Clevans, E.L. (1976). The Depressive Reaction. Mod. Psychoanal., 1:139-147.

Modern Psychoanalysis

(1976). Modern Psychoanalysis, 1:139-147

The Depressive Reaction

Ethel L. Clevans

The depressive reaction serves to defend against an awareness of reality with a repetitive, stereotyped thought process, as well as a feeling process, which, when conscious and verbalized, might be expressed with the words, “I am stupid, ineffectual, sinful, unattractive, dull, clumsy, etc.” Typically, there is a simultaneous unconscious conviction of omnipotence: “I should have known. If only I had done something other than what I did.” Or, “He (or she, or even it) would have behaved better toward me if only I had….” A recovering patient reported a conflict between, “How clumsy of me to trip over the rug!” and “Damn the rug for sliding!”

The depressive patient primarily attacks his judgment: “I do everything wrong.” The self-blame overlies unconscious unwillingness to use reason to differentiate between one act and another, between one person and another. “People are all alike; naturally they will take advantage of my ignorance—but I am still to blame for being ignorant.”

When the analyst learns that the patient's unconsciously preferred reaction to stress is depression, the analyst will need to study the factors in the early infant-mother relationship that led to this preference. The depressive reaction to stress seems to develop in infancy at the stage of emotional growth that follows the undifferentiated period when schizophrenia begins, and precedes the period when the paranoid reaction develops. Since all human beings

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probably go through all these stages of development in growing up, some remnants of each type of reaction remain, in varying degrees, in everyone. The transference gives the best clues to an understanding of the process, and the patient's childhood memories continue to confirm or modify the presentation of his true experience. When the depressive begins to learn through analysis that responsibility is not his alone, he is ready to seek knowledge of what his true contribution is to the course of events.

Some schizophrenics need to become depressed as the next step toward maturity. The true schizophrenic seems to have no awareness of any feeling. He shows no feeling on his face, while the depressive's face, in repose, is sad. The schizophrenic withdraws from objects. He does not blame himself for the bad behavior of the object, nor does he blame the object—the object does not exist. The depressive may blame the object, though he leaves himself a loophole for self-punishment through guilt feelings to follow. Or, if he is successful in some endeavor, since his feeling of accomplishment does not last, he soon feels the success to be worthless. One patient said, “It was great, but it didn't change the world”; another, “I sometimes get what I want, but it turns out to be bad.”

This self-attacking is rewarded by the continuing unconscious presence of the mother of his infancy. Separation—standing alone—is unknown and dangerous. The object, when seen clearly and recognized for what he or she is or has done, is separate and different. The depressive, having left the mother after birth, holds his mother inside him. She is felt unconsciously as the same primal mother: all-nurturing, all-knowing, a jealous mother-god. A patient said, “Mother told me that God writes down all my sins in a little black book!” A depressive in a marital relationship with another depressive will sometimes replace the self-reproaches with criticism of the partner, but since the depressive feels responsible for the behavior of the partner, these reproaches are also self-reproaches. The superego requires perfection; perfection is impossible; yet the depressive aspires to it in order to assure himself an endless source of self-blame.

The loneliness of the depressive patient is not really aloneness. His internal objects are always with him, affording some comfort even while they criticize. These internal objects are not felt as hating

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or cruel. (When they are finally perceived as such, they can be hated in turn.) They are good—the depressive could always have done better. If the analyst asks the depressive patient why, if he wants the patient to behave in another way, the analyst doesn't help him to behave that way, the patient will surely answer that there is something wrong with the patient, not the analyst. Some inborn flaw, he believes, keeps him from benefiting from the good analytic treatment given by the analyst.

The depressive who relieves his depression by an occasional paranoid reaction often blames a substitute object, one too remote to respond, such as fate, or the government, or the traffic authority. Eventually he will conclude that his anger is unjustified if it is felt toward anyone but himself. Even then, although he may label the feeling “anger” against himself, what he typically describes seems to

be a sort of self-blame that differs from anger. The feeling of depression does not resemble anger; indeed, if anger is felt against any object, it replaces depression. If the depressive does feel anger instead of self-reproach often enough, he has formed a new habit. He "feels better"; that is, he likes himself better. In analysis, if he advances to a paranoid defense, he may feel satisfied and quit analysis. Of course, habitual anger agaïnst objects (or substituted objects) is no more realistic or satisfying or productive than habitual self-blame. For example, a patient who found it easy to fly into a rage at a disappointing object then used the rage as a reason to break off relations altogether. When he did this, loneliness and self-reproach inevitably followed. "I should never have let myself feel angry. If I get angry at you [the analyst], I'll have to leave analysis."

