. But despite this seemingly convincing evidence of the relationship between parental loss and depression, clinicians questioned its validity. It was argued that maternal deprivation or separation does not necessarily result in depressive reaction. Given an appropriate maternal substitute, some have argued, most of the symptoms and disorders described by Spitz and Bowlby could be prevented.

The work of Bettelheim in the 'kibbutz' in Israel illustrates the point about the prophylactic effects of maternal substitute.

Attempts at linking adult depression to early object loss have also failed to provide unambiguous data. A study that managed to establish a connection between these two variables is that of Brown (1961). Brown found that 41% of 216 depressed patients examined reported a loss of a parent before the age of fifteen, compared with only 16% of a sample of medical patients. A more recent study by Brown and Harris (1978) went even further – they linked adult depression to a loss of mother before the age of eleven. Although their data showed that only 10.5% of the depressed women examined and 6% of normal women included int the study ever reported a loss of mother before eleven, they nevertheless emphasised its importance in the aetiology of depression:

> *"Thus, loss of mother before eleven may well permanently lower a woman's feeling of mastery and self-esteem and hence acts as a vulnerable factor by interfering with the way she deals wityh loss in adult life".* (p. 240, 1978).

While the above two studies may seem to confirm the hypothesisded causal relationship between childhood loss and depression later in life, that of Beck and his co-workers (1963) rejects any aetiological implication for early or childhood loss. The results reported by Beck and his colleagues showed quite clearly that neither maternal nor paternal loss is related to depression. They found that parental loss (loss of mother of father in childhood) failed to distinguish a depressed patients group from a non-depressed patients group. Other authors such as Birchnell (196[illegible]; 1970a; 1970b) have linked childhood beravement and other types of losses not on[illegible] to depression but also to other forms of psychiatric disorders.

It apears then that neither clinical observations nor research reports support the claim for an aetiological role of childhood losses. In a recent review of the relevant literature, Tennant and his colleagues (1980) arrived at a similar conclusion. These authors refuted any claim for a causal link between parental loss and depression:

> *"We conclude that the current state of knowledge indicates that parental death in childhood on its own has little impact upon the risk of depressive illness in adult life".* (p. 298, 1980).

Stressful life events in adult life have also been considered of a great importance in the development of depression. Much of the research carried out in this area, consisted of showing that depressed patients experience more stressor events than non-depressed patients prior to the onset of depression. Most of the studies published so far reported results which showed only a weak association between stress and depression, although some have made wild claims about such relationship. The most widely quoted study in this line of research is that of Paykel (1974). His results indicated that only 25% of the depressed patients studied experienced stress prior to their episode of depression; although a stronger link was later established between so-called 'exit events' and depression.

Despite the claims for a causal relationship between stressor events and depression, doubt must be expressed as to the possibility of these events playing an aetiological role in depression – there is a lack of evidence concerning the specificity of stress to depressive illness (Tennant et al, 1981). In fact, medically orientated research showed that depression is not the only disorder associated with aversive events.

Medical conditions such as coronary artery disease, myocardial infection, peptic ulcer, rheumatoid arthritis, and even skin diseases have been linked to stressor events, (e.g., Rahe et al., 1964; Rahe et Lind, 1971). In another review of the studies that claimed to have established a causal relationship between stress and depression, Tennant and his colleagues (1981) once again refuted such claims:

> *"Our conclusion is that many of the studies from which a causal connection between life events and depressive illness is inferred are so weak methodologically that little can be made of them"* (p. 387).

It appears then that stress may be important, but other variables such as personality traits, cognitive styles, coping styles may be better predictors of depressive illness.

3. SUMMARY AND CONCLUSIONS

Although not exhaustive, the present review has pointed to 'deficiencies' inherent in psychoanalytical theorising and thinking about depression. The theories reviewed here were found to be speculative and of little or no predictive value. As noted earlier, their extensive use of metapsychological terms and metaphorical concepts makes their experimental or empirical verification difficult if not impossible. Beside the various deficiencies from which they suffer, these theories have little or no relevant relationship to the clinical reality of depression. Nevertheless, psychoanalysts deserve recognition not only for initiating the psychological research into depression but also for giving respectability to this approach.

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