

RE-VISIONING THE DEPRESSIVE IMAGINATION

by

LUIS ALBERTO ALVARADO

A clinical case study
submitted in partial fulfillment
of the requirements for the degree of

DOCTOR OF PSYCHOLOGY IN CLINICAL PSYCHOLOGY

INSTITUTE OF IMAGINAL STUDIES

2008

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This clinical case study has been accepted for the faculty of the
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To David with gratitude

Empty

Like the bottom of a well
Like an echo in a canyon
Like the hope that vanished.

All in a feeling, in a longing.

In my soul I search for an answer,
In my soul I search for the truth
The truth to end all pain
The truth to answer all questions
The truth to soothe all worries.

In my heart I find nothing but a feeling
In my heart I find nothing but a wound
A hurt that has made me realize –
nothing
A hurt with no cause and no effect
A hurt with no beginning and no end.

It's just there
waiting
to grow
to feed
to kill.

I die.

Empty.

Luis Alvarado (age 16)
"Empty"

ABSTRACT

RE-VISIONING THE DEPRESSIVE IMAGINATION

by

Luis Alberto Alvarado

The topic of this Clinical Case Study is adult depression. Numerous studies have shown that depression is a fairly common occurrence within the general population and that untreated depression can have serious consequences for individuals, and for society as a whole. This case study documents the onset and resolution of a depression of a middle-aged man.

The literature reviewed for this Clinical Case Study includes several different perspectives on adult depression: the biological perspective, the cognitive/behavioral perspective, the psychodynamic perspective, the sociocultural perspective, and imaginal approaches in relation to depression. The biological, the cognitive/behavioral, the psychodynamic, and the sociocultural perspectives on depression are presented as lenses through which depression is imagined. In the literature on depression, none of these four perspectives holds the ultimate truth about depression. The metaphor of lenses through which the soul imagines its own experience is a core tenet of Imaginal Psychology; the literature in general is silent on the imaginal approach to depression.

The subject of this Clinical Case Study was engaged in a therapy journey that lasted 19 months, and the progression of the treatment is presented as he slowly regains

his bearings and his depression is resolved. The progression of the treatment explores the major themes from the therapy journey, including the most significant interventions and turning points. Imaginal Psychology provided the overall contextual understanding of the therapeutic process.

When the Learnings were reviewed, it became clear that the client's therapy journey was reflective of mythic themes found in the stories of Demeter and Persephone, Cupid and Psyche, and the myth of Inanna. The notion of codependency and relational stress were evident in shaping the depression and resolution of the client, and the response of the therapist. The overall Learnings support an approach to treating depression that focuses on the soul and its mythic images.

The conceptual structure presented in this Clinical Case Study is the notion of the depressive imagination, the re-visioning of depression as a necessary imaginal process for the soul. Three myths were utilized in this case study for an understanding of the depressive imagination. The approach to myth presented sees in the myth a ritual enactment that contextualizes suffering within the realm of the particular God or Goddess from whom the affliction proceeds.

ACKNOWLEDGEMENTS

Reaching the end of this particular journey, as I look back upon the road I have traveled, I see the downs and ups: the moments that felt like defeat, and the small epiphanies along the way. I also see that along this road, at every turn, there were loving individuals, helping me up when necessary, commiserating with me, encouraging me. I see that I would not have reached this milestone – in fact – without their support. It humbles me and it fills my heart with gratitude.

My partner, David Miles, has been uncompromising in his support. He is my teacher in what compassion and generosity must look like when done correctly.

There are two men without whom this achievement would not have been possible. The first, Dr. F. Myron Hays, has been my clinical supervisor in private practice and has allowed me to realize a dream of a lifetime. His trust and confidence in my clinical abilities has been healing, his friendship a gentle and steady comfort. Merle Yost, LMFT, has been a one man cheering section and a no nonsense ally, a Trickster with an impish smile. I thank them both.

I started and ended this writing journey with the help of the members of my study group, now my friends. We met monthly and sustained each other with soul food when the thickets appeared on the road and we required some help with pruning them. I wish to express my appreciation to Sandra Andresen, Lisa Rohe, Kim Stevens, Anna Maria Winkler, and Tracy Williams.

I wish to express my gratitude to Dr. Aftab Omer, a sage and wise man, and the Institute of Imaginal Studies, for providing the outer vehicle of the inner grace that is this Clinical Case Study.

I would like to note that spiritual allies were with me on this journey as well, a great source of sustenance and comfort.

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CHAPTER 1

INTRODUCTION

Clinical Topic

The topic of this Clinical Case Study is adult depression. Andrew Solomon provides an image of the suffering that is depression:

My depression had grown on me as that vine had conquered the oak; it had been a sucking thing that had wrapped itself around me, ugly and more alive than I. It had had a life of its own that bit by bit asphyxiated all of my life out of me . . . and in the end I was compacted and fetal, depleted by this thing that was crushing me without holding me.¹

Depression can appear as a momentary shadow in one's experience, or it can disable an individual to the point of paralysis. It appears in children as well as adults, in women as well as men, in the poor as well as the privileged, in people of any race, and at any time of life. It is a common presentation in the consultation room of helpers of all kinds, whether professional or lay healer. Depression is a common occurrence and an uncommon experience when we suffer from it. The National Institutes of Health have declared that depression is a genuine health issue within the United States.²

The individual who suffers from depression is surrounded by the conflicting opinions that the larger culture holds towards depression. In the last 20 years, depression as suffering has emerged front and center in the cultural discourse of what determines a mental illness, and what constitutes painful but unavoidable human experience.

According to Allan Horwitz and Jerome Wakefield the demarcation between normal

human response and dysfunction has been blurred by the way psychiatry defines depression.³ Sharon Begley in an essay for *Newsweek* documents that the “the push for ever-greater well-being is facing a backlash, fueled by research on the value of sadness.”⁴

This cultural discourse highlights the tension between the advocates for the medical model of mental illness and their preferred treatments, and the resistance of depressives to have their experience pathologized and targeted for eradication. This passionate difference of perception might be because depression, even though experienced as strangely other, always seems distinctly mine, as Solomon shows with his metaphor of the vine and the tree. The numerous memoirs and writings on depression like Solomon’s, which have surfaced in the past 20 years, appears to suggest that depression is a very personal type of suffering that nonetheless calls for recitation.

Depression presents a claim whenever it surfaces in a life. As will be suggested in this Clinical Case Study, depression is neither simple nor aberrant. I would like to propose that depression is a necessity for the soul that allows for the emergence of complexity and the deepening of the human experience. The problem is that sometimes, due to many factors that will be examined, the switch that turns on depression remains on. The uncertain distinction between sadness, and depression as dysfunction, will be a tension maintained throughout this Clinical Case Study.

The subject for this Clinical Case Study, “Tim Olsen” (pseudonym), is a European-American male who was 39 years old at the start of our therapy work together. During our first session he voiced the concern that he was straddling the line between being okay and “lapsing into a deep depression.” He reported that he was binge eating

and had gained weight. He was not sleeping well, and he was not exercising regularly. His alcohol consumption had increased beyond his comfort level. And he reported moments of getting weepy and crying when alone at home.

Tim's story has been selected for this Clinical Case Study on adult depression for three reasons. First, this client's journey in therapy typifies many of the important processes that embracing one's depression imply, such as a review of the biological, interpersonal, and intrapsychic dimensions of depression. Tim's courage in turning towards his suffering and seeking a remedy is another reason for the choice of this client. Finally, Tim's depression course and resolution mirrors the archetypal stories or myths used to inform the understanding of depression in general, and Tim's treatment in particular. These myths are the stories of Inanna, Demeter and Persephone, and that of Cupid and Psyche.

In order to contextualize Tim's personal experience, a summary on the topic of depression may be helpful. Most of the studies and the literature within the mental health professions today concerning the subject of depression are about Major Depressive Disorder (MDD), the most extreme, disabling form of depression. MDD, as defined by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), is the leading cause of disability in the United States for persons between the ages of 15 and 44.⁵ MDD, a type of mood disorder, affects approximately 14.8 million American adults in any given year; the estimated lifetime prevalence of having a mood disorder is 28.8 per cent of the overall population.⁶ In 2004, as reported by the Centers for Disease Control and Prevention, there were 32,439 suicides in the United States.⁷ Y. Conwell and D. Brent report that more than 90 percent of people who

kill themselves have a diagnosable mental disorder, chief among them being a depressive disorder or a substance abuse disorder.⁸

Depression as an area of concern in psychology appeared early in the writings of Sigmund Freud who, in 1914, wrote an essay titled “Mourning and Melancholia.”⁹ *Melancholia* was the term used in Freud’s day for depression. One of Freud’s observations in this essay was that melancholia was not easily defined within the field of psychiatry, appearing in various clinical forms that precluded establishing depression as a single psychiatric entity. The complexity of depression’s many forms continues to this day. This complexity is detailed in the *DSM-IV* where depression symptoms are listed for several other psychiatric diagnoses other than MDD.¹⁰

Aaron T. Beck provides a summary of the symptoms of depression in his seminal work *Depression, Causes and Treatment*.¹¹ He divides the varied manifestations of depression into four categories: emotions, thoughts, behaviors, and physical events. Emotional expressions of depression include dejected mood, negative feelings towards oneself, reduction in pleasure and satisfaction, crying spells, and loss of emotional attachments. Cognitive expressions of depression include negative expectations, low self-evaluation, and self-blame. Beck lists motivational manifestations of depression such as paralysis of the will, suicidal wishes, and increased dependency. Body expressions of depression appear in sleep disturbance, loss of libido, and increased tiredness. Beck’s breakdown of the symptoms of depression into emotions, thoughts, behaviors, and physical events continues to be used today as a way to understand the complexity of the depressive experience.¹² The *DSM-IV* includes all four areas of expression in its listing of symptoms for MDD.¹³

The suffering of depression predates the attention given to it in within the discipline of psychology. The agony of loss, mourning, and subsequent depression is found within the story of Gilgamesh, the oldest written story on record, as translated by Maureen Kovacs.¹⁴ This story originated in Ancient Sumeria sometime between 2750 and 2500 BCE, and was discovered written on 12 clay tablets in an ancient script. It is the story of the King of Uruk named Gilgamesh, who was part human and part god. In the story, the Gods kill his friend Enkidu, who Gilgamesh refers to as his “other self,” because Gilgamesh insulted the Goddess Ishtar and she demanded retribution.¹⁵

“Hear me, O Elders of Uruk, hear me, O men! I mourn for Enkidu, my friend, I shriek in anguish like a mourner,” cries Gilgamesh upon witnessing the death of Enkidu.¹⁶ The epic continues. “He covered his friend's face like a bride, swooping down over him like an eagle, and like a lioness deprived of her cubs he keeps pacing to and fro.”¹⁷ Gilgamesh refuses to bury his friend for seven days while in his mourning, watching as Enkidu’s body decomposes and burial becomes a necessity.

Gilgamesh is so profoundly impacted by his friend’s death that he begins to contemplate and worry about his own mortality. Loss, and the confusion that arises due to that loss, awakens within Gilgamesh a desire to change the usualness of his life. Gilgamesh sets out on a long and epic journey with the aim of finding a way to avoid dying.

The suffering of Gilgamesh suggests that depression is a complex event that requires a complex response. The simple listing of symptoms that is used in the *DSM-IV* is, in my opinion, inadequate to address depression’s claim on the soul. I have come to this conclusion based on my own personal struggles with depression and from therapeutic

work with clients over many years. My approach to depression's complexity, the basic conceptual structure presented in this Clinical Case Study, is the notion of the *depressive imagination*.

It would be dishonest for me to claim that the idea of the depressive imagination is something created by me. I have lived in this imaginal landscape for so long – my first conscious encounter with depression occurred when I was 16 years old – and I have researched so many authors, that I could have easily come across this idea, although probably not in so many words. What I do know for certain is that somewhere in my own journey of healing depression, the notion of the depressive imagination began to take root.

There is a model that informs my move from depression as simply an experience that some go through, to viewing the depressive imagination as a three-dimensional landscape that the soul inhabits. Thomas Moore provides an example of this model in his book *Dark Eros, The Imagination of Sadism*, which is an examination of the writings of the Marquis de Sade.¹⁸ Instead of turning away from what Moore refers to as the soul's love of evil and shadow and darkness, he turns towards de Sade's images of sex and torture as a way to understand the byway of the soul's dark eros.

Moore turns towards the soul's imagination, understanding that the soul lives in ways imaginal that we want to deny, or want to fix, or want to eradicate. This model of turning towards the soul's imagination is also demonstrated by James Hillman, who presents the idea of *reversion*, the notion that all things desire to return to the archetypal originals of which they are copies and from which they proceed.¹⁹ By finding the imaginal house for the depressive experience, depression is given a home within the soul.

This has significance for the discipline of psychology, which in postmodern society has become a profession in need of the soul.

My first introduction to the ideas of soul and image occurred when I was 18 years old. While reading a book on astrology, I came across a reference to Carl Jung and his definition of the *anima*, the personified image of the feminine that all men carry in their personality.²⁰ I was intrigued by this idea, and I spent that summer reading several volumes of Jung's *Collected Works*. I was introduced to a *depth psychology* that resonated deep within me and seemed to make sense from many different perspectives, especially from the perspective of my own lived experiences.

At age 22, still struggling with depression, I began to see a therapist, Herta Payson. Our work together was imaginally based: we used my dreams, my poetry, my paintings, my journal entries, and Greek myth as ways of accessing and fostering a deeper understanding of my depressive suffering. We shared and continue to share a deep abiding love of images and their power.

Later in my professional life, during the years of 1988 and 1990, while I was researching my thesis topic for a Master's Degree in Counseling Psychology, I embraced Hillman's ideas about the soul and its images, found in his many essays on archetypal psychology. In my thesis, I was exploring the concept of God-images (plural) within the soul, and how these God-images order the soul's experience. The title of my Master's thesis was "God-Images in Counseling." The thesis was rewritten and reedited and published by Llewellyn Publications in 1991 under the title *Psychology, Astrology, & Western Magic: Image and Myth in Self-Discovery*.²¹

Hillman's books, especially his editing of the work *Facing the Gods*, which he also coauthored, provided for me the conceptual permission, rationale, and validation that I needed to complete my thesis. Like Jung before him, Hillman became for me a father of psychological ideas, a male ancestor in soul. Hillman's archetypal psychology has influenced for several decades my own understanding and theorizing about the ways of the soul. I find Hillman's ideas and suggestions accessible, as well as, supported by my own experiences of the soul and image.

I found eventually that Hillman, like Jung before him, was unable to fully articulate my own particular experiences of *being-in-soul*, a phrase often used by Hillman.²² Hillman states that archetypal psychology makes a situational move south, away from Northern Europe and the German language, to the Mediterranean culture, Greek and Roman, to the polytheistic world view of these cultures and times.²³ What remains unstated is that one can go further south, to Egypt and the rest of Africa, and south as well can be Latin America. These locations south and their cultures have other ways of being-in-soul that my Northern European soul-fathers, Jung and Hillman, have been unable to articulate psychologically, and understandably so. That task remains to be done by others whose experience is rooted in cultures further south of Greece and Italy.

During my three years of coursework at the Institute of Imaginal Studies, I learned that Imaginal Psychology reaches beyond the Northern European history and identity for an understanding of the ways that the soul lives its images. Indigenous wisdom both ancient and modern is welcomed within Imaginal Psychology's purview.²⁴ As a man of color and indigenous inheritance, this openness to, and embracing of my identity within Imaginal Psychology has been healing. My deepest religious promptings

also found expression within the Institute's learning environment, since ritual and spiritual traditions are an aspect of the Institute's educational process.²⁵

Aftab Omer explains that Imaginal Psychology turns towards the soul and its images.²⁶ In presenting the various ways of describing depression as lenses rather than literal theories, this Clinical Case Study is a contribution to Imaginal Psychology. A move is made to give image primacy and in so doing place the soul at the center of this psychological inquiry.²⁷

From my own personal suffering with depression, as well as the research done over the years on depression, there is, in my opinion, one essential consideration in placing the soul and its images at the center of psychological inquiry. The biological and cognitive behavioral emphases found in current mainstream psychology appear to leave out the most important aspect of a depressive illness: *the subject*. Certain aspects of the subjective experience of depression are catalogued, labeled as symptoms, and then distanced from the experiencing subject. In the *DSM-IV* psychological suffering is reduced to a listing of syndromes devoid of any personal contextual meaning. The symptom becomes a reified fact to be "treated." Human beings, however, live in subjective and contextual environments that influence and shape their experiences.

This Clinical Case Study is written with the intention of understanding the necessity of the depressive imagination to the soul. By turning towards the soul's imagination, the soul and its images are given priority. Embracing the soul's experience of the depressive imagination allows for the complexity of depression to be witnessed without reservation or judgment. All of the domains that the soul inhabits can enter into this understanding of depression: thoughts as well as emotions, behaviors and somatic

complaints, personal history and cultural influences, science, religion and mythology, creativity and art.