The compulsion to act is a prevailing component of the depressive reaction. The patient may warn the analyst, "If you insist on my using the couch (or if you don't talk, or if I don't talk, or if you want me to pay regularly, etc.) I'll leave." He may be trying to help the analyst find the right formula for keeping him, for he often doesn't want to leave. He may run from one analyst to another, hoping to be caught like the gingerbread boy. He believes that the analyst will eventually tire of him. Indeed, he suspects that the analyst was tired of him when he made the first telephone call requesting an appointment. Mother, too, was tired of him, he feels.

He does not believe that any relationship can end by mutual

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agreement. A patient asked, "Does the analyst ever recommend terminating analysis?" He wanted to hear that, since he could not live without the mother, neither could the mother live without him. A recovering patient said to the analyst, "You'll always be a part of me, like mother. But the mother inside of me is sad, and you are smiling. Now I have a choice."

Sometimes the eventual, fearful outcome of a successful analysis is unconsciously sensed by the patient in the first interview, with the result, frequently, that the patient will manifest surprising and sudden anger. The analyst may react to the outburst of rage with an induced anger. To a statement such as "You are not going to say anything either, just like all the rest," followed by the patient storming out, the analyst may feel "Good riddance!"

The analyst may decide later, however, that the patient had only just begun to develop a transference, or that the patient was fighting the sensed possibility of a new (and therefore frightening) experience. With all action-oriented patients, the analyst needs to be especially alert to treatment-destructive behavior. If the patient calls from a roadside telephone booth to say that she has an impulse to drive her car into a tree, the analyst may suggest that she call her husband and ask him to come and get her. The patient is thus informed (1) that once outside the office it is her husband's duty, not the analyst's, to protect her; (2) that the analyst wants the patient to remain alive so that the analyst can cure her; and (3) that the analyst appreciates and approves of the patient's wish to know the right thing to do and how to do it.

The depressive is usually dedicated to learning the rules of the analytic relationship so he can follow them. He is also negativesuggestible, however. He clings to the belief that if he fails in analysis (and he believes he will inevitably fail), his failure will derive from his own inability either to know what he must do or how to do it. He sometimes tells the analyst, "You know something that you are not telling me." Analyst: "Why am I not telling it to you?" Patient: "Because I have to find it out for myself."

Typically, his mother was depressed when he was a child, and was either unaware of the roots of her own sadness or of how her depression encouraged her child to be depressed. She may have taught him good behavior, but she failed to teach him that he was

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not responsible for her depression, nor did she teach him how to be happy while she was unhappy. The depressive has eventually learned, through early and long experience, that "following the rules" or "doing the right thing" will not help him to feel better. No matter how "good" he is, mother will never love him any more than she did. The pertinent question for which the depressive patient seeks an answer in successful therapy is not, "Will I become lovable enough so that mother will love me?" but rather, "Will I love my mother (or my wife or my child or my friend) even though I am not lovable?" The road to such maturity may only be through the fullest awareness of the deepest despair. The constant protest of the recovering depressive is that he has always suffered, and that now at last he is ready to experience some *joie de vivre.* If he continues in therapy beyond finding satisfying activities with which to defend himself more successfully against his preconscious or unconscious feelings of helplessness, worthlessness, and unlovableness, he may discover that an ability to experience the depth and wealth of all his formerly forbidden feelings will lead him to greater satisfaction even in the emotions he has found more acceptable.