The depressive imagination has historical precedence and is found in other places and other times prior to the discipline of psychology. The Ancient Greeks believed that disease was the result of the interplay between the four bodily fluids of phlegm, yellow bile, blood, and black bile.²⁸ Excess black bile in the brain was believed to cause melancholia (depression). Before the advent of science in the late 1700s, astrology's use in Western medicine included the belief that the planet Saturn was responsible for melancholia.²⁹ The Ancient Chinese system of divination, the *I Ching*, contains eight figures of three lines each called trigrams. The trigram *K'an*, which translates as The Abysmal (Water), signifies melancholy in humans and those with sick hearts.³⁰ In the more recent system of the Enneagram and its nine points, derived from the psychological observations of George Ivanovich Gurdjieff, depression and melancholia are found within Point Four, which Helen Palmer labels "The Tragic Romantic."³¹

There are many ways of imagining depression. How depression is imagined determines how we respond to it, including the basic attitude towards depression itself. Included in the Literature Review are five ways of imagining depression: the biological aspects; the cognitive behavioral approach to depression; the psychodynamic perspective; the sociocultural understanding of depression; and a re-visioning of depression using imaginal approaches to depression.

Exploration of the Subject/Topic Choice

Depression as a research topic has a very personal significance to me. When I reflect back on my life, I believe my first conscious experiences of depression occurred around the age of 15 or 16, although I was probably also depressed as a child. My parents separated when I was five years of age. At the age of six I moved with my mother to the United States from Puerto Rico, and those first few years of schooling in a new country and a new language were stressful and painful. I spent my middle childhood years split between two environments that at times seemed a universe from each other. I was a withdrawn, quiet, and introverted child. If I thought that living in two cultures simultaneously was difficult as a child, high school, and later college, both reminded me that I was a stranger in a strange land.

My adolescence was a time of depression and confusion. I remember occasions when I would weep uncontrollably, when my soul felt as if a great sorrow and emptiness was all there was to my being. I struggled with depression on and off throughout my 20s, 30s, and early 40s, but each year I found myself psychologically stronger. I have engaged my depressions from many different perspectives and I have utilized many different tools: this multiple approach appears necessary to heal depression.

I prefer to use the word depressions in the plural, because I do not believe that depression is static. I lived each depression at different periods in my life, during varying developmental milestones, finding or creating specific tools for a specific depression. While I still consider myself a depressive, depression no longer dictates where my energy

goes, or how I live my life. Depression has shaped who I happen to be today, but no longer determines my tomorrow; it is my history, but is not my future.

The vast majority of clients I have worked with have presented with some form of depression. Given my own history, and the cultural view that depression is a malady best gotten rid of, I often have to remind a client that their depression has purpose and carries within it some essential meaning. Depression, I tell them, is the soul performing a necessary kind of work, and we, therapist and client, are the attendants to this work. Assuming the client is not a danger to themselves or to others, which would require a different remedy, we sit and talk and walk together through the depressive landscape as it pertains to them uniquely. This ability to turn towards the darkness of depression, to explore the topography of the landscape, is an inadvertent capacity that I have acquired in the process of healing my own depressive wound.

In retrospect, there is no other topic that I could have chosen for the case study in a doctoral process. I realized that I had to re-vision the depressive imagination as a way to better understand my own past journey and the journey of my clients. Imaginal Psychology begins with the assumption that the soul is primary, that image is how the soul experiences itself, and that soul is both individual and universal.³² If aspects of the personal are universal, then this case study on the topic of depression is a mirror wherein which I can continue to find healing. To live and survive depression is to understand the nature of paradox, and I consider this capacity to live within the soul's paradoxical nature a bright gift from a dark place.

I hope that the principal benefit of this case study will be for persons wanting to better understand their own depression. Secondly, I would hope that it would benefit the

treating practitioner who must address the subjective experience of the complex human being who is asking for their assistance. It is also my hope that this Clinical Case Study will be a benefit to anyone who feels a need to re-vision depression away from the dominant pejorative cultural view.

Framework of the Treatment

I began seeing Tim on June 25, 2005. Our termination session was November 17, 2006, making the time frame for the therapy to be a year and a half. Our work together totaled 36 sessions. The orientation to psychotherapy while treating Tim was psychodynamic, and Imaginal Psychology provided the overall contextual understanding of his therapeutic process for me. The method of therapy was conversation.

In our first session, Tim reported that he was lapsing into a depressed state, and he was able to cite what his indicators for depression were: his weight gain, compulsive eating, feelings of sadness and weeping when home alone at night, insomnia, and increased alcohol consumption. In our sessions, he rarely demonstrated overt depressed behaviors, and it was difficult at times to imagine him being as depressed as he claimed. Sometimes, when he spoke about his relationship stress, he would become pensive and silent. I note this in order to emphasize a key point made in several places throughout the Clinical Case Study: that depression is expressed uniquely in each individual life, and requires an individual approach to healing.

Tim was a highly motivated, intelligent client who took charge of his treatment, including its focus. He was able to learn quickly, and would rework his treatment plan according to his learning. He followed through with his homework assignments; even

these developed from his own process. I provided the psychological container and the reflective ear he needed to process his healing, as well as validation for the reasons for his suffering. Tim's high self-motivation forced me to practice *being present* as opposed to *doing*, which was not always easy for me.

Confidentiality and Ethical Concerns

The use of case studies in psychology was firmly established by Freud who used case studies throughout his writings to illustrate clinical considerations and theories, as he understood them. Freud was careful to protect the identity of his patients when he cited their stories. All pertinent, specifying information that might identify my client in this case study has been left out when not integral to the study, or altered, as in using a pseudonym. I would like to thank a former teacher at the Institute of Imaginal Studies, Alexander Shaia, who taught me by example and insistence during class the importance of holding someone's psyche gently, lightly, and with compassion. I honor Tim's willingness to share his struggle with others, and to trust me with his psyche, both in therapy and outside of it, by protecting his privacy, and by my asking of the reader to hold his psyche gently and with respect as they read about Tim's hard work and achievements.

Tim did not have to consent to my request to use his struggle with depression as the focus of this case study. In my view, the fact that he did consent says positive things about his character. One capacity that he has, that surfaced in therapy, is his generosity of spirit. This generosity, along with his solid and healthy sense of himself, made it easier for me to approach him regarding the case study. Tim already knew that I was working

on my doctorate, since I reveal this and the fact that I am under supervision with every new client.

Towards the end of our therapy work together, about three months before our last session, I asked Tim if he would consider being the focus of this case study and I asked him to think about this request and let me know. He immediately volunteered, but I asked him to hold his decision until it looked like we were closer to ending our work together, when I would ask him again. I let him know that strict confidentiality would be maintained throughout the case study. He agreed to give me permission to use his information and at our agreed upon last session, he signed the consent form.

Since October 2004, I have been a Registered Psychological Assistant under the supervision of F. Myron Hays, a licensed psychologist, in private practice in Oakland, California. I had originally done my Ph.D. doctoral internship doing community work with an administrative emphasis. When I decided to transfer out of the Ph.D. program and into the Psy.D. program of the Institute of Imaginal Studies, I realized that I did not have a relevant client case. Hays proposed registering me as a Psychological Assistant under his employment in order to create the opportunity of having a client case for the completion of the Psy.D. requirements.

During my work with Tim, I had weekly supervision sessions with Hays for at least one hour per week to discuss progress with Tim as well as with other clients. Hays' primary orientation is cognitive behavioral and he has strong diagnostic skills. He was open throughout to my approaches in treating depression, and he challenged me to express my ideas in a clear way. I especially appreciate that Hays allowed me to struggle with the *DSM-IV* system of diagnosis, to think out the diagnosis process carefully, as I

feel that the process of diagnosis is an awesome responsibility. He was able to hear my critiques about the notion of mental illness and the medical model in general without taking umbrage or taking it personally. I believe our differences of approach allowed for optimum therapeutic treatment of Tim as well as my other clients.

Client History and Life Circumstances

Tim was 39 years old at the time of beginning therapy work, and his anticipation of his upcoming milestone age of 40 was a motivation to heal and get better. From the first encounter with Tim I saw evidence of his extraverted nature. He was warm, funny, gregarious, and involved in many social groups and events within the larger gay community. His friends sought him out for his company and for his advice. He expressed a high degree of comfort with his medical research supplies sales position, traveling throughout the state with little trepidation or concern, negotiating, bartering, and making the sale.

Tim's developmental history as he reported it was ordinary. He was one of six children and all his siblings were living at the time of our work. His parents were still married and enjoyed a happy life together.

Tim shared that he had a vague idea he was gay at age 10, knowing for certain he was gay between the ages of 15 and 21, at which time he had his first sexual encounter with a man. He stated he came out to his family when he was 23 years of age. After some initial tension, his family was and continued to be supportive of his homosexuality. He has brought his significant others home for family visits. Except for his coming out

process, Tim stated that there had been no major conflicts with his family of origin. Tim expressed a secure bond with his family.

Tim came into therapy with a former diagnosis of bipolar disorder, having been treated with lithium between 1989 and 1996. Between 1996 and 1998, he was given a round of medications to treat depression and stabilize his mood (Wellbutrin, Zoloft, Prozac, and Neurontin). He stated that the Prozac and Zoloft caused sexual side effects, so he stopped taking them, and he felt that the Wellbutrin and Neurontin were not helpful. He reported that in 1996 he attended several behavioral change classes through Kaiser Permanente where he learned relaxation techniques. He stopped taking all medications by the end of 1998. Tim reported being medication free since 1999, even though his grandfather died in 1999, and his primary relationship of seven years ended in 2002. Tim expressed pride in having accomplished this self-care without use of medications.

Tim did not remember whether he had originally been diagnosed with Bipolar I or Bipolar II Disorder. Since it had been over eight years since his bipolar diagnosis, I could have assigned the new diagnosis of Adjustment Disorder. Another possible diagnosis could have been the V Code of Partner Relational Problem, since Tim's main complaint was the relationship with his boyfriend. Myron and I decided on a conservative approach and kept the Bipolar I diagnosis. We included a differential diagnosis for Cyclothymic Disorder. This decision was made because of the way that Tim described his behavior at the time of his bipolar disorder diagnosis, which did not seem to meet the more extreme manic behaviors and potential disability associated with bipolar disorder.

Once therapy was under way, the diagnostic considerations moved to the background, since Tim's psychological state, while impacted by depression, was nonetheless stable. It should be noted that once a bipolar disorder is diagnosed, it tends to resurface, and it is unusual that Tim has not had recurrence of these symptoms since 1998. Tim's proactive attitude and self care may help explain this fact.

Tim was confronting several issues and events that were challenging him. These included the fact that his boyfriend of 14 months, "Rick" (pseudonym) drank alcohol regularly and Rick's drinking impacted their interactions. One conflict was Rick's assertion that his alcohol use was something he had under control, while Tim felt that when drunk, Rick became angry and emotionally abusive. After these emotional outbursts, usually the next day, Rick would express remorse for his behavior and promise to never do it again. This was a pattern in the relationship that left Tim distraught, confused, and exhausted.

More recently, Tim had been overlooked for a job promotion, and while continuing to be a regional salesman of biomedical equipment and supplies, he now had a boss he disliked. He had lost a beloved aunt earlier in the year, and his aging father had had heart surgery the year before and was recovering slowly. He was remodeling his home to include a rental unit, with all the chaos that implied, and his aging dog required more attention from him. Financially, he was investing money in frequently repairing his convertible automobile from the 1960s, which, although the car was a source of joy and pleasure for him, the infusing of money into its repair was another source of stress for him. At the end of describing all of this to me, Tim revealed his sense of humor for the first time. He stated that a friend had said to him, "You have a high maintenance

boyfriend, a high maintenance house, a high maintenance dog and a high maintenance car.”

Over the course of our work together, Tim ended his relationship with Rick. Another biomedical research supply company hired him for a new sales job. He completed his home repairs and he rented out part of his home to assist in his mortgage payments. During the early part of our work together, he underwent surgery for sleep apnea; this event was pivotal in motivating him to take actions to change his life. All these changes and their relationship to the resolution of Tim’s depression are detailed in Chapter 3 of this Clinical Case Study. By the end of our work together, Tim had restructured his life and had created a five-year life plan that he proceeded to implement with enthusiasm and earnestness.

Progression of the Treatment

In retrospect, there seemed to be three distinct phases to Tim’s therapeutic journey between the months of June 2005 and November 2006, when we terminated therapy. The first phase occurred between June and December of 2005, punctuated by Tim visiting his family in Montana without Rick. It was during this phase that Tim made the decision to leave the relationship with Rick. In November of this period, he underwent throat surgery to improve his sleep apnea. During the anesthesia process, Tim briefly came to consciousness and could not breathe. Terrified, he struggled to get this across to the surgical staff, and when the anesthesiologist realized the situation, he was put under quickly. The result of this brush with his mortality was to motivate Tim to initiate a course of life reassessment as part of our work together. This frightening event

also provided a new urgency and motivation for Tim to heal his depression and reshape his life.

The second phase of the treatment took place between January and April 2006. During this time, Tim let himself feel his anger and disappointment over the loss of his relationship with Rick, and he was open to examining himself and reassessing his life. During this time he began to prepare for his future life without Rick. The final phase of treatment occurred between May and November 2006, when Tim consolidated the changes he had initiated during the second phase, and his depressed mood had mainly resolved. Our final session was on November 17, 2006.

At the time of intake Tim was both under intense psychosocial stressors as well as suffering from depression. The depression was his main complaint. In his description of the cycles of alcohol use by his boyfriend, Rick, and the subsequent conflicts, codependency was clearly an issue. The definition of codependency, according to Melody Beattie, is that a codependent (co-alcoholic or para-alcoholic) is an individual whose life has become unmanageable as a result of being in a committed relationship with an alcoholic.³³

Tim's extraverted caretaker style masked his sensitivity, vulnerability, and sentimentality. When his parents sent him items from his deceased aunt's estate for his own home, he remarked that he surprised himself at how much sadness he still felt about losing her. His take-charge attitude appeared to mask his more vulnerable nature and he rarely allowed himself to visibly descend into his depression while we were in session. His was a quiet kind of suffering, a late night cry here and there when he allowed himself the experience. He stated that eating a whole pizza when depressed was more his style.

Tim stated that he was in love with Rick, though he was convinced that Rick had hidden the extent of his alcohol use from him until he was emotionally engaged. Tim expressed his conviction that Rick was an alcoholic, and felt that the stress of being with an alcoholic had resulted in depression, and lack of healthy self-care. He had gained weight and was not eating properly, he was not sleeping well, and he was not exercising regularly. Tim stated that he had taken better care of himself before being with Rick.

Tim expressed anxiety at not knowing whether Rick was sober or drunk when they interacted, and this was overshadowing any good interactions between them. Tim stated that part of his dilemma was that when Rick was not drinking, he was a sweet, loving, and kind man. When drunk, Rick was angry and accusatory, pushing for he and Tim to move in together and take their relationship to a new level. Tim, unresolved over Rick's alcohol use, was resistant to the idea, which made Rick even angrier. Over the course of therapy, Tim came to accept that Rick's primary relationship was with alcohol. Rick refused repeatedly to stop drinking, to seek help in stopping his alcohol dependency, or for that matter, to acknowledge his drinking and its consequences on his behavior and the relationship.

Tim came into therapy prepared to work and get better. He faced each new challenge directly. For instance, at my suggestion, Tim began to attend Al-Anon groups to better understand alcoholism and how best to take care of himself. He was brutally honest with himself and nonavoidant of the work he needed to do. He made the decision to leave the relationship with Rick after Rick repeatedly refused to acknowledge that his alcohol use impacted Tim and the relationship negatively. He sought and found a new job. He found a workout partner and returned to the gym on a regular basis. He did a

thorough life review, and decided that in five years he wanted to sell his house and move back to Montana to spend time in the company of his aging parents. The resolution of his depression is a study in courage and perseverance, an example of the passion and devotion that can be found within the depressive imagination.

Learnings

Tim's struggle reminded me how depression and relationship stress are linked at times. Tim and I worked on understanding his codependency issues as they appeared in his relationship with Rick, and upon further exploration, with other people in his life as well. Codependency can be seen as the shadow side of being a caretaker, a strong aspect of Tim's personality style. Tim's personal learning, explored in detail in Chapter 4 of the Clinical Case Study, was how his caretaking style contributed to his depressed state.

Tim's struggle with codependency and Rick's alcohol use resonated deeply with my own personal history of having had an alcoholic stepfather. I knew from my own experience how difficult it could be to love someone deeply, and have to consistently define personal boundaries. My work as a therapist taps deeply into the caretaker role, and I was presented with an opportunity to model for Tim how it is possible to balance caring with personal and clearly defined limits.

Edward Whitmont notes that Jung strongly believed that an analyst could not help a client come to an understanding of the soul's experience they themselves had never experienced.³⁴ My own personal history of depression was an important element in my work with Tim, allowing me to be present to his suffering and attentive to his depression

experience. I came to appreciate how my own depressive wounding could be used in the care of others.

Personal and Professional Challenges

A personal challenge I encountered while writing the case study is that the topic of depression is a very personal one for me, and at moments I found myself deep within the landscape. During the literature review for example, when I was reading Robert Karen's book *Becoming Attached*, I came across his description of the Mary Ainsworth stranger experiment with young children. In this now famous experiment, mothers and toddlers were separated and reunited while being observed, to assess the strength of the mother-child bond.

Karen describes the anxiety and distress of some of the toddlers during the experiment when they were separated from their mothers, the description indicating the panic of loss. I found myself silently weeping at this image and had to take a moment to compose myself before I could proceed. The description reminded me of my own loss of my family of origin through the divorce of my parents at age five. It is this very personal connection to depression that almost stopped me from choosing this topic. I eventually concluded that I would find a different kind of healing for myself by engaging the topic directly.

My professional challenge during the writing of the Clinical Case Study as well as the entire doctoral process has been coming to terms with who I am as a future psychologist. I became engaged with psychology as a discipline in 1979 when I had to

choose my undergraduate major. I chose psychology as my major and philosophy as my minor areas of study.

My first job out of college was as a mental health worker in an inpatient psychiatric hospital. I did this job for three years. It was here that I first came into contact with the depth of human suffering known as mental illness. And here, at the beginning of my work within psychology, I struggled to accept the medical modeling of mental illness, a struggle that remains with me to this today.

The ongoing professional challenge for me is one of professional identity and how it merges with personal identity. During coursework at the Institute of Imaginal Studies, I learned that the word *psychologist*, the practice of psychology, and reference to the use of psychological methods, are protected in California. That is, legal regulations of the State of California regarding the term, psychologist, stipulate that only state-licensed psychologists or academics within departments of psychology can use the word, psychologist, to describe themselves and only state-licensed psychologists may employ the implied practices conveyed by this term.

It is thus imperative for me to let the reader know that in this Clinical Case Study, when I refer to myself as a “psychologist,” I use this term to mean that at the deepest soul level I have been a “psychologist” ever since I read Jung’s works at the age of 18, and discovered an inner universe populated by images. Hillman notes that etymologically, psychology derives from the Greek word for soul, *psyche*.³⁵ As a “psychologist,” I believe that soul and image are the primary concerns for psychology. Professionally, it has been difficult for me to integrate the medical model of mental illness with the theoretical framework of a psychology based on soul.

Depression as medical disorder dominates the way that depression is thought about in the field of psychology. I have come to the understanding that within the discipline of psychology, while all clinicians are psychologists, not all psychologists are clinicians. I have concluded that I am a psychotherapist and a future psychologist, and I hold the medical modeling of human suffering lightly and with intention. Eric Wilson summarizes my personal attitude when I attend to depression, my own as well as my clients', in this way: "Melancholia is the profane ground out of which springs the sacred."³⁶

CHAPTER 2

LITERATURE REVIEW

Introduction and Overview

Freud's essay on mourning and melancholia highlights that psychology, for a long time, has been challenged to explain the etiology of depression.¹ Depression is a common presentation of clients, is often recurrent, and can be disabling for some individuals. The goal has been to alleviate as quickly and as thoroughly as possible the extreme suffering that depression initiates within any given person. This urgency to formulate a cure may come about because depression has an impact on all those within the environment of the person who is depressed, their intimates as well as strangers.

Depression is evocative, meaning to call forth, to lay a claim to, in the etymological meaning of that word that is given in the Merriam-Webster Dictionary.² As will be seen in the review of the literature, rarely is the response to depression indifference. The response to depression – the theories of causation – inform interventions which ultimately impact the *patient*, which is both a person, a noun, and an adjective meaning the ability to show forbearance under stress. Ethical consideration suggests that theories of causation of depression can never be benign.

Mary Ann Beall documents the personal impact of causality assertions: "In the consumer community those of us who are middle-aged or older are survivors of what I've come to call the Etiology Wars."³ A way to honor Beall's suffering is to acknowledge

that how the etiology of depression is framed has direct consequences to the recipient of mental health services. David Healy observes: “As applied to beliefs about the nature and treatments of mental illness, ideologies can be distinguished by their judgments of what ought to be regardless of what actually exists.”⁴ This can be a caution that any working theory of depression can become an ideology used to defend a vested interest at a direct cost to the client.

Theories and ideologies are influenced by the relative position of the observer to the observed phenomenon so that truth may be found in all observations. A way to hold theory lightly throughout the Literature Review is best illustrated by an anonymous joke. An individual is walking along a path until they reach the bank of a wide river. They look left and they look right but there is no means of getting across the river. Finally, they spot a person on the other side. They yell to that person, “How do I get to the other side?” The other person yells back, “You are on the other side!”

The studies and opinions presented in this Literature Review, either quantitative or qualitative, rely on the definition of depression found in the *DSM-III-R*, and later the *DSM-IV*. The more severe forms of depression, MDD and Bipolar Disorder, are the concerns of most studies on depression. MDD is also referred to as Major Depression (MD) or Major Depressive Episode (MDE), as well as Unipolar Depression, to contrast a depression only course. The milder form of depression, Dysthymia, or Dysthymic Disorder, is noted in the literature, but is not the direct focus of much of the research.

The difficulty in reviewing the etiology and treatment of depression within the psychology literature is not lack of information, but limiting the sources in order to engage in an effective examination of the topic. For purposes of this Clinical Case Study,

the Literature Review will be limited to five broad perspectives on the understanding and treatment of depression. These perspectives are the biological, the cognitive behavioral, the psychodynamic, the sociocultural, as well as, imaginal approaches to depression.

The Biological Perspective on Depression includes the three research areas of brain physiology, genetic inheritance/influences, and brain chemistry, and how all three may contribute to the etiology of a depressive disorder. Corrective treatment is done through the use of antidepressants and other mood stabilizers. The cognitive behavioral perspective focuses on the thought processes of depression, and cognitive behavioral therapy (CBT) is used to help a person learn about their unrealistic expectations, automatic negative thoughts, and negative core beliefs which some believe determine how one feels. The discipline of psychiatry is the natural home of the biological view of depression, while many present day psychologists have adopted CBT as their primary psychotherapeutic intervention.

The Psychodynamic Perspective of the Literature Review examines the notion that unconscious processes and conflicts, and/or developmental failures, contribute to the experiencing of depression. In psychodynamic psychotherapy, understanding one's unconscious dynamisms is the best guarantee of deep change that leads to the resolution of depression. The sociocultural perspective examines the environmental and social pressures that can lead to depression. Finally, imaginal approaches will be explored that give primacy to the image in the understanding of depression.

I would like to suggest that the biological, the cognitive behavioral, the psychodynamic, and the sociocultural perspectives on depression can be understood to be *lenses* through which depression is imagined. A lens is something that facilitates and

influences perception, comprehension or evaluation. This idea of lenses of perception acknowledges what is clearly shown in the literature on depression: none of these perspectives holds the ultimate truth about depression, and even proponents within each perspective do not agree on what actually is being observed or treated. This suggestion of theory as lenses of perception is not meant to relativize any perspective, but rather to allow for a more flexible holding of theory and observation, so that the truth contained within each perspective can be understood and honored. Omer states that the metaphor of lenses through which the soul imagines its own experience is a core tenet of Imaginal Psychology.⁵

Biological Perspective on Depression

The biological model of depression provides an invitation to imagine the body as a locus of suffering. Psychology, the study of the mind or soul, and psychiatry, the medical treatment of mental illness, have had a long and parallel, at times ambivalent, at times conflicted, relationship. This tension between the two disciplines is reflective of the Western separation of the mind from the body. Freud, Alfred Adler and C.G. Jung were all medical doctors. In common speech, Freud is sometimes said to have asserted that biology is destiny, which is a misquote from his essay “The Dissolution of the Oedipus Complex,” where he wrote, “anatomy is destiny.”⁶ Freud struggled with articulating a psychology that changed over time, but he never totally abandoned the biological drive theory with which he began his psychological theorizing. According to Jay Greenberg and Stephen Mitchell, Freud hoped that “. . . his hypothesized psychic structures would someday be confirmed by anatomical findings.”⁷

Medical technology in the form of *neuroimaging* has allowed detailed research on the activity of the brain and its functions.⁸ According to John Preston, John O’Neal, and Mary Talaga, better understanding of brain chemistry, the acceptance that mental illness appears to have a genetic basis, and more effective drug therapies began to revolutionize the biochemical treatment of depression in the 1960s.⁹ A *Time* article by David Bjerklie et al. cites a study at UCLA, which has shown that beginning in 1988 with the introduction of selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants, the suicide rate in the United States has fallen. Investigators in the research estimate that “. . . nearly 34,000 lives have been saved.”¹⁰

It is ironic that 100 years after Freud moved away from a totally biological basis of psychological suffering, the finding that depression has a biological component has shifted the nature versus nurture debate back towards biological determinism. The effectiveness of one simple intervention – the use of an antidepressant – has contributed greatly to the medicalization of depression. J. P. Docherty estimates that 50 percent of all depressive episodes are treated in a primary medical care setting and that the tendency for depressed patients to present with somatic complaints may mask the underlying affective disorder, implying that depression is often under diagnosed.¹¹

M. Olfson et al. in a comparison study concluded that between 1987 and 1997 there was an increase in the numbers of persons treated for depression in an outpatient setting.¹² The authors note that antidepressant treatment went up during this time while psychotherapy declined. The medicalization of depression is supported by the conclusion in the study that more patients were treated by their family physician during this time, coinciding with increased insurance payments for antidepressant medications. The

authors state: “These changes coincided with the advent of better-tolerated antidepressants, increased penetration of managed care, and the development of rapid and efficient procedures for diagnosing depression in clinical practice.”¹³

There are strong proponents within the biological perspective on depression that depression is essentially a biological dysfunction. This assertion will be explored in this section of the Literature Review. First, the genetic evidence for heritability of depression will be presented. Second, there will be a brief mention about the structural abnormalities of the brain that are believed to correlate with depression. Third, based on the observation that antidepressants and other drugs can alleviate the symptoms of depression for some individuals, the belief that the etiology of depression is due to neurotransmitter and neuronal failures in the brain will be discussed. Fourth, there will be a broader look at how the medicalization of depression has impacted treatment and care of those who are depressed.

Charles Kaufman, Janet E. Johnson, and Herbert Pardes explain the three genetic paradigms as they have developed over time.¹⁴ They explain that the early Greeks believed traits were inherited and blended through the blood and it was the Greeks who suggested that disease was the result of the four bodily humors. Kaufman, Johnson, and Pardes call this paradigm of heritability the continual paradigm since attributes, both good and bad, are passed directly from one generation to the next. They note that beginning with the experiments on heredity by Gregor Mendel in 1865, the monogenic theory postulates a one gene-one characteristic correlation to heritability of traits. The dialectical paradigm, the authors propose, is the emerging paradigm for genetics. They write: “No longer do monogenic theories of etiology suffice to explain the complex

interplay of multiple genetic and environmental risk factors. Moreover, genes do not simply cause disease: *they confer susceptibility* [emphasis mine].”¹⁵

Family genetic studies have been used extensively in trying to tease apart both genetic and environmental influences in relationship to heritability of mental illness. Ming Tsuang and Stephen Faraone explain that the two main types of studies have been twin studies and adoption studies.¹⁶ Twin studies are valuable, because identical, or monozygotic, twins share 100 percent of their genetic make up. Fraternal, or dizygotic, twins share 50 percent of their genetic make up. The assumption would be that genetic heritability of a mood disorder could be demonstrated if there was a high concordance rate between identical twins, meaning that both twins develop a mood disorder sometime in their life.¹⁷

In 1991, Peter McGuffin, Randy Katz, and Joan Rutherford studied twin pairs where one or more hospitalizations for depression were documented.¹⁸ They concluded that the concordance rate between identical twins was 68 per cent, while the concordance rate for fraternal twins was 43 percent. A variety of definitions of depression were applied to the twin pairs, all of which resulted in markedly higher rates of disorder than are found in the general population. Model fitting assigned 51 percent of the variance on genetic factors and 31 percent to common environment.

A research study with large sample size, conducted by Kenneth Kendler and Carol Prescott that addresses the issues of both genetic inheritance and environmental contributions to Major Depression is the Virginia Adult Twin Study of Psychiatric and Substance Use Disorders, or VATSPSUD.¹⁹ This study is comprised of several smaller

studies spanning the years between 1987 and 1998. The researchers note that one main flaw of the study is the absence of twins from ethnic minority backgrounds.

In the Virginia Adult Twin Study, Kendler and Prescott found that Major Depression as defined by the *DSM-III-R* was a very common disorder in the study, with 34.4 percent of women and 28.5 percent of men experiencing Major Depression during their lifetimes.²⁰ Consistent with earlier family studies, the VATSPSUD results showed a strong evidence of resemblance for Major Depression within twin pairs, with consistency greater among identical twins than with fraternal twins. Resemblance among females was higher than for males. The authors also concluded that based on the statistical analysis, “Contrary to expectations of some major segments of the mental health community, twin studies have found that for mood and anxiety disorders, the effects of shared environment are quite modest.”²¹

Tsuang and Farone present other evidence of genetic heritability of mood disorders. Adopted children whose biological mothers had a mood disorder were more likely themselves to develop depression.²² Conversely, there appears to be greater psychiatric illness among biological parents of bipolar adoptees than among their adoptive parents. Tsuang and Farone conclude:

The risk for mood disorders increases with the proportion of genes shared with a mood-disordered patient. The risk to relatives is higher than the risk to the general population. . . . Thus family data unequivocally indicate that mood disorders are familial, i.e., they run in families.²³

As noted by Donald Klein and Paul Wender, one aspect of genetics and biology that is important to mention is the repeated statistic that depression is twice as common in women as in men.²⁴ The VATSPSUD study showed that as defined by *DSM-III-R*, depression appeared in 34.4 percent of women and 28.5 percent of men. This is not a

statistically significant finding of difference and clearly does not support the conventional wisdom. However, Kendler and Prescott after parsing their findings, as well as reviewing other genetic studies on twins, concluded that genetic risk factors were more significant for depression in women than in men.²⁵ They point out that there are genes that are expressed in women but not in men. There are hormonal differences that impact women during early development as well as the hormonal effects of the menstrual cycle and pregnancy. Postpartum depression appears to be linked to genetics in women. Over and above this, the interaction with the environment of the developing child, as well as the adult, that is, the fact that boys and girls are treated differently and are exposed to different stressors, may evoke certain genetic predispositions to depression in women.²⁶

Genetic theories of causation in regards to mental illness have some distinct limitations. Peter McGuffin and Anne Farmer found one limitation is that of the definition of a mental disorder and what exactly are the measurable thresholds that indicate a disorder is present in any given individual.²⁷ Kathleen Merikangas warns that while the one gene–one disorder idea is tempting to believe, she concludes: “There is substantial evidence that a lack of one-to-one correspondence between the genotype and phenotype exists for most of the major mental disorders.”²⁸ The *phenotype* is the observable aspect of gene expression, in this case a psychiatric disorder, and the *genotype* is the actual genetic composition of the individual.²⁹ Laura Lee Hall makes one more point about psychiatric genetics: “The genetic contribution to these conditions is complex and incompletely understood. Certainly, there are no genetic tests for mental disorders. Even what is inherited is unclear.”³⁰

Genetic expression is believed to play a role in the second biological aspect of depression presented in the literature, that of brain structural abnormalities. These studies use neuroimaging, lesion analysis, and postmortem dissection to examine brain cell structures and volume. While the science involved is too extensive to include in such a brief review of the literature, Wayne Drevets summarizes the belief that mood disorders may be caused by abnormalities in the volume of cells in certain parts of the brain, particular types of cells lost within certain brain regions, and the abnormal binding of neurotransmitters at specific neurotransmitter sites within the brain neurons.³¹ Drevets notes however that causation is difficult to establish, since mood disorders are not associated with any gross brain pathology. Brain abnormalities may be the result of recurrent depressive illness, or they may be developmental abnormalities that lead to a mood disorder, leaving us with what came first, the chicken or the egg, dilemma.³²

The third biological contribution to the etiology of depression is better understanding of neurons and neurotransmitters. Preston, O'Neal and Talaga explain that a neuron, or nerve cell, is a long fiber-like impulse-conducting cell found throughout the body, and in great numbers in the brain and spinal column.³³ The sole purpose of neurons is to communicate with each other and with other cells. For example, impulses travel from the brain to a muscle group via neurons, and a person's arm moves.

A neuron consists of a nucleus, appendages called dendrites that extend outwards from the cell on the one end, and a long fiber known as the axon moving away from the nucleus on the other end. The dendrites of one nerve cell grow close to the axon of another nerve cell but never touch. The small gap in between one cell's dendrite and another cell's axon is known as the synapse.³⁴

Nerve cells communicate with each other by releasing chemicals known as neurotransmitters into the gap, or synapse, between cells.³⁵ These chemicals travel across the synapse and when they come in contact with another nerve cell stimulate that nerve cell. The stimulating neuron then reabsorbs any chemical that is not used in the communication process. Klein and Wender state the belief that three neurotransmitters and their dysfunction are important in the etiology of depression: norepinephrine, dopamine, and serotonin.³⁶

Antidepressants – synthetic chemicals introduced into the body – are thought to repair, or at least compensate for, neurotransmitter malfunction.³⁷ F. Scott Kraly writes that depending on the perceived mode of action, antidepressants are classified into several groups. The Tricyclics, the Monoamine Oxidase Inhibitors (MAOIs), and the Atypical antidepressants regulate (increase) norepinephrine (and sometimes serotonin) availability at the synapse, while SSRIs (selective serotonin reuptake inhibitors) regulate serotonin availability at the synapse.³⁸ The SSRIs in particular, have created a revolution in the way depression is treated.

The first SSRI made available to the American public for treatment of depression was Prozac, or fluoxetine hydrochloride.³⁹ The drug became available in 1987. Prozac was one of the first antidepressant drugs referred to as a designer drug, meaning that it was created with a goal of altering neurochemical activity in a very specific way. Today there are a total of six SSRIs available to treat depression.⁴⁰ Each drug has a different molecular structure, so that one SSRI may work better than another in individual cases of treatment. One of Prozac's attractive features when it first became available was the fact that most persons only needed to take one tablet of 20 milligrams daily. Prozac was

deemed effective, easy to take, and had tolerable side effects when compared to other known classes of antidepressants of the time.