The depressive person is so eager to act, impulsively, in order not to feel depressed, that he may try anything to avoid depression. He may use alcohol, drugs, shock treatment, war, promiscuity, marriage, divorce, parenthood, travel, hobbies, and unconscious enjoyment of self-torture. He may kill another, and he may kill himself. These diversions sometimes work. Many worthwhile activities, some of which are considered to be sublimatory, like art or writing, are successfully used by depressives to avoid depression. A depressive patient said that he could not allow himself to feel depression deeply because he was afraid he would act on the feeling and kill himself. He probably meant that he might kill himself in order to avoid the full feeling of depression.

Death is only intellectually accepted as nothingness; it is emotionally perceived as separation from the life-giving and nurturing force or mother. If the analyst conveys the conviction that he will continue to work with the patient and will try to find the right

therapy for him, no matter how helpless, worthless, and hopeless the patient feels, the patient will continue in analysis and work toward maturity.

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The wish to avoid feeling depressed (the feeling which was felt so painfully as a child with mother) leads some patients to try to leave analysis before the first session. One patient was in a mental hospital at the time of her referral to me, recovering from a postpartum depression. It was one year after the birth of her child. A few days before her first appointment, she called to ask if I understood that it would only be a consultation. (Later, she said she had hoped I would say, “Then don't come.”) When she came to my office, she said that she was there only because her male psychiatrist had said that she should have a female analyst. Unconsciously she felt that he was rejecting her, and she expected me to reject her, too. She continued to call me before every session for the next four sessions to say that she had decided to quit analysis. Each time, I answered that she could quit if she wanted to but that it was better to come to the office and discuss it, and she did. Soon she began leaving the hospital regularly each day for two hours to take care of her young child, as well as once a week for her session with me.

The technique of psychological reflection proved helpful. Every objection to coming to treatment was joined. I said, “Yes, it's a very long trip,” and “It certainly is expensive!” and so on. She continued her sessions with her psychiatrist, and when she reported that he had told her that she was getting angry at me in order not to get angry at him, and that wasn't good, I said that she was supposed to do what her doctor told her to do but that with his permission she might get angry at both of us. When she said that I confused her, that I talked too much, that I asked her too many questions, I remained silent. When she said, “Now you are too quiet; say something,” I asked if it was all right to ask a question, and when she said yes, I did so. When she said, “I don't want to come here because you are putting too much pressure on me to grow up and talk,” I said, “I'm in no hurry; you can take as long as you want to.” When she said that her doctor had told her that she wanted to stop coming to me because she was afraid of becoming too attached to me and that she found it hard to separate, I said that when it came time for separation, I might help her to separate. When she called to cancel our session because she was leaving the hospital to return home and to a part-time job, I gave her another appointment, which she failed to keep. When she came in the next time, she said

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that she had overslept, that she was angry at me and didn't want to come. She was angry, she said, because I didn't tell her to leave me, and why didn't I? I said she had a right to be angry, but I hadn't decided yet whether I should agree to her leaving or not. (I was reflecting her own indecision.)

After a session in which the patient fell asleep on the couch and slept for twenty minutes, she called me—for the first time not in order to cancel the session, but to ask what she should do about her sad feelings. Since her request for help indicated that she was perceiving me as separate from herself and perhaps ready to help her, I suggested that she ask her husband to say something friendly and comforting to her and if he would not she should tell him that I wanted him to do it. She went on to say that she was annoyed at herself for sleeping too much. I said that it was good for her to sleep, that she needed the rest. I then asked her to save her other thoughts to tell me at her next session. When she came in, she said she still didn't want to come, but “I keep coming, so maybe I do want to come.” She told me she felt comforted by what I said on the telephone, but she got “furious” at her husband because he took too long to tell her something friendly and comforting. When he finally said that she was beautiful and sensitive, she didn't believe him. However, she said she was taking good care of the baby: “He is cute and I really love him.” (In her psychotic episode she had been afraid she would kill him.) After two months she seemed closer to deciding to work with me, though she unconsciously sensed that this meant a re-experiencing of painful feelings.