Peter Kramer in his book *Listening to Prozac* was one of the first vocal advocates for the use of Prozac in the treatment of depression. The expression that became synonymous with Prozac's effect, "better than well," appears in this book as a statement made by one of the first patients that Kramer treated for depression using Prozac.⁴¹ In his book, outlined in many chapters, Kramer makes a case for a grouping of symptoms, maybe even personality traits, which appear to respond well to Prozac, and subsequently, other SSRI's. These symptoms/personality traits are: compulsivity and compulsive behavior; sensitivity to relational pressures, especially rejection and interpersonal conflict; stress vulnerability; risk aversion; low self-esteem; and thought and memory inhibition.⁴²

Kramer makes the claim that Prozac can accomplish what traditionally was done within the realm of psychotherapy, which is, to alter a particular element of personality such as rejection-sensitivity. He writes:

The problem is not that the medicine fails to confer affect tolerance or fails to move people towards an adaptive interaction with reality, but, rather, that it succeeds. In doing just what psychotherapy aims to do, Prozac performs chemically what has heretofore been an intimate interpersonal function.⁴³

Given Peter Kramer's assertion, and the reality that antidepressants are routinely prescribed, it is important to review what is known about antidepressants, in particular the SSRIs. A good place to start is the study of antidepressant medications for treating depression called the Sequenced Treatment Alternatives to Relieve Depression, or STAR*D. This clinical trial encompassed six years and cost the National Institute of Mental Health \$35 million. There were four steps, or phases, to the study with the last

summary published in September of 2006. Participants selected for the study were individuals who sought treatment for depression in 23 psychiatric and 18 primary care outpatient settings. The participants were screened for moderate to severe Major Depression. There was no control or placebo arm. The participant population was not randomized, meaning that participants self-selected by initially choosing to seek treatment.

The report of the results on the first phase of STAR*D was published in January 2006 by Madhukar Trivedi et al.⁴⁴ The total number of individuals who were enrolled in the study was 2,876 participants. During phase one, all participants were prescribed citalopram, brand name Celexa, an SSRI antidepressant. Individuals were treated for 12 to 14 weeks, longer than the 8 weeks of treatment used to establish efficacy by the manufacturer of Celexa. The end goal that determined treatment success was remission of depressive symptoms. This end goal was reached by 27.5 percent of all participants. Celexa was less effective if the person was unemployed, of lower income, non-Caucasian, male, less educated, poor functioning and with lower quality of life at baseline.

This low success rate in remission of depression for an SSRI is not a new finding to STAR*D. A different study, one that can be used to compare the STAR*D phase one results to, was reported in April of 2002.⁴⁵ This study compared St. John's Wort, sertraline (Zoloft), an SSRI, and a placebo in a double blind randomized placebo-controlled trial (RCT). The participants for this trial were diagnosed as having Major Depression. One of the same instruments that was used in the STAR*D study, the

Hamilton Scale of Depression, was used in this trial to determine remission of depressive symptoms.

The results of this study were as follows: full response occurred in 31.9 percent of the placebo-treated patients versus 23.9 percent of the St. John's Wort-treated patients and 24.8 percent of sertraline-treated patients.⁴⁶ In this study, sertraline treated patients' remission rate of depressive symptoms at 24.8 percent is close to the Celexa remission rate in the first phase of STAR*D noted above at 27.5 percent.

Examining the placebo effect a bit more closely, B. Timothy Walsh et al. reviewed placebo control groups in studies of medication treatment for depression. In this study, the authors searched MEDLINE/PsychLit for all controlled trials published in English, from January 1981 to December 2000, in which adult outpatients with major depressive disorder were randomly assigned to receive medication or placebo. There were 75 trials that met the criteria for inclusion.⁴⁷

The mean proportion of patients in the placebo groups who got better without treatment was 29.7 percent.⁴⁸ Most studies examined had more than a single active medication, and, in the active medication group with the greatest response, the mean proportion of patients responding to antidepressant treatment was 50.1 percent, or about half of the participants. In this review of studies, there is a mean proportion of about 20 percent greater efficacy for the medication response over placebo effect regardless of antidepressant used in the 75 studies.⁴⁹

Healy suggests a way to understand the placebo effect.⁵⁰ Healy refers to specific and nonspecific factors in the resolution of depression. Specific factors are those things that can be analyzed in the treatment of depression, such as the dosage of a particular

drug or length of treatment. Nonspecific factors may be the way a physician interacts with a patient, or perhaps, the fact that in a study the personal interactions have therapeutic effect. It is worth quoting Healy at length, in his own words, about his opinion of the placebo effect:

The crucial point to realize is that the placebo phenomenon is not something left over after the effects of specific treatments have been accounted for, nor is it some throwback to older humoral models of disease – although clearly the phenomenon has a lot to do with the why of a disease rather than the how.⁵¹

Klein and Wender distinguish between depression as a normal human emotion in response to a loss, disappointment or failure and *biological depression*, a disease that may require lifelong treatment.⁵² Since diagnosing depression can be difficult, they advise that medical doctors who know the difference between a psychological and a biological depression should make the diagnosis of depression. From their perspective, the optimum treatment involves the use of medications. The prescription of antidepressant medication should always be the first step in treatment, relegating psychotherapy to be used after relief of symptoms from medication, “. . . to alleviate many of the residual psychological symptoms.”⁵³

Kramer’s rhetoric in his latest book, *Against Depression*, is paradigmatic of the passion and logic behind the medicalization of depression. Kramer compares depression to other diseases like cancer, diabetes, epilepsy, and tuberculosis.⁵⁴ He notes that the general population is not ambivalent when it comes to aggressively treating these diseases, and eradicating them is not resisted. He sees ambivalence when it comes to treating and eradicating depression, especially from professionals. He writes: “But alternative views of depression, the ones I have called romantic, are so ordinary a part of our assumptions that they persist even in the face of decades of work with patients.”⁵⁵

The biological treatment of depression, while a clear benefit to individuals who suffer depression, has created an over dependency on treating the symptom as opposed to the whole person. In a landmark study by the National Council on Disability published in September 2002, the authors wrote: “Systems also must commit to serving the whole person, and not merely the most obvious symptoms. In other words, mental health systems will have to develop the expertise to deliver not just medication and counseling, but housing, transportation and employment supports as well.”⁵⁶ The report cites that often in the community setting, individuals with a mental illness may see a provider every two months and are sent home with a supply of medications and nothing else.⁵⁷

In summary, the biological perspective on depression has many modern day champions. It becomes clear in reviewing the depression literature on the biological perspective that there is an animated discourse within the discipline of psychology around this central question: to what degree is depression a biological state, inclusive of genetic heritability, and how much of depression is a state of the soul independent of biological determinism? On the one end of the continuum, championed by Kramer, depression is a result of abnormal brain chemistry and physiology and should be aggressively treated.⁵⁸ On the other end is the opinion, held by Hall, that mental disorders are multifactorial conditions.⁵⁹ This spectrum of opinion is evident within the overall context of the biological evidence suggesting that depression has a body component. The placebo effect may suggest that there are still many unanswered questions regarding the biological etiology of depression, as well as, the treatments used that are based on assumptions of biological process.

Cognitive/Behavioral Perspective on Depression

It seems reasonable to assume that any treatment for depression that is not medication based, or somatic based, and that utilizes verbal exchanges between client and practitioner would of necessity contain a cognitive element. For the moment, *cognitive* can be defined as any verbalization of thoughts, and thoughts imply mind or mental events.⁶⁰ The cognitive behavioral perspective focuses on the thought processes of depression. Cognitive behavior therapy (CBT) is used to help a person learn about their unrealistic expectations, automatic negative thoughts, and negative core beliefs. At a deeper level of cognitive process, CBT is used to help a person alter cognitive structures known as *schemas*. A schema is a cognitive map that determines what is noticed and how it is interpreted.

Two men who have contributed to the development of *cognitive behavioral therapy* are Aaron Beck and Albert Ellis.⁶¹ Beck called his therapy *cognitive therapy*, although as will be explained, Beck and his followers employ behavioral techniques. For the moment, Beck's preference of calling his theorizing cognitive therapy will be used.

Beck expresses what he sees as the basic assumption underlying neuropsychiatry, psychoanalysis, and behaviorism as follows: "The emotionally disturbed person is victimized by concealed forces over which he has no control."⁶² To address this assumptive error, Beck suggests that the experimental method is an important element in treating emotional disorders.⁶³ The individual must be able to create and test hypotheses regarding their perceptions of reality. Beck writes: ". . . the patient needs to be capable of testing hypotheses before accepting them as valid."⁶⁴

Beck makes the case in favor of viewing depression as a thought disorder in his early book *Depression: Causes and Treatment*.⁶⁵ This work focuses on what he terms *cognitions*, specific verbalized thoughts such as an interpretation, or a self-critical statement. These cognitions, or automatic negative thoughts, distort reality and the therapist's role is to help the client realize that preceding an inner experience of affect, a certain kind of thought occurs.⁶⁶

Here is Beck's description of cognitive therapy:

This new approach-cognitive therapy-suggests that the individual's problems are derived largely from certain distortions of reality based on erroneous premises and assumptions. These incorrect conceptions originated in defective learning during the person's cognitive development. Regardless of their origin, it is relatively simple to state the formula for treatment: The therapist helps a patient to unravel his distortions in thinking and to learn alternative, more realistic ways to formulate his experiences.⁶⁷

Albert Ellis developed his own variation of cognitive behavioral therapy, which he called *Rational-Emotive Therapy* (RET). He writes: ". . . rational-emotive therapy assumes that thoughts, feelings, and behaviors are interactional and transactional, and that emotional-behavioral problems mainly (but not exclusively) arise from powerful irrational beliefs."⁶⁸ Where Beck implies one direction of determination – what one thinks determines what one feels, Ellis posits an interactional model, where thoughts, feelings and behaviors influence one another in creating irrational conclusions about oneself, others, and the world.⁶⁹

Ellis acknowledges by example that many, if not most, cognitive therapists today utilize behavioral techniques, hence cognitive *behavioral* therapy. RET utilizes behavioral techniques such as desensitization, reinforcement and penalization methods, response prevention and skills training.⁷⁰ E. Thomas Dowd observes that over the years

Ellis modified his thinking of cognitive therapy from rational therapy (RT) to rational-emotive therapy (RET) to rational-emotive-behavior therapy (REBT).⁷¹

Before continuing with a closer look at Beck's cognitive therapy and how it is applied, it is necessary to note that the pairing of behavioral techniques and cognitive therapy is an ongoing tension among its practitioners. John Cloud in an article for *Time* notes that some fundamental questions about cognitive therapy have yet to be resolved, partly because cognitive therapists also utilize behavioral techniques. Cloud reports that two studies done at the University of Washington have shown that among more severely depressed patients behavioral techniques worked as well as antidepressants and significantly better than cognitive therapy alone.⁷²

A study reported by N. S. Jacobson et al. in 1996 compared various components of cognitive behavioral therapy (CT) to treat depression as developed by Beck et al. in 1979.⁷³ The authors randomly assigned 150 outpatients with major depression to be treated in three different ways: exclusively by behavioral activation (BA); a second treatment arm that included both BA and the teaching of skills to modify automatic thoughts (AT); or a third treatment arm that included BA, AT, as well as components of cognitive therapy that focused on core schema change. The authors report that despite excellent adherence to treatment protocols by the therapists, a clear bias favoring CT, and the competent performance of CT, there was no evidence that the complete treatment produced better outcomes (at either the termination of acute treatment or the 6-month follow-up) than either BA, or BA and AT treatment.⁷⁴ Given the treatment arms, one interpretation of this study is that behavioral changes are sufficient to cause positive results in patients with depression devoid of any cognitive interventions.

It is worth noting that Jacobson et al. use the term cognitive behavior therapy, but the acronym they use is CT (cognitive therapy). Beck in his writings consistently calls his therapy cognitive therapy, yet it is pretty much assumed that behavioral interventions are a part of Beck's use of the term cognitive therapy as stated in an article by Jacqueline Persons, Joan Davidson, and Michael Tompkins.⁷⁵ In the literature, cognitive therapy (CT) and cognitive behavior therapy (CBT) are used interchangeably and often mean the same thing. Beck and his followers use the term CT while other cognitivists use CBT. From this point onwards, for purposes of this case study, CT and CBT will be used interchangeably depending on the use of the author quoted, with the assumption that behavioral techniques are a given.

Returning to Beck, it is important to give Beck credit for understanding that depression, especially severe or chronic depression is a complex and sometimes intractable suffering. His theorizing on depression has changed from his initial work in 1967, *Depression: Causes and Treatment*. A short essay from 2002 titled "Cognitive Models of Depression," is more sophisticated than his 1967 seminal work. In this essay he lists six models that incorporate known findings of depression research up to the time of the essay.⁷⁶ Beck's consistent belief in all his writings is that negative cognitions are the tinder that eventually ignites the constellation of depression. He calls this the primacy hypothesis and defines it this way: "The *primacy* hypothesis suggests that if the cognitive or information processing is biased in some way, there is going to be a corresponding modification in the affective responses and in the individual's behavior."⁷⁷

Persons, Davidson, and Tompkins give the overview of Beck's cognitive therapy as the following: behavioral interventions are introduced first, as a way to counter the

depressive's negative cognitions about themselves (e.g. "I can't do anything"). Once the rationale against automatic negative thoughts is empirically challenged by behavioral interventions, *schema* change interventions are introduced towards the end of the treatment.⁷⁸

Cognitive therapists define schema in various but consistent ways. E. Thomas Dowd and Karen Courchaine give a description of mental or mind activity from the general to the more specific as summarized.⁷⁹ Mental or mind activity can be conceptualized as moving from cognitive events, to cognitive processes, to cognitive structures or schemas. Cognitive events can be thoughts, internal dialogue, belief systems, and even imagery. Cognitive processes are mind activities that shape, guide and process mental representations. Cognitive structures or schemata, a variant word for schema, according to Dowd and Courchaine, "...can be thought of as an organized system of tacit rules or assumptions that are the result of repeated cognitive processing over time that in turn supports further cognitive processing."⁸⁰

In a separate essay, Dowd notes that an individual cannot pay attention to everything that is happening around them. A schema is a cognitive map that determines what is noticed and what is not, allowing an individual to categorize and interpret experience meaningfully.⁸¹ Worded differently, a schema is both content (past experience) and process, acting as a filter that allows only a certain kind of parallel experience to be allowed into consciousness. A schema is both what is seen, and how one sees it. Dowd explains the schema as follows:

Because of this self-reflective nature, wherein schemas are both caused by interpretation of experiences and in turn determine the interpretation of subsequent experiences, they are very resistant to alternative constructions of reality and tend to be self-perpetuating.⁸²

Cognitive therapy as practiced has shifted from conscious thoughts to an increasing focus on underlying cognitive schemata that operate at an unconscious level, according to Dowd and Courchaine.⁸³

For chronically depressed individuals brief psychotherapy as used by cognitive therapists is not effective according to Richard Moore and Anne Garland, and at least 16-18 sessions or more may be needed.⁸⁴ They note that as regards other acute disorders, acquiring clinical experience helps clinicians focus on a few factors that can be used in addressing the patient's problems. Chronic depression appears to be just the opposite. The authors write that clinicians:

. . . become more and more aware of an increasing number of factors. . . these include not only intrapersonal, cognitive, behavioural and emotional factors, but also interpersonal, relational, environmental, biological, historical and cultural factors. If this impression is correct, we will have to accept that no single approach to the treatment of persistent depression is likely to be universally successful.⁸⁵

Nevertheless, Moore and Garland note that acute major depression has been shown to respond to structured therapies including cognitive therapy; that compared to medication alone cognitive therapy helps individuals maintain improvements at end of treatment; and that maintenance use of cognitive therapy after acute treatment helps reduce the risk of recurrence of depression.⁸⁶ Persons, Davidson, and Tompkins simply state: "Numerous RCTs of CT for depression show that it is more effective than no treatment and as effective as antidepressant medication."⁸⁷

Dowd notes in the general that cognitive psychotherapy is more effective than no treatment, but it has not consistently been shown to be more effective than a variety of other treatments, and when it comes to depression, equivocal comparative results have

been found.⁸⁸ Persons, Davidson, and Tompkins write that whether CT is equally efficacious in treating severe as opposed to mild depression is a disagreement within the CT community.⁸⁹ They also note that when it comes to low-income, minority, and medically ill patients the outcomes using CT are worse than for other subjects in random controlled trials.⁹⁰

Some clinicians have taken the aspect of CT that seems to work best – structured therapeutics – and have elaborated their own treatment strategies in response to client need. Neil Jacobsen and Andrew Christensen came to the conclusion, separately, that work with couples using CBT improved when attention to affect was included in the therapy process.⁹¹ Marsha Linehan in 1991 performed a clinical trial working with Borderline Personality Disorder clients with the goal of decreasing the incidence of self-injurious behaviors by these clients. She writes: “. . . the therapist actively teaches and reinforces adaptive behaviors, especially as they occur within the therapeutic relationship . . . the emphasis is on teaching patients how to manage emotional trauma rather than reducing or taking them out of crises . . .”⁹² Linehan named her approach Dialectical Behavioral Therapy (DBT).

Since 1991, DBT has been expanded to treat other populations other than Borderline Personality Disorder clients. T. R. Lynch et al. performed a small pilot study with age 60 and older adults whose depression did not respond to treatment with antidepressants or psychotherapy.⁹³ Although a small number of subjects, 34, were part of the study, their results indicated that the group with medication and DBT showed significant improvement over just medication treatment of depression alone.

James McCullough has developed a cognitive based psychotherapy for persons with chronic depression using what he calls disciplined personal involvement. The title of his approach is long: the Cognitive Behavioral Analysis System of Psychotherapy (CBASP). McCullough summarizes this therapeutic approach: “The core of CBASP involves teaching patients an approach to social problem-solving that provides them with concrete skills to address the seemingly overwhelming interpersonal problems in their lives.”⁹⁴ J. D. Teasdale et al. performed the first RCT study using mindfulness to treat recently recovered depressed patients in order to decrease relapse in the future.⁹⁵ They refer to their approach as mindfulness-based cognitive therapy (MBCT). Patients were trained in MBCT in a group setting. The authors describe their approach as follows:

Unlike CBT, there is little emphasis in MBCT on changing the content of thoughts; rather, the emphasis is on changing awareness of and relationship to thoughts. Aspects of CBT included in MBCT are primarily those designed to facilitate ‘decentered’ views, such as ‘Thoughts are not facts’ and ‘I am not my thoughts.’ The focus of MBCT is to teach individuals to become more aware of thoughts and feelings and to relate to them in a wider, decentered perspective as ‘mental events’ rather than as aspects of the self or as necessarily accurate reflections of reality.⁹⁶

Study results of the 145 randomized patients in the study demonstrated that relapse/recurrence to major depression over a 60-week study period was significantly reduced for patients with 3 or more previous episodes of depression (77% of the sample).

In summary, cognitive behavioral therapy focuses on the thought processes and content of the depressed individual. Behavioral techniques became embedded into cognitive therapy early on in its development. Beck and others claim that CT has been shown to consistently improve depression as well as or better than antidepressant use, or no intervention at all. However, when the literature is examined more closely, CT in the treatment of depression shows equivocal results depending on the study.

While CT has been practiced for 40 years, CT has been amended and redesigned due to its apparent limitations in practice. Dowd lists some of these amendments and changes to CT within the last 25 years. These include the addition of hypnotherapy, narrative (as an offshoot of the constructivist paradigm), the use of imagery, and the acceptance of the unconscious aspects of schema.⁹⁷ This last notion, that schema maintain their influence due to their unconscious nature, comes close to the idea of the unconscious found within depth psychology, but Dowd and Courchaine are quick to point out, "...without the elaborate explanatory structure and metaphorical constructs characteristic of psychoanalytic thought."⁹⁸ All of these augmentations and appended qualifiers to CT, including the belief that schemas operate at an unconscious level, reintroduce to CT some of the earliest observations and practices of the depth psychologists.

Psychodynamic Perspective on Depression

Psychodynamic psychotherapy finds its theoretical roots in depth psychology.⁹⁹ Jung named his depth psychology analytical psychology to distinguish it from Freud's psychoanalysis.¹⁰⁰ Hillman named his theories archetypal psychology to distinguish it from Jung's analytical psychology.¹⁰¹ There are post-Freudians, neo-Freudians and post-Jungian theorists to designate these men and women and situate them within the history of depth psychology. Regardless of the development, the principal idea of depth psychology is the idea of an unconscious and/or a multiple construction of the mind/psyche/self/soul. According to Omer, the interplay between these multiplicities

within the soul, conscious and unconscious, and the soul and its environment, is the source of conflict and suffering.¹⁰²

The literature available on psychoanalysis alone would take this narrative far a field. It becomes necessary to limit the sources within the depth psychology literature on depression to pertinent theorists. This section will focus on Klein's development of the *depressive position*.¹⁰³ There are many object relations theories within the psychoanalytic literature, and we can borrow from some of these authors as well to better understand Klein's theorizing on the depressive position. Thomas Ogden offers an evaluation of Klein's idea of positions, and his ideas will be explored and integrated in this section. Finally, an integration of Klein's theory and Ogden's observations will be used to suggest that the decentering from one's subjective experience constellates the depressive imagination as a way to recenter the subject within its subjective experience.

In order to understand Klein's idea of positions, the current discourse moves in an important direction, that of object relations theory. It is necessary to begin with Freud and his ideas. According to Greenberg and Mitchell, in Freud's drive theory, a biological drive seeks to express itself externally and must therefore find an object that allows the biological drive expression.¹⁰⁴ The object is both a thing and a goal or target of the drive.¹⁰⁵ In infancy, the object of the drive is not given or innate, the object must be either discovered or created from interaction with the environment.¹⁰⁶ At first, it is *part-objects* that are discovered and created, such as the mother's breast. Later, as the instinct differentiates, so does the object, so that eventually the infant discovers *whole-objects*, such as the experience of mother as a whole person.

Greenberg and Mitchell write: “For Freud, as for most psychoanalytic theorists, the benchmark of successful development is the ability to establish consistent relationships with a whole object.”¹⁰⁷ These *object relations* are internalized as mental representations and become the primal units that constitute the soul. Freud discovered early on in his work with patients that people react to and interact with both an external other and an internal other, “. . . a psychic representation of a person which in itself has the power to influence both the individual’s affective states and his overt behavior.”¹⁰⁸ Freud referred to these internal psychic representations as fantasy.

Melanie Klein was the first analyst to use Freudian concepts when working with infants and children. She believed that psychoanalytic interventions with children were possible, and proceeded to apply psychoanalytic thought in the treatment of children. According to Harry Guntrip, Klein’s theories, in a subtle way moved psychoanalytic theory in a new direction, that of object relations.¹⁰⁹ Object relations were implied in Freud’s theorizing, but for Freud object relations had a neutral implication. Klein’s writings provide the foundation from which later theorists moved away from the drive/structure premise of personality development, to the relational/structure model of personality development.¹¹⁰ Summarizing Melanie Klein’s contribution to object relations, Greenberg and Mitchell observe: “*Drives, for Klein, are relationships* [emphasis in the original].”¹¹¹

Klein believed that object relations exist from the beginning of life, with the first object being the mother’s breast.¹¹² For Klein, the infant appears to be in an internal state of chaos, unable to differentiate between inner objects, which Klein refers to as fantasy, and outer objects, such as the mother’s breasts. Klein describes the process in this way:

From the beginning the ego introjects objects ‘good’ and ‘bad,’ for both of which its mother’s breast is the prototype – for good objects when the child obtains it and for bad objects when it fails him. But it is because the baby projects its own aggression on to these objects that it feels them to be ‘bad’ and not only in that they frustrate its desires: the child conceives of them as actually dangerous – persecutors who it fears will devour it¹¹³

The infant projects the bad aspects of itself that it cannot integrate, the aggressive impulses, onto external objects that then become bad objects, and these bad objects are then perceived to persecute it. During these first three months of life the infant processes experience through the paranoid position, later called by Klein the paranoid-schizoid position. This position is paranoid because the infant fears it will be destroyed. This position includes the defense of splitting good objects from bad objects, which is the schizoid aspect.

During the second quarter of the infant’s life, between the third and sixth month, the infant struggles to master the paranoid-schizoid position. Klein believed that from the beginning, there is interplay between inner fantasy and outer reality. Klein writes: “From the very beginning of psychic development there is a constant correlation of real objects with those instilled within the ego.”¹¹⁴ The paranoid struggle for the infant parallels its own ego development: since the ego is in “bits” so is the object relations capacity of the infant. The splitting of good from bad objects, the schizoid defense, has the purpose of preserving the good object, and by extension, the infant’s ego. As the infant masters the paranoid-schizoid position, the depressive position is constellated.

There are two developments of note that the infant accomplishes as it integrates the paranoid-schizoid position and moves into the depressive position. In the first accomplishment, the infant begins to relate to its mother as a whole person, not as a part object, and it “. . . becomes identified with her as a whole, real, and loved person.”¹¹⁵

What is disturbing to the infant is the realization that both the good and bad object is in fact one and the same object, the mother. Klein writes: “The synthesis between the loved and hated aspects of the complete object gives rise to feelings of mourning and guilt which imply vital advances in the infant’s emotional and intellectual life.”¹¹⁶

The second feat the infant accomplishes as it integrates the paranoid-schizoid position and moves into the depressive position is the capacity to love. There is a parallel process occurring for the infant between inner fantasies and outer reality. As it perceives the mother as a whole object it is able to perceive of itself as a subject with an inner and outer world. Empathy develops, for now the infant is able to project personhood onto the mother. The infant realizes that the mother is also a person with an inner and outer world and that she can be hurt by the infant’s aggressive impulses. This is where feelings of guilt, mourning, and reparation enter the child’s experience. It mourns its own capacity to harm others, the realization that it may have harmed the mother with its aggressive impulses. This is the depressive position.

Klein felt that the mastering of the depressive position was the most pivotal accomplishment of the child’s development. She writes: “The very experience of depressive feelings in turn has the effect of further integrating the ego, because it makes for an increased understanding of psychic reality and better perception of the external world, as well as for a greater synthesis between inner and outer situations.”¹¹⁷ Klein believed that failure to overcome the infantile depressive position could result in depressive illness, mania, or paranoia in the adult.¹¹⁸

Ogden believes that Klein’s positions neither follow nor precede each other, but each exists with the other in a dialectical relationship. Ogden explains that dialectic is a

process in which opposing elements each create, preserve, and negate each other by standing in a dynamic, ever-changing relationship to each other. Integrations are never fully achieved for new integrations create a new form of opposition, and the dialectical process begins all over again.¹¹⁹ In Ogden's formulation, the dialectical processes of splitting as a result of the paranoid-schizoid position and the integration ability of the depressive position allows for the generation of new psychological possibilities, or psychic change.¹²⁰ The splitting aspect of the paranoid-schizoid position counters the stagnating eventuality of the integrations of the depressive position.

The premise of Ogden's book, *Subjects of Analysis*, is the exploration of where the subject resides within dialectical relationships. He writes: "The Kleinian subject exists not in any given position or hierarchical layering of positions, but in the dialectical tension created *between* positions."¹²¹ This implies that the Kleinian subject is decentered from itself as a result of the dialectical tension of the positions.

Ogden further notes that the tension that Klein describes between outer reality and inner fantasy, the tension within which the ego develops, is itself another dialectical relationship. Ogden elaborates: "The Kleinian subject is decentered from itself in that none of the multiplicity of components of the ego and internal objects is coextensive with the subject."¹²² In other words, the subject is greater than the sum of its parts and exists, decentered, from any identification, across multiple locations united within psychic space.

Klein's formulation of the positions is dependent on the interplay between inner and outer objects, internal fantasy paralleling external reality. In the depressive position, the infant recognizes the mother as wholly other, with the realization that it (the infant)

can hurt the mother. The infant also has the realization that loss of the other is possible, another reason for the mourning associated with the depressive position. Hanna Segal notes that introjection, or the infant's taking into itself the experience of the external other, is intensified during the depressive position.¹²³ Klein never uses the word decentering in her writings. However, Klein implies that for the infant the recognition of the Other during the depressive position is a cause of being decentered from itself, the subject being found between the dialectical tension of self and other, inner fantasy and outer reality, an interpretation articulated by Ogden.¹²⁴

Summarizing Ogden, the Kleinian subject is decentered from itself in three ways. It is decentered from itself within the dialectic of the positions. It is decentered from itself within the dialectic of multiple locations within psychic space. And the subject is decentered from itself within the tension of the relationship between self and other.

Klein felt that a reasonable resolution to the depressive position is necessary in order for the individual to not fall into depressive states. She also wrote that the depressive position is never fully resolved. Ogden maintains that a dialectical process is never resolved, nor should it ever be resolved if psychic stagnation is to be avoided. Ogden suggests that the tension between Klein's positions allows for psychic change. This leads me to propose that the depressive imagination points towards something beyond itself. This something is the greater capacity of the soul for containing complexity and nuance. The depressive imagination engenders the emergence of new capacities within the soul.

Klein's notion that the depressive position is necessary to human development is in sharp contrast to the biological and cognitive behavioral models of depression. Rarely

in that literature is there a suggestion that depression might have any type of redeeming quality essential to the soul. From the biological perspective on depression, Kramer sees little evolutionary benefit in depression.¹²⁵ From the cognitive behavioral modeling of depression, Beck also struggles in finding any evolutionary benefit to depression.¹²⁶ As Kramer concludes - as already noted in the section on biological contributions to depression - this can only imply that depression is a disease, and any beliefs to the contrary can only be romantic, and incorrect, notions.

In summary, I have limited the exploration of the psychodynamic perspective on depression to psychoanalytic object relations theory, in particular Klein and her formulation of the depressive position. This delimiting is necessary due to the complexity and breadth of the depth psychology literature. Klein's implication that the depressive position is the result of the decentering of the subject, and my own observation that the depressive position constellates the depressive imagination, will be further elaborated in the next three chapters of the Clinical Case Study.

Sociocultural Perspective on Depression

Sociocultural circumstances have an impact on the way a person feels about him or herself, contributing to the experience of depression. Specific sociocultural events such as economics, race, gender, and psychology's formulation of what constitutes a mental disorder can all impact an individual's mood state and the treatment that is offered. In this section of the Literature Review there is an emphasis on the relational environmental contribution to depression, as well as other factors impacting mood states.

Human beings develop and remain embedded within a social/relational cultural context, one aspect of environment. Klein's emphasis on the relationship between depression and our social interactions is reflected within the overall literature on depression. Beck notes that precipitating factors in depression may be a loss of a relationship or a loss of autonomy.¹²⁷ He states that there are people who have a sociotropic personality, a personality where relationships are important to self-concept, and when they lose an important relationship they become depressed. In his essay "Mourning and Melancholia," Freud concludes that even when no external loss is in evidence for the depressed patient, careful analysis will show that there is an object upon which, neurotically, the melancholic's condition rests.¹²⁸ John Bowlby's observations of the parental loss suffered by children convinced him that beneath the antisocial behavior of these traumatized children was to be found a profound depression.¹²⁹

VATSPSUD was presented under the biological perspective on depression. Genetic studies cannot be separated from the social and physical environment within which human beings develop. When exploring the genetic results of the VATSPSUD, the authors concluded that their twin modeling did not produce any evidence that shared family environment has a causal relationship to adult psychiatric disorders. Later in the analysis of their findings, they claim modest causal relationship between parenting behaviors and risk for the same disorders. How can there be contradictory findings? The authors note a conceptual and a statistical reason for the discrepancy, but nonetheless are confident of their results.¹³⁰

With this caveat in mind, the VATSPSUD study produced some modest correlation between parental behavior during childhood (the three dimensions studied

were parental Protectiveness, Authoritarianism, and Coldness) and the development of internalizing disorders, notably, depression and anxiety disorders.¹³¹ Worth noting, is the authors' conclusion that strength of association for developing adult disorders of mood is similar for mothers and fathers, with the observation that for girls, poor quality parenting from fathers appears as important as poor parenting from mothers. Two other causal correlations of this study with the development of adult mood disorders include parental loss and a history of child sexual abuse (CSA).¹³² The correlation between child sexual abuse is strong, with the more severe forms of abuse associated with a three to six fold increase in risk of illness. Parental death in childhood stood out in having a specific association with a single disorder, Major Depression. The authors conclude: "...disturbed parenting, loss of a parent in childhood, and CSA appear to be true environmental risk factors for adult psychopathology."¹³³

Two more environmental factors in adulthood were studied in VATSPSUD: stressful life events and lack of global social support. For stressful life events, the authors conclude that a substantial proportion of the association between stressful life events and Major Depression are causal. Low social support appears to be a true risk factor for the development of Major Depression and Generalized Anxiety Disorder. In addition, the authors concluded that high levels of social support do not seem to protect individuals from the "... depressogenic effects of stressful life events."¹³⁴

Other studies within the literature have documented that the social and cultural contexts of individuals have a direct relationship to their mental health. Bonnie Moradi and Cristina Risco have demonstrated that perceived discrimination by Latinos correlates positively with higher rates of depression.¹³⁵ Other factors that can influence depression

may include poverty, rapid social change, gender, religiosity, and feeling loss of control over one's life. Leilani Greening and Laura Stoppelbein discovered that orthodox religious Christian beliefs appear to be a strong psychosocial buffer against suicide in adolescents.¹³⁶

Cultural context can impact an individual from the outside in regards to the care they may receive within the mental health system, how they are diagnosed, and whether certain treatment strategies are effective. A study by Ly Nguyen et al. demonstrated that African American and Hawaiian youth were more likely than their White counterparts to be diagnosed with disruptive behavioral disorders while White youth were more likely to be diagnosed with depression or Dysthymia.¹³⁷ As noted above in the section on the biological treatment of depression as well as the section on cognitive behavioral therapy, sociocultural factors appear to influence the efficacy of treatments. Specifically, Celexa, an SSRI, and CBT treatment, produce poorer results when the individual being treated is poor, a racial/ethnic minority other than White, and have lower education achievement. These kinds of stressors appear to contribute to deeper and longer depressions requiring more intensive interventions.