A successful businessman who came to me to get rid of his “paranoia,” which he said interfered with his business relations with women, obeyed all the rules of therapy. He came on time, lay on the couch, talked, and paid regularly. However, he never answered any of my infrequent questions and seldom asked a question of me. Following his cancellation of a session to go to the hospital for x-rays of a sprained arm, he told me that I was responsible for his injury. He said that in the session before the one he cancelled I had said something which triggered his unconscious wish to hurt himself; namely, that the reasons that he had once not acted on a declared wish to leave his wife for a weekend and have sex with another woman were that he felt his wife didn't want him to do it, that I

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didn't want him to do it, and that his mother would not have wanted him to do it. He then said that I should not have mentioned his mother. “I'll have to strengthen my defenses or get rid of you,” he added, and after a long silence he cried, “Board up the windows!” He began the next session saying in a determined voice, “Never say anything to me unless you are certain it will not have a destructive effect.” I was silent for the next few sessions, during which he spoke little, sighed, told me that now he couldn't trust me, that he had a pain in his chest, that my husband was probably “a cardiac.” One day, he began the session with, “A friend of mine is in

group therapy, and some of the group members began sexual relationships with each other. I feel that's wrong. *(Pause.)* Now, I'd like you to say that I'm right. *(Silence.)*" He then said that he was jealous of that friend, that he'd like to act on his own sexual feelings but he'd feel guilty. He explained, "There is a definite link between you, my wife, and my mother. You're all rigid. *(Silence.)* I've had thoughts of trading you in. But I decided I'm not going to look around New York trying to find another female analyst. I'm too old. Besides, you are all alike; you all stink.... I just had the thought that there's a baby inside of you and it's complaining." After many months in analysis, he became increasingly more willing to experience the depressive feelings of helplessness and worthlessness which his paranoia kept in check.

Joining techniques were also effective in the early treatment of a schizophrenic patient. He had come to therapy with complaints of blackouts, insomnia, and a fear of acting violently. I closed the paper I wrote about him* with the following statement:

> *The therapist presents herself to the patient as the hated object, but without slyly concealing her real feelings nor provocatively displaying them. She also acts consistently in the service of the therapeutic relationship. In this atmosphere, the schizophrenic dares to tell his fears, at first in fantasy form and then more directly. Eventually, he releases his aggressions verbally. Once he learns to discharge and control his aggression, his fear becomes unnecessary and so dissolves. It may indeed take a "lifetime" to struggle free from a bondage such as his, but there are few freedoms which would be won more heroically!*

"The Fear of a Schizophrenic Man," *Psychoanalysis*, Vol. 5, 1957, pp. 58-67.

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Since that paper was written, this patient married his lover and had two sons with her. He became self-supporting and bought his own home. He sent both of his boys to private nursery school and pridefully reported that his older son had impressed his teachers with his intelligence and industry. His own education had been neglected, and he was determined to help his boys eventually attend college and find intellectual work. His many physical symptoms also cleared up—headaches, blackouts, ulcers, etc. In a later session, he told of a dream that he had had repeatedly, in which a monster represented his father and also me. Now he said, "I know the monster is part of myself—the angry part. I'm still afraid of my temper. I feel I might kill somebody, although I know I won't. Maybe the dream means that I still want to be afraid. But I'm really not afraid, and you're not afraid either." True! Toward the end of his analysis, he allowed himself to have unhappy feelings, feelings of real misery. That depressive reaction was a major step in his progress toward maturity. He did know at long last that this is a "terrible world," that it contains "injustice, racism, war, hippies in the church, earthquakes in California." He sometimes returned to his recurrent fantasy of going to live in California, but he finally realized that it can be cold there, too.

This same man, while driving, had long been accustomed to curse every driver out of earshot on the road. One day he reported another proof of the increased strength of his inner controls over his impulses to destructive action. He had been driving on the highway when he suddenly saw a car traveling in the other direction swerve toward him. As he realized that his car might be hit head-on, his rage boiled up and he felt an impulse to vent it spitefully by accelerating his car into the other car. However, the words came to his mind, "Do the right thing!" And he turned in time to avoid the collision, thus saving himself and the other driver from the consequences of his acting on his homicidal and suicidal urge. For him, the "right thing" was no longer to sacrifice himself in order to preserve the internalized pre-oedipal mother, but to treasure the supreme gift of life in himself and in others.

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Clevans, E.L. (1976). The Depressive Reaction. *Mod. Psychoanal.*, 1:139-147

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