Horwitz and Wakefield note that some mental health professionals claim that depression can lead to certain outcomes such as drug use, poverty, and dysfunctional relationships. They propose the opposite: these severe kinds of stress events lead to depression. When an individual's life circumstances improve, their depressive symptoms improve.¹³⁸ The authors also take the time to note that what constitutes loss, sadness, and depression can be culturally determined. They give the example that in Zimbabwe, a woman who has not been able to give birth to a male child has a decline in social status,

becomes undesirable as a marriage partner, and may be divorced by her spouse. In another study examined by the authors, due to severe loss events, 30 percent of women in an urban township of Zimbabwe reported symptoms of depression.¹³⁹

Paul Watson and Paul Andrews examine through an evolutionary lens the notion that depression serves an adaptive purpose in human society.¹⁴⁰ They begin their analysis by noting that the prevailing medical view is that depression is maladaptive. The authors then summarize the many studies showing that depression and depressives tend to be sensitively attuned to social relationships, dyadic as well as communal relationships. They note studies that indicate that depressed individuals improve when their social relationships and social standing improve. Based on the research evidence, Watson and Andrews proceed to ask the question: what social benefit does depression serve to the depressive and to those around them? Using the Social Navigation Hypothesis, the two authors conclude:

First, depression induces cognitive changes that focus and enhance capacities for the accurate analysis and solution of key social problems. . . . Second, the costs associated with the anhedonia and psychomotor perturbation of depression can persuade reluctant social partners to provide help or make concessions . . .¹⁴¹

Watson and Andrews, examining the research literature and based on their Social Navigation Hypothesis, suggest that therapeutic interventions should focus directly on the relational issues of the depressed person.

Relational stress and dysfunctional relating can contribute to a mood disorder as noted. Dysfunctional relating is a key concept within the socioculturally influenced codependency movement. The conceptual history of codependency begins with those individuals associated with Alcoholics Anonymous, according to John Steadman Rice in his book *A Disease of One's Own*.¹⁴² Co-alcoholics or para-alcoholics were defined as

spouses and children of alcoholics who developed psychological problems as a result of loving someone with an alcohol addiction. Since these family members often accompanied alcoholics to their 12 Step meetings, the groups Al-Anon and Ala-Teen slowly developed to support these family members. When advocates changed alcohol treatment to the more general chemical dependency treatment, co-alcoholics were renamed codependents. According to Rice, codependency's definition shifted, making it a disease, just as alcoholism was defined as a disease, with an onset, middle, and an end phase usually conceived of as being death.¹⁴³

Beattie notes that codependents have characteristics that revolve around attempts at controlling other people. These negative attributes include repression, obsession, denial, dependency, weak boundaries, lack of trust, and anger.¹⁴⁴ The longer a codependent denies their own experience while attempting to control the behavior of others, the more likely that their emotional life will be compromised and for depression to be the result.

It would seem logical that if relationship stress contributes to the occurrence of depression, then social therapeutics might help a person resolve their depression. Psychoanalysts, inclusive of object relations theorists, have been using the therapeutic relationship since Freud to address emotional suffering including depression. John Bowlby suggests that one should address the individual with depression in the present, and then proceed retrospectively to find real causes in the person's social history.¹⁴⁵

It seems illustrative that one way to address the limitations of cognitive therapy has been addressed by way of introducing the relationship between therapist and client as the vehicle through which change occurs (as noted in the above section on cognitive

therapy). Linehan's Dialectical Behavioral Therapy uses the therapeutic relationship as the vehicle for change, while McCullough goes on to develop a whole system based on social modeling and shaping of behavior within the therapeutic process even as he uses cognitive techniques.

There is evidence within the literature that social therapeutics is a viable treatment option for individuals suffering from a mood disorder. Karen in his book *Becoming Attached* writes:

A growing body of evidence indicates that these three variables—having had a loving supportive figure available in early childhood, having undergone in-depth psychotherapy, and/or being in a stable relationship with a supportive spouse—are perhaps the most important elements in breaking the cycle of emotional damage.¹⁴⁶

In summary, study evidence suggests that sociocultural circumstances can contribute to the experience of depression. Specific sociocultural identity markers such as class, race, gender, and education level can impact depressive symptoms. Cultural identity and expectations can create a decentering experience when an individual is unable to meet cultural expectations, potentially resulting in depression experiences. Poor parenting may create a disposition in adults towards depression. Relationship stress is noted across the literature on depression, implying that relationship stress correlates positively with the onset of depression.

Imaginal Approaches to Depression

Imaginal Psychology reclaims the soul as the primary concern of psychology.¹⁴⁷ The soul expresses itself through its images, so that attending to images is an essential practice of psychological inquiry. In this section Imaginal Approaches on depression will

be examined in relation to some structural theories of the soul, including some of the ways that the image and the imaginal have been articulated. This section will end with three relevant myths to depression as one knowledge domain wherein the soul's expression of the depressive imagination can be found.

Freud suggested a drive/structure theory of human development and he postulated that the soul had three main components – Id, Ego, and Superego.¹⁴⁸ The Ego has the task of negotiating between the demands of the biological drives contained within the Id, and the social constraints that are internalized by the Superego. Contents of the soul's experience can remain unconscious to the Ego, so that Freud's psychology is psychodynamic, with the constituent parts of the soul in constant and often conflicted relationship. As cited earlier, Greenberg and Mitchell have noted that Freud thought that subjective fantasy images and outer reality are in dynamic relationship to each other within the individual.¹⁴⁹

Freud theorized that instinctual drives seek an external object for its fulfillment, and the object is both discovered and created simultaneously as Mitchell and Greene have summarized. Jung takes the idea of the *instinct*, a highly uniform mode of action, in a different direction. For Jung, the objective psyche, or collective unconscious, which all human beings inherit, contains not only the instincts, but also the archetypes, or primordial images. Jung writes:

The primordial image might suitably be described as the *instinct's perception of itself*, or as the self-portrait of the instinct, in exactly the same way as consciousness is an inward perception of the objective life-process. Just as conscious apprehension gives our actions form and direction, so unconscious apprehension through the archetype determines the form and direction of instinct.¹⁵⁰

The primordial image, the archetypal image, or the archetype – all used interchangeably by Jung throughout his writings – guides the instinct to its specific object in order that the instinct can be discharged correctly. For Jung, the biological instincts and their archetypal images can be defined as the basic elemental building blocks within the soul that give human beings their distinctness. Given Jung's definition, an image does not have to be visual or seen in order to influence perception and behavior. Whitmont writes that the image contains forms of perception, modes of behavior including somatic experience, emotion, and ways of cognition, including ideas.¹⁵¹ It is in the nature of the archetypal image that certain ways of perceiving are universal and expressed by human beings everywhere and at all times. Jung felt that the archetype as an image of instinct is psychologically the spiritual goal toward which the whole nature of man strives.¹⁵²

The soul's use of image appears to derive from outer experiences that have been internalized, a view held by Sigmund Freud, and from deep within the soul outwards as described by Jung. In his *Collected Works*, Freud asserts that all fantasies within the soul arise from outer experience. Freud writes: "Phantasies arise from an unconscious combination, in accordance with certain trends, of things experienced and heard."¹⁵³ This opinion by Freud remains consistent throughout his writings, even at times when the fantasy material from a patient strains his assertion that these images come entirely from external sources. One such fantasy related by a male patient that occurred when the patient was three and a half years old, has the patient playing both a masculine and feminine part in giving birth to a younger sister, which is an image-event that could not have possibly come from the patient's outer experience.¹⁵⁴

Jung began to notice in his patients that the fantasy material they shared at some point in the analysis began to contain fantasies no longer based upon personal memories. He began to suspect that these fantasies came from a different layer of the soul. He writes:

In this further stage of treatment, then, when fantasies are produced which no longer rest on personal memories, we have to do with the manifestations of a deeper layer of the unconscious where the primordial images common to humanity lie sleeping. I have called these images or motifs ‘archetypes,’ . . . ¹⁵⁵

The primary content of the soul for Imaginal Psychology is the imaginal structure, which is defined by Aftab Omer as follows: “Imaginal structures are assemblies of sensory, affective, and cognitive aspects of experience constellated into images; they both mediate and constitute experience.” ¹⁵⁶ Imaginal structures are shaped by interactions with personal and cultural influences, and these personal and cultural influences, at the deepest level, are archetypally informed. Omer states of the complex nature of the imaginal structure, specifically the personal and cultural influences and the archetypal contribution to those influences: “These influences may be teased apart by attention to the stories that form personal character and the myths that shape cultural life.” ¹⁵⁷

Having established some aspects of the nature of the image, and the image in relationship to the soul, one final piece of Omer’s definition of the imaginal structure can be given. Omer further says of the imaginal structure:

During the individuation process, imaginal structures are transmuted into emergent and enhanced capacities as well as a transformed identity. Any enduring and substantive change in individual or group behavior requires a transmuting of imaginal structures. This transmutation depends upon an affirmative turn toward the passionate nature of the soul. ¹⁵⁸

Implied within the notion of an imaginal structure is the latent potential for emergent capacities, but this potential rests upon meaningful and conscious work. Through an act of reflection – the turning towards the soul’s necessities as noted by Omer – an individual becomes aware of the imaginal structures that determine and shape their experience. The individual learns to disidentify from the imaginal structures that up to now have been unconscious.¹⁵⁹ This allows for a fluidity of the self that can move into and out of the multiplicity that comes with the having of a soul.¹⁶⁰

Jung often made note of the soul’s multiplicity, and one parallel idea to that of an imaginal structure is Jung’s use of the word *complex*. A complex according to Jung is an image of an autonomous situation within the soul that exists independently from the conscious idea of one’s self.¹⁶¹ Imaginal structures, with their core archetypal influences, can become a unit of experience around which a center of subjectivity can become encapsulated, so that the soul’s subjective nature is multiple.

Before leaving Jung and his theories, one concept that I came to realize as important in understanding Tim’s style of problem solving is Jung’s idea of the attitude-type. Jung postulated two fundamental attitude types as a general descriptor of an individual’s psychology. He called these the introverted and the extraverted attitudes, or introversion and extraversion, respectively. He writes:

The first attitude [introversion] is normally characterized by a hesitant, reflective, retiring nature that keeps itself to itself, shrinks from objects, is always slightly on the defensive and prefers to hide behind mistrustful scrutiny. The second [extraversion] is normally characterized by an outgoing, candid, and accommodating nature that adapts easily to a given situation, quickly forms attachments, and, setting aside any possible misgivings, will often venture forth with careless confidence into unknown situations. In the first case obviously the subject, and in the second the object, is all-important.¹⁶²

A nuance in understanding the problem of attitude-type is Jung's belief that the unconscious plays a compensatory role to the conscious attitude. The introvert, who is engaged with their subjective processes, has a secret or unconscious fascination with the object. The extravert, who is engaged with the external object, has a secret unconscious fascination with the subject (themselves).¹⁶³ How this idea of attitude-type manifested in the therapy journey with Tim will be elaborated upon in Chapter 4 of the Clinical Case Study.

Imaginal Psychology invites the subjective nature of the soul to be expressed. The Imaginal Psychologist helps the client understand their subjective multiplicities, the imaginal structures that shape context and meaning, helping to move the story of the client forward. As Omer states, it is by attending to the stories that the personal and the cultural dimensions to an imaginal structure are found out.

One area of knowledge that Imaginal Psychology turns to, to find stories, is that of mythology. Myths are great and universal stories that contain archetypal ways of perception, the lenses through which the soul interprets experience. I would add the opinion that a myth is a story of the going of the Gods, so that myths, these lenses of perception of the soul, contain sacredness: this suggests that myth is less secular story and instruction, and more akin to ritual enactment.

James Hillman states of myth as metaphor:

Mythical metaphors are not etiologies, causal explanations, or name tags. They are perspectives toward events which shift the experiences of events; but they are not themselves events. They are likenesses to happenings, making them intelligible but they do not themselves happen. They give an account of the archetypal story in the case history, the myth in the mess.¹⁶⁴

The stories that the soul inhabits can also be found in culturally relevant narratives, in fairy tales, in folk wisdom, or religious iconography. Dreams are another source of narrative, and so are fantasy and fiction in the general. The popularity of such movies as *Star Wars*, or *The Lord of the Rings*, may be due in part to recognizable archetypal images and situations found within these stories: the hero/heroine, good versus evil, the magician, the king, the priestess, the salvation of the world.

There are three myths that have been utilized in this case study for an understanding of the depressive imagination. The myths will be presented here in summary, and the mythic contribution to understanding depression will be developed in Chapter 4 of the Clinical Case Study. The first myth is, “From the Great Above to the Great Below,” a story of Inanna, Queen of Heaven and Earth, the first Goddess of recorded history, from ancient Sumeria.¹⁶⁵ The second myth is the story of Demeter and Persephone, found in the *Homeric Hymns* of the ancient Greeks.¹⁶⁶ The third myth is that of Cupid and Psyche, contained within a Roman story written by Apuleius known as *The Golden Ass*.¹⁶⁷

Inanna, the Queen of Heaven and Earth makes the decision to go to the underworld, the land of death, to pay her respects to her elder sister Ereshkigal, Queen of the Underworld.¹⁶⁸ Ereshkigal’s husband, the Bull of Heaven has died. Before Inanna knocks on the gates of the underworld, she instructs her servant Ninshubur to plead with the gods to not allow her, Inanna, to die. With this precaution, Inanna knocks on the gates of the underworld and asks for admittance.

Ereshkigal grants admission, instructing the gatekeeper to lock the seven gates of the underworld, and to allow Inanna entrance through each gate. At each gate the

gatekeeper removes one of Inanna's garments, and then her jewelry, until at the seventh gate Inanna stands naked. Inanna enters the throne room where Ereshkigal sits.

Ereshkigal fastens upon Inanna the eye of death, pronounces judgment, strikes her, and turns Inanna into a corpse, a piece of rotting meat. Inanna's corpse is hung on a hook on the wall.

Ninshubur, waiting three days and nights, hastens to the gods to plead for the life of her mistress. Only Father Enki, the God of Wisdom, responds to Ninshubur's distress. He scrapes the dirt from under one fingernail of each hand and creates two creatures, neither male nor female. To one he gives the water of life and to the other the food of life. He instructs them to go to the underworld to save Inanna. The creatures, like flies, slip through the cracks in the gates of the underworld and come upon Ereshkigal in her lamentation. Each time Ereshkigal moans in agony, the creatures repeat her lamentation. They mourn with her.

Ereshkigal, who is grateful for their willingness to mourn with her, offers the creatures whatever they may wish. They ask for the corpse of Inanna and give the corpse the food and water of life. They bring Inanna back to life. Inanna is allowed to leave the underworld, but only if someone else takes her place. Inanna decides to name her husband Dumuzi as her replacement in the underworld, since he did not mourn for her, nor attempt to rescue her. In one last twist to the story, the gods allow Dumuzi to escape his fate.

The second myth that reflects the depressive imagination is the myth of Demeter and Persephone, which comes to us from the ancient Greeks.¹⁶⁹ Persephone is the young virgin daughter of Demeter, Goddess of the Grain, and Demeter's brother, Zeus, King of

the Olympian Gods. Zeus grants Hades, the God of the Underworld and his brother, permission to abduct Persephone to be his bride. While Demeter is distracted, and since Demeter would surely object, Zeus and Hades agree upon a plan to steal Persephone away.

Persephone, while playing with her girlfriends in a meadow, comes upon a narcissus bloom so miraculous that the young Goddess stops momentarily and reaches out to grasp the flower. In her distraction, the Earth opens wide and out springs Hades riding his chariot. He scoops up the screaming young woman, taking her below, to the land of the dead, to be his wife and queen. Demeter, hearing the screams of her daughter, rushes over land and sea but too late to stop the abduction of her daughter.

No one can tell Demeter what has transpired and in agony she searches for her daughter for nine days and nights. The Goddess Hecate, who had also heard the screams, assists Demeter in her search. Together they set off to find Helios, God of the Sun, under whose gaze all appears as he journeys across the sky. Helios informs Demeter of the pact between Zeus and Hades, and encourages her to accept the marriage decreed by Zeus. Distraught, Demeter wanders the Earth until coming upon the land of Eleusis. She becomes the nurse to the young son of the king of this land and remains apart from the Gods in Olympus.

She is eventually found out by the royal household and in her Goddess splendor orders that a temple be built in her honor. The people of this place do as they are told and Demeter hides away in her temple, away from mortal and immortal eyes alike. It is said that during this time she instructed humanity in the secrets of the grain, and in the mysteries of her cult.

In her long absence, no seed will sprout and famine threatens humanity. Zeus sends all the Gods one by one to implore Demeter to relent, and she, furious, decrees that no grain shall ever again sprout upon the Earth. Zeus, fearful lest mortals die and worship of the Gods cease, sends his son Hermes to Hades and instructs him to release Persephone.

During her captivity, Persephone has refused food and drink, and has kept herself apart from her husband. Hades, fearful that he will lose Persephone, slips into her mouth the seeds of the pomegranate even as he tells Persephone that she will be returned to her mother. He forces her to swallow some of these seeds. Persephone, upon returning to her mother Demeter, tells her mother what has happened. Demeter is pained, because Persephone has eaten of the food of the dead. Because of this, Persephone must spend a third of the year with Hades, as Queen, and the other two thirds of the year she can spend with her mother Demeter. It is in this way that Persephone becomes Queen of the Underworld.

The third myth, the story of Cupid and Psyche, is found within three chapters in *The Golden Ass* written by Apuleius, a Roman author.¹⁷⁰ It is a myth that is cited often in our Western culture and depictions of Cupid and Psyche are traceable as far back as 500 BCE. Psyche was the beautiful daughter of a king and queen. Her beauty was so profound that humans began to worship her and compare her to the Goddess of Love, Venus. The worship of Venus by humans was ignored. The Goddess angry and jealous devised a plan for the downfall of Psyche. When the king went to Apollo's oracle, the king was told that Psyche's fate was to be married off to a hideous monster.

Psyche's parents, heavy with grief, bring her to a mountaintop and leave her to her fate, as instructed by Apollo. Soon, the West Wind gently lifts Psyche and brings her to a grand palace deep in a wood. Psyche enters the palace and is immediately attended by invisible hands and voices. At night, her husband comes to her bed and he is invisible. Unbeknownst to Psyche, the God Cupid, after having been instructed by his mother Venus to make Psyche fall in love with a desperate and broken man, falls in love with Psyche himself. It is his palace that Psyche is brought to, and it is he who makes love to her and makes her his wife. In time, Psyche becomes pregnant with child.

Psyche's sisters, looking for her, come to the mountainside and are transported to the palace by the West Wind. They ask many questions of Psyche, and envious of her, devise a plan to make Psyche miserable. Even though the invisible Cupid warns Psyche about her sisters, she listens to them. The sisters remind Psyche that the oracle said her husband would be a monster. They convince her to take an oil lamp and a knife, and try to kill this monster in his sleep. Psyche does as she is told, but discovers that her husband is none other than Cupid. While she holds the lamp, a drop of oil falls on Cupid's right shoulder and he wakes up. He scolds Psyche and then flies away, leaving her alone.

Psyche wanders far and wide in search of her husband. None of the other Gods or Goddesses will help her because they all fear Venus's wrath. Psyche finally comes upon the temple of Venus and pleads to be reunited with her husband. Venus, taking the opportunity presented to her, gives Psyche four tasks to complete, each time certain that Psyche will be killed. At each task, helpless, Psyche receives assistance: from ants who sort out a pile of seeds given to Psyche by Venus; from a river reed who instructs Psyche on how to obtain the golden wool of murderous sheep; from an eagle, who fetches the

water from the river of death, the river Styx; and from a speaking tower, who instructs her on how to enter the underworld and return with the beauty of Persephone in a jar.

Psyche decides often to end her own life, and at each desperate moment, she receives assistance. The last task, bringing the beauty of Persephone in a jar, is accomplished and Psyche, eager to remain beautiful to her husband Cupid, opens the jar only to be overtaken by the sleep of death. Cupid, in alarm, wakes her, and goes before Jupiter, King of the Gods, asking that he and Psyche be allowed to wed in a manner befitting a God. Jupiter consents, and begs Venus to let go of her anger and accept her new daughter-in-law. Jupiter gives Psyche a drink of ambrosia, and making her immortal, marries the young couple. From the union of Cupid and Psyche, a daughter, Pleasure, is born.

In summary, the image has a long history in the development of depth psychology beginning with Freud, who incorporated fantasy images as an aspect of the soul's experience. Jung elaborates on fantasy images by observing that in his clients these images were of an archetypal and not just of a personal nature. Imaginal Psychology, a distinct branch of psychology, elaborates upon the observations of depth psychologists regarding the image and its central importance to the soul. Imaginal structures are the units of experience of the soul. The archetypal basis of an imaginal structure can be discerned by turning to myth as one domain where the soul expresses its images.

Conclusion

The first wave of American psychology, behaviorism, became the dominant view in psychology from the 1920s to the 1960s after behaviorists rejected Freud's theories

about the soul.¹⁷¹ Behaviorists were intent on creating a psychology that was scientific. This meant that the idea of the mind, or soul, was not necessary to the understanding of human behavior. During the 1960s the development of cognitive behavioral therapy became the driving force in the second wave of psychology, cognitive therapy.¹⁷² The desire by some psychologists for a scientific psychology was transferred from behaviorism to cognitive therapy, and behavioral and cognitive techniques became merged into one perspective that has dominated psychology for the past many decades. Cognitive therapy embraces the idea of the mind while ignoring the idea of the soul.

The biological perspective, psychiatry, which has developed in parallel to cognitive therapy, like behaviorism, has no need for the idea of the soul or even of mental processes. Change the biochemical composition of the brain, and you change the individual's experience, maybe even their personality, as Kramer believes. One tension within the biological model of mental illness that remains unresolved, is determining what normal adaptive suffering is, and what constitutes dysfunction or dysregulation of a necessary system of biological or psychological repair, as noted by Horwitz and Wakefield.

Depression as suffering consistently challenges both psychiatry and psychology. Psychiatrists, as shown in a close examination of the *DSM-IV*, continue to evolve diagnoses, indicating that depression is difficult to pin down into tidy categories, as Freud observed. The psychiatric approach remains equivocal. Horwitz and Wakefield ponder how it can be that better and improved diagnosis of depression in the primary medical setting, and better drug treatment of depression, can result in ever increasing numbers of depressed persons? Shouldn't the numbers of depressed individuals be decreasing, not

increasing? They conclude: “What has happened, we argue, is largely diagnostic inflation based on a relatively new definition of depressive disorder that is flawed and that, combined with other developments in society, has dramatically expanded the domain of presumed disorder.”¹⁷³

The soul’s complexity – alluded to by the nonspecific factors in the etiology and resolution of depression suggested by the placebo effect – marks with an asterisk all of the absolutist claims made by psychologists of the biological, behavioral, and cognitive models of mental illness as documented in the Literature Review. The soul’s complexity cannot be contained by reductionist theories of suffering. Solomon summarizes this fact:

Let us make no bones about it: We do not really know what causes depression. We do not really know what constitutes depression. We do not know why certain treatments may be effective for depression. We do not now how depression made it through the evolutionary process. We do not know why one person gets a depression from circumstances that do not trouble another.¹⁷⁴

CHAPTER 3

PROGRESSION OF THE TREATMENT

The Beginning

A colleague, who did not have the available time to add another client, referred Timothy Olsen to me in late June of 2005. My first impression of Tim was that he was an extroverted, motivated, intelligent, attractive, young, overweight, and a take-charge kind of guy. Tim shared that he had been thinking about seeing a therapist for several months. He had thought out possible strategies to avoid being pulled further into a depression, and seeing a therapist was one of those strategies. From the beginning of our work together, Tim operated from a stance of logic. His was a problem solving, figure-it-out, and get-on-with-it personality style.

Tim was being decentered from his subjective experience in many ways. He reported that lately he would get weepy and cry when alone at home. He shared that he was struggling with depression due to many concurrent life stressors. His boyfriend of 14 months, Rick, drank alcohol on a regular basis, and Tim noted that Rick's mood and behavior changed as a direct result of his drinking. Tim stated that at first Rick appeared to be hiding the amount of alcohol he consumed, or that in the very least, he was not aware of the extent of Rick's alcohol dependence at the beginning of the relationship. The pattern was that Rick would get drunk, pick a fight in person or over the phone, and the next day would apologize to Tim, promising not to do it again.

Tim had a pointed sense of humor. He referred to Rick's cocktails as Rick's "big boy drinks." By this he meant that Rick would fill up a large 16-ounce tumbler with rum and coke and then proceed to drink several of these in a row. Rick would then sink back into his chair and proceed to get depressed, angry and verbally combative.

Tim shared that he himself had inherited an "addictive gene." He stated that both of his parents were honest with all six of their children that alcoholism was evident in both sets of grandparents. Tim's parents were low to moderate drinkers, and they felt it was their responsibility as parents to educate their children about the family history of alcohol abuse. Tim was alarmed that during the past year while being with Rick he had increased his own alcohol consumption from having an occasional drink to three times a week on average.

Tim faced a dilemma. Rick would vacillate between admitting he had a dependence on alcohol, to denying that he had a problem, and by extension denying that his behavior was impacting Tim and the relationship negatively. Tim stated upfront that he loved Rick very much, and that when sober, Rick was a warm, loving and faithful companion.

Tim had other life stressors that he was also managing. He had been overlooked for a promotion at his place of employment where he had worked for six and one-half years, and now he had a much younger, inexperienced boss. He was in the process of having a separate living space built in his house so that he could rent the space and get assistance with his mortgage; consequently, his home space was chaotic and not restful. His father had had heart surgery six months previously, and was still weak and

recuperating, placing a strain on his mom. And finally, his aunt, whom he loved deeply, had passed away earlier in the year and Tim was still mourning her death.

Tim also had to accommodate and take care of several physical issues. He had sleep apnea and needed a machine to sleep well at night. His increased weight since being with Rick was impacting the sleep apnea negatively. Tim also monitored his diet due to having Type 2 diabetes, although he was not taking any medications for it and was able to control his blood sugar with diet and exercise. Whenever he and Rick had a fight, he would eat comfort foods – pizza being his food of choice – which was an unwise act due to his diabetes and his need to maintain a healthy blood sugar level.

Tim had a history of asking for and accepting assistance when he needed it; being raised in a moderately large family where communication and mutual aide were modeled probably instilled this capacity. He had been thinking over his life issues, and being a problem solver, he had several ideas that he presented at the beginning of our work together. I gave Tim wide latitude to direct his healing process. Once these initial parameters were established, we set to work.

It was evident from the beginning that Tim was motivated to confront his problems directly. I found it important, and sometimes difficult, to get out of the way and let Tim have all the control that he needed to heal himself and his life. Given that Tim felt he had little control over his life circumstances, I came to see that it was important for him to have a therapeutic space where he could be in control of his choices. Until a deeper therapeutic alliance developed between us, it made little sense to get in Tim's way. I quickly adjusted to being the sounding board, and provided Tim with ongoing

mirroring and validation of his experience, and together, we adjusted his treatment plan when necessary.

Treatment Planning

Tim had already mulled over his situation in his own mind for several months. He was ready to take action. As I discovered over the course of therapy, whenever Tim was able to understand a situation and take an action to resolve an issue, his depression lightened. During the first month of therapy, we prioritized. He felt that for the moment, it was not top priority to seek a new job. He accepted that he had to persevere with the house repairs, and there was little he could do to speed up the process. He comforted himself that at the end of the repairs the added income from a renter would decrease his financial stress. He accepted that it was important to grieve the loss of his aunt, and that this would take time. He shared that while frustrating, there was little he could do, due to distance, in taking care of his father.

It became clear to both of us that the issue most pressing and most emotionally debilitating was his relationship with Rick. Tim never used the word codependent to describe his situation; codependency as a concept was something I utilized in my understanding of Tim's struggle, so that I could frame and then reflect the issue for him. Tim was always honest and courageous with himself, and he agreed with my observation that his depression behaviors – overeating and gaining weight, insomnia, increased alcohol consumption, crying spells, and lack of regular exercise – were a direct result of his response to Rick's drinking and the conflict it caused. Tim had already thought about

attending Al-Anon to get assistance with his emotional entanglement around Rick's alcohol use, and I concurred with this observation.

Tim researched locations of Al-Anon meetings, and his attendance at meetings became part of the treatment plan. Individual therapy would focus on his learnings and progress. I would provide support in his journey, and assist him in understanding how all the pieces fit together in either promoting his well being or impeding it.

I asked Tim what he thought about doing a medication consultation for an antidepressant to treat his depression. He replied that he did not like the idea of taking an antidepressant, given the sexual side effects he had experienced when he had been treated with Prozac and Zoloft. He was clearly proud of having been off of all medications for many years, as well as his self-care, and he wanted to maintain this achievement. I respected this decision, and it became an agreement between us that a part of the treatment plan would be constant monitoring of his depressive symptoms so that they did not overwhelm him. He promised to be honest with me about any and all symptoms he experienced, especially any symptoms that might indicate a manic phase of bipolar disorder.

The Therapy Journey

Reviewing the case notes of our work together over 18 months, it became apparent in hindsight that there were three distinct phases to Tim's therapeutic journey. The first phase occurred between June and December of 2005, and can be summarized as a time when Tim accepted the limitations of the relationship with Rick. The end point to this phase was Tim's visit with his family for the Christmas holiday in Montana without

Rick, a celebratory occasion for his family. Making the decision not to invite Rick was a painful one for Tim as he realized that he was retreating emotionally from Rick.

This painful decision exemplified Tim's native sensitivity to the feelings of others. It also brought out Tim's capacity for compassion, even in the midst of his own suffering. He felt that having Rick with him to spend the holidays with his family would set Rick up for being hurt more deeply if he were to decide to end the relationship. It was at the end this first phase that Tim made the decision to leave the relationship with Rick. Compounding his emotional struggle during this time, in November of this period, he underwent throat surgery to improve his sleep apnea and had his "near death experience."

The second phase of the treatment happened between January and April 2006. The decentering that he experienced due to the loss of his relationship with Rick overwhelmed his extraverted defenses, and he was able to feel his anger, disappointment, and sadness. In different words, Tim was able to grieve the loss of his relationship. In this way, he became open to examining himself and reassessing his life. During this time he began to prepare for his future life without Rick. The final phase of treatment occurred between May and November 2006, when Tim consolidated the changes he had initiated during phase two, and his depressed mood had all but resolved. Our final session was on November 17, 2006.

One aspect of Tim's personality was his ability to communicate verbally and articulately. Asserting himself was not an inherent problem for him, which confused him when it came to his relationship to Rick, where asserting himself was met with anger and accusations. By the time he had come to see me for therapy, he had already shared with Rick his observations and his frustrations. He was acutely aware of how Rick's drinking

was impacting his own behaviors. Had Rick been able to address his alcohol dependence and engage Tim directly, I doubt that Tim would have sought out psychotherapy since depression would not have been constellated.

While the more traditional definition of codependency is that a codependent person is someone in a relationship with an alcoholic, Melody Beattie provides a broader definition of codependency: “A codependent person is one who has let another person’s behavior affect him or her, and who is obsessed with controlling that person’s behavior.”¹ While the first half of Beattie’s definition applies to all relationships, it is the second part of her definition that more commonly induces pain and suffering. This was clearly the case with Tim, who was spending much of his time and emotional effort in trying to control Rick’s behavior.

Tim described how he now kept minimal amounts of alcohol in his home, so as not to encourage Rick’s drinking. At the beginning of the relationship, the two of them would go to bars with friends. Now, Tim avoided doing this, and Rick would meet his friends at the bar without Tim. If they attended a social event, Tim would keep track of how much Rick was drinking. And in the evenings, when they spoke by phone, or when they exchanged emails, Tim was vigilant, and depending on Rick’s wording and emotionality, would determine if Rick had been drinking, and anticipated whether their conversation would result in a verbal fight.

Tim was clear in our very first session that he could not continue to be in a relationship with Rick if Rick continued drinking. He was prepared to support Rick in getting help for his underlying depression and anger (Tim’s opinion), but only if Rick was sober. Tim’s codependency moved beyond keeping alcohol away from Rick. He was

determined to help Rick stop drinking. He suggested to Rick that he should see a therapist, and strongly encouraged Rick to attend Alcoholics Anonymous meetings. He even agreed to attend couple's therapy with Rick if that assisted him in becoming sober. The problem was that Rick was not admitting to having a problem with alcohol, or when he did, he would recant and soon return to drinking.

At the beginning of phase one of Tim's therapy work, Rick precipitated a crisis for the relationship by asking Tim if they could move in together. Tim, shocked, told Rick that he could not even consider moving in with him until Rick resolved his alcohol use. Rick responded by becoming angrier and more depressed. He begrudgingly started seeing a therapist in August, and reported to Tim that it was somewhat helpful. Rick began to take an antidepressant medication, and several times through the Fall season would stop for short periods but would then begin to drink again.

Tim went to one of the sessions with Rick and his therapist at the end of October. For Tim, it was an opportunity to try to get through to Rick that Rick had a problem with alcohol. Tim shared with me after the session with Rick and his therapist that it was becoming obvious to him what Rick's intentions were during the therapy session. Tim was of the opinion that Rick had two goals for the couple's session: to negotiate his continued alcohol use and to have Tim commit to not leaving him. Tim did not agree to either one of these.

By the end of the first seven months of our work together (December, 2005) their relationship had significantly deteriorated. Tim was clearly a decent and compassionate man, and he found it difficult to be put in the position of constantly hurting Rick. The pattern throughout the Fall season was predictable: Rick would drink at night, or on the

weekends, and he would then return from the bar, and phone Tim. In these conversations, Rick would get angry at Tim for not moving in with him. Tim for his part would become sad and depressed, sometimes angry, and would terminate the phone conversation. Tim would share with me his confusion as to why Rick would keep asking for something that Tim had to repeatedly deny him. In the process of saying no to moving in, or later, continuing the relationship, Tim felt he was wounding Rick.

By the beginning of November, Tim was slowly accepting the fact that he could not remain in the relationship with Rick. Tim worked on acknowledging the unavoidable hurt each of them felt, and the necessity for him to come to terms with his decision. There was a continuing push/pull dynamic as Tim first believed and then realized that even being friends with Rick was to continue in a dysfunctional and hurtful situation. As Rick slowly accepted that the relationship was over, he stopped seeing his own therapist, stopped taking his antidepressant medication, and continued to drink without interruption. Tim told me that Rick proceeded to rationalize the reasons for the relationship not working out as other than his drinking.

One of the other reasons for the breakup that Rick was alluding to was the fact that Rick was not out as a gay man, either to his family of origin or his boss and peers at work. When Tim's surgery to cure his sleep apnea was scheduled for September, the plan was for Tim to recuperate during the first week of recovery at Rick's house. The surgery was postponed until the beginning of November. Since Rick was not out to his boss, when his boss arranged an elective business training out of state during the time of Tim's surgery, Rick was not able to ask his boss to reschedule nor tell his boss that his boyfriend was undergoing surgery and needed his assistance recuperating. This lack of

support really hurt Tim, and he came to conclude that he could not be in a long-term committed relationship with a man who was still hiding his gay identity.

There was one significant and key occurrence during this first phase of therapy: Tim's surgery. Tim had made arrangements to have two of his friends take him to the surgery site, and pick him up afterwards. He remained with these friends the first three days after surgery. While Tim was being anaesthetized for the surgery, he briefly came to consciousness and realized that he could not breathe. He panicked and tried to move, but he could not, which only increased his terror. One of the medical team saw what was happening, and alerted the surgeon. The surgeon asked the anesthetist to put him under quickly, and Tim lost consciousness.

Several weeks later when Tim was recounting this event to me, he termed it a near death experience. He told me that he briefly thought he was dying, and what made him sad as well as scared, was the thought that he would die alone since there was no one in the waiting room attendant to his recovery. This last thought added more resolve to Tim's decision to leave Rick. By the end of December, before leaving for his family visit, Tim had stopped all contact with Rick.

Resolving the codependency dynamic was painful for Tim, as well as for Rick. He genuinely loved Rick, and was genuinely interested in Rick's well being. The more Tim retreated behind firm boundaries, the more demanding Rick became, and the more anger Rick expressed. This forced Tim to pull back even further, and to realize that he could not change Rick, nor was it likely that Rick would change. Tim came to realize how much energy he was expending taking care of Rick, and in trying to save the relationship from dissolution. He finally accepted that Rick's primary relationship was to

alcohol. Tim's capacity for compassion is seen in his acceptance of my observation that in wanting something from Rick that Rick was unable to do, he was inadvertently hurting Rick.

Phase Two of the therapy journey commenced in January of 2006 upon Tim's return from visiting his family during the holidays. Tim was struggling with his feelings of anger and rage over the loss of his relationship. He struggled implementing the Al-Anon strategy of accepting that Rick was powerless over his alcohol use and that Rick was not being willful or stubborn, but had an illness. Tim shared a statement from his medical doctor, who, alarmed that Tim's weight had gone up 60 pounds in two years, told him: "Alcoholics don't have relationships, they take hostages."

I suggested the neutral image that Rick's primary relationship was to alcohol. Tim was able to understand this analogy. He stated several times during our sessions that his anger at Rick was irrational. I encouraged Tim to feel through his anger, as this was part of the healing process. Rick in the meantime was still sending Tim maudlin and angry emails, with statements such as, "You *were* the one," which Tim ignored with great effort.

During the middle of January, Tim had what he called his "small meltdown." He was having lunch with his first long-term partner, Dennis. Tim and Dennis had been together almost seven years, and during six of those years they lived together. The last seven months of the relationship, Dennis had moved to Taiwan for work. Dennis' behaviors changed, and when a friend of Tim's suggested to Tim that Dennis was having an affair, Tim flew to Taiwan unannounced and confronted Dennis. His partner admitted to having an affair. Tim asked Dennis to make a decision one way or the other, and when

Dennis refused to choose between either relationship, Tim ended the partnership. Heart broken, Tim returned to the States.

Tim maintained a friendship with Dennis over the years, and when Dennis would visit from Taiwan, sometimes with his current sexual partner (Tim's description), he would stay at Tim's house. I found this perplexing, as sometimes ex-partners remain sensitive to each other's new relationships, at least for a time. I asked Tim if he and Dennis had ever discussed what had happened many years previously. Tim told me they had not. I asked Tim if this was difficult for him, to be around Dennis and his current sexual partners, to which Tim responded that it was okay with him.

This time, right after the break up with Rick, the two of them were having lunch. In the middle of lunch, Tim "unloaded" (his word). He talked about Dennis' betrayal, and of how hurtful it had been for Tim to end the relationship. He pointed out to Dennis how Dennis had never admitted to having betrayed him, or even offered an apology for what he had done. Dennis began to cry and the lunch date all but ended. Then, when Tim returned home, Tim composed an email to Rick which expressed his anger and frustration over Rick's emails and phone messages. He asked Rick to please leave him alone, once and for all.

As Tim shared with me, in an embarrassed tone, the events of this day, I asked him if he had been mean or hurtful in either of these situations, or simply angry and honest. He replied that being mean was "not in my personality," but that he did feel good about finally expressing his rage and hurt and disappointment, directly. I commended him for allowing himself to feel his anger, and for expressing it in an assertive way. Tim was able to use his newfound anger to make a resolve to not be "friends" with either Dennis

or Rick. I agreed with him that being friends with someone while not wanting to be friends was another way of not being honest with himself – and taking care of someone else’s feelings at his expense.

Finding his anger, expressing it, and using it to motivate himself, Tim made significant changes during the months of February through April of 2006. He no longer expressed guilt about taking care of himself first. He interviewed for and accepted a new sales job to begin in March. He returned to the local gym and took up exercise again, realizing that the weight issue was best dealt with by regular exercise and eating healthily. He hired a personal trainer who helped him design a workout routine. And by the end of March, he had found a workout partner who also lived in Alameda. They began to train at least three mornings a week.

During this same time, Tim’s mood would alternate between stable and depressed. I suggested he might be grieving the loss of his relationships (Rick and Dennis). I reflected that he would need to grieve his losses, and that the grieving process was cyclical, although necessary. Tim asked out loud in one session, “What is wrong with me?” This was in reference to his thinking that he was 39 years old and single. He had stated in a previous session that he would rather be single than in a relationship and miserable, and I reminded him that he was making a choice.

This painful but honest reflection can be a gift of the decentering experience of loss and the subsequent depression. In the story of Gilgamesh given in the Introduction, Gilgamesh can be thought of as a partying frat boy, King of the city, terrorizing the citizenry. This is why the Gods, to calm him down, created Enkidu. Instead, the two together continued the party. It was only when he lost Enkidu that Gilgamesh began to

reflect in a deep way the entire meaning of his life. When Tim asked, “What is wrong with me,” he indicated a genuine vulnerability and openness to honest self-reflection.

I reframed the situation and reminded him of what he had learned about relationships, even though his learnings had come at a personal cost. Tim now had a better idea of how true intimacy developed, and what the significant intimacy milestones were like for him. He was now able to realize that intimacy included conflict, and that it was important to express his feelings, even when he was angry and disappointed. He came to realize how important it was to include himself as part of the relationship, to be present and deserving of being treated with respect. And he knew the boundaries of what was acceptable to him in a relationship, and what was not acceptable. In short, through his pain and suffering, he was now a mature adult man wanting an adult partnership.

Tim’s openness to reflection and his honest self-questioning allowed us to explore other issues. During this phase of the therapy journey, we were able to examine Tim’s role in the codependency dynamic in his relationships. In one session he was talking about a friend who would always call him for his advice whenever he had a problem. Intuitively, I asked Tim, “Do *you* have anyone you call when you have a problem?” He thought long and hard and replied that other than his parents, there wasn’t anyone he counted on for advice or support on a regular basis. He was silent for some time.

I asked Tim if he was a caretaker, one of those people that are always taking care of others’ needs. I reflected that being a salesman is an adaptive way of being a caretaker, since sales involves finding the fit between a product and the needs of a client. A salesman sees to it that a client’s needs are satisfied in a timely and fulfilling way. Tim was very reflexive during this session, and he looked at me and said, “Maybe my taking

care of others contributes to my depression?” This was a significant and pivotal insight for Tim. We discussed how important it was for him to be both a caretaker of others, and caretaker for self: one did not exclude the other, and in fact it was important to achieve a balance of both. We talked some more about what mature, healthy interdependence looks like, and how important it was for Tim to eventually have this with his future partner.

Phase Three of the therapy journey occurred between May and November of 2006 as Tim consolidated his new life choices. Once he came to terms with his decision to end the relationship with Rick, and he resolved to monitor his caretaking tendency, Tim moved quickly and didn't look back. He was putting in a lot of time at his new job to get oriented. He had a renter in his home. He continued to exercise and eat better. Rick would still email him, and Tim would respond, writing maybe some day they could be friends, but not until Tim was ready. We monitored his mood, and Tim repeatedly shared that he was not feeling depressed. He would get sad when Rick would email him, but he had insight about why, and would keep his resolve to stay away from Rick.

Tim's near death experience was a deep motivator for him. During this final phase of the treatment, Tim did a thorough life review, and slowly created a five-year life plan. He was very close to his family, and his experience of loneliness during the surgery scare made him realize that he wanted to be closer to his family. He worried that his parents were getting older and that he had less time with them to enjoy their company. He also felt that he wanted to be closer geographically in case either one of them became ill. He knew that there was a sales position in his company responsible for sales in Montana, and if he played his cards right, he might be able to get the job if it became available in the future. He could sell his house in Alameda at a profit, and use the profit to buy a modest

home in some small town in Montana far enough away from his parents for privacy, but close enough to be available.

Our sessions became spread out over time, from sometimes weekly, to once a month for the last three sessions to see how Tim adjusted to his new life and to see if his mood remained stable and free of depression. Tim quickly engaged his new goals. He began to date again, but he was clear that he was in no hurry to settle down. He knew that any future partner would have to be open to moving to Montana, or he would wait until moving to Montana to seek a life partner. Tim felt good about himself, and his life. On November 17, 2006 we met for the last time. We both agreed that he had had a long, painful, but fruitful year. I congratulated him for his hard work and I wished him the best in his future life.

Legal and Ethical Issues

I was fortunate to have in Tim a client who was able to express himself in a direct way, so I could trust that he would communicate to me what issues he was experiencing from week to week. One concern when working with a client with depression or bipolar disorder history is monitoring for suicidal thoughts and impulses. Keeping the client safe is both an ethical as well as a legal issue. Tim stated during the intake session that he had never had suicidal thoughts or suicide attempts. During the therapy journey Tim never once stated that he was having thoughts about his death, or about hurting himself the occasions I inquired.

An ethical consideration when working with someone with bipolar disorder is that medication treatment can be complex. Improper medication treatment can actually

precipitate either a depression or a manic phase. Lithium therapy can be toxic and lethal if administered improperly. Only a trained medical doctor of psychiatry who is experienced in the use of the various drugs available is qualified to venture into psychopharmaceutical treatment of bipolar disorder. Fortunately for Tim, and for our treatment collaboration, the bipolar disorder never occurred.

Outcomes

By the time Tim came to see me, he had exhausted all avenues in regards to Rick and his drinking behavior. He was ready to make hard decisions and take appropriate actions. Tim's depression resolved as he engaged his suffering and the various life stressors precipitating his depression in a proactive manner. As our therapeutic relationship progressed, he was able to allow me to engage him more directly, and to challenge his imaginal structures about relationships and about being a caretaker. Making decisions and acting on them freed up emotional energy from external issues that we were able to use to explore internal psychodynamics. Once he understood himself better vis-à-vis relationships, he was able to reengage his life in a positive way.

He still had moments of sadness about the end of his relationship with Rick, but these moments were appropriate since grieving is rarely a linear process. Tim was able to acknowledge his sadness in a direct way. Tim could have chosen to spend more time in therapy exploring personality psychodynamics, but due to his extraverted nature (which will be explored in Chapter Four), Tim expressed readiness to move back out into the world and engage the goals he had set for himself free from depression.

CHAPTER 4

LEARNINGS

Key Concepts and Major Principles

There are two key concepts and one major principle that are integral to understanding Tim's progress; these concepts are useful as well in describing the intersection of his personal psychology with my own. The two concepts and major principle were interactive and additive, operating in a synergistic fashion in the therapy process. The first of the two key concepts is Jung's observation of the attitude-type, detailed in the Literature Review. The second key concept is the socioculturally developed idea of codependency. The major principle in understanding Tim's therapy journey is the notion of decentering and its relationship to the depressive imagination.

One concept that I came to realize as important in understanding Tim's style of problem solving was the observation that his attitude-type was one of extraversion. Whitmont writes that the extravert is a person whose consciousness is mostly directed toward external objects or the outside world.¹ Both attitude-types are operative in every individual, but over time a person tends to favor one attitude over the other. Each attitude-type can exhibit the weakness implied in relying on one attitude. For the extravert, Whitmont explains: "The extravert has a subject fear; he mistrusts the inner world. He undervalues his inner self and projects this lack of self-valuation; the extravert's typical complaint is that nobody appreciates him or takes them seriously."²

Tim's extraverted attitude-type came across in his active engagement of external events, people, and even support. Attending an Al-Aon group would probably be a more comfortable source of support for an extravert than for an introvert, since the introvert tends to be wary of the external world. Tim's success as a salesman would also speak to his extraverted attitude. His problem solving, jump into action preference would point to extraversion. I came to realize that intensive inner analytical work on himself and the make up of his personal psychology would not come naturally to Tim.

The concept of codependency has been included in the Literature Review's section on the sociocultural perspectives of depression. Rice notes that over time codependency was given the broad definition of any unhealthy, pathological dependence on processes external to the individual, whether a person or a substance. This broader definition of codependency, according to Rice, implies a holding of specific beliefs that provide a way of making sense of and organizing one's life.³

Tim's dilemma in his relationship with Rick speaks to both the original definition of codependency as the psychological results of loving an addict as well as the more individual psychology of Tim being a caretaker. Tim's overall personality structure did not meet the overly broad definition of codependency as articulated by Beattie, one of the definers of codependency during the 1980s.⁴ The aspects of codependency particular to Tim will be discussed in the next section.

The major principle in understanding Tim's therapy journey is the notion of decentering, its relationships to loss, and the constellation of the depressive imagination as a response. The complex idea of decentering was explained in the Literature Review's section on psychodynamic perspectives on depression, specifically, the ideas of Klein and

Ogden. Integrating the ideas of Klein and Ogden, I propose the following synthesis: the decentering of the subject from its own experience, the depressive position, leads to activation of the depressive imagination as a process of integration. Depression can be a creative act of integration, a move to put the subject back into the center of its own experience.

The sense of mourning and loss is the result of the decentering event itself, which external to the subject is a perceived loss, and internally, a movement between the paranoid-schizoid position and the depressive position, resulting in a loss of soul. I would like to propose that the depressive imagination is both how one sees and what one sees, process *and* content, very much like the formulation of the schema found in cognitive therapy, or the notion of the imaginal structure as articulated within Imaginal Psychology. This parallels the ambiguous nature of Klein's positions as both how the infant organizes its experiences and what it experiences.

One conclusion that I have drawn from examining the overall literature on depression, as well work with clients, is that depression seems to be constellated whenever the subject is decentered from itself. The notion of decentering seems compatible with all the various contexts that appear to contribute towards depression: biological and hormonal determinants, developmental milestones such as adolescence or old age, life altering experiences like the birth of a child, stress and trauma, or the seeming contradiction of an achievement followed by depression. All of these events result in the decentering of the subject from its own experience.

The conceptual dual nature of an imaginal lens being both content and process implies that loss is both the result of the decentering event, as well as constellating the

decentering experience. Stated differently, loss and decentering are mutually constellating. Decentering appears necessary, as a way for the personality and the soul to develop new capacities for life and living, an imaginal death process (the depressive imagination) that makes room for the birth of something new within the soul. I believe depression can have benefit, but this opinion only makes sense when depression is contextualized as necessary to the soul's dynamic processes.

What Happened

The focal point of therapeutic work with Tim was the link between relationship stress, the decentering of the subject from its experience, and the subsequent constellation of the depressive imagination. Tim came into therapy with the dilemma that Rick was pushing for them to move in together, even as Tim recognized Rick's alcohol use and its stress on their relationship. Tim wondered if Rick had concealed the extent of his drinking at the beginning of the relationship and this made Tim mistrust Rick. Tim felt trapped by his sense of love and loyalty for Rick on the one hand, and Rick's refusal to admit that his primary relationship was to alcohol on the other hand. Tim's self-reported depression was probably the result of this acute decentering, a distress perhaps compounded by Tim's extraverted, action-oriented attitude-type. There was no quick fix or fast resolution for this situation.

Relational stress challenges the full range of relationship expression: dependency, codependency, independence, and interdependence. Tim's learning of the differentiation among these variations of intimacy was an indirect but necessary result of the therapy work. The fact that alcoholism was an aspect of Rick's psychology further confused the

boundary lines for Tim of what was a healthy relationship and what was a dysfunctional one. Tim expressed his conviction that a love relationship is a serious matter, often citing his parent's decades long marriage as his model. Tim expressed this sense of commitment and was attempting to do everything in his power to make Rick well, including pushing Rick to go to Alcoholics Anonymous groups and/or see a therapist. This obsession with making Rick well easily slipped into the area of codependency.

Tim felt abandoned by Rick when he went in for surgery alone and had his "near death experience." This act of betrayal wounded Tim, and together with his near death experience propelled Tim into a deeper decentering. It seems, in retrospect, that only such a deep wounding allowed for Tim to finally accept that he could not be with Rick, nor could he fix him, or the relationship.

As his therapist it was difficult to be a witness to Tim's suffering through relationship, yet being a therapist meant that I had to monitor and model the same relationship boundaries that Tim was slowly learning. I was reminded in Tim's struggle of my own experience of loving an alcoholic, as my stepfather during my childhood was an active and daily drinker, and required looking after when he was drunk. This relationship with an alcoholic forced me to learn something about the boundaries of what was a healthy loving relationship, and what was dysfunctional caretaking. This personal learning supported my quiet witnessing of Tim's struggle, and I recognized the importance of this learning for Tim as well.

I recognized and understood the urge to take care of others that Tim exhibited, and I felt that this ability, in and of itself, was valuable, and a gift that he could utilize to the benefit of others. I was touched that even through his extreme suffering his gentleness

remained intact, that even when expressing his anger to Rick and Dennis, he monitored his capacity to hurt others. When Tim felt better and moved extravertedly into life again, his loving and kind attitude remained intact. He would be wiser in the future in how he engaged this caretaking ability, however, or so I hoped.

After Tim expressed his disappointment and anger to Rick and Dennis, a significant milestone for Tim, we were able to examine in more detail Tim's caretaker behavior. I thought it important for Tim to better understand the boundary line between unconscious, knee-jerk caretaking, and conscious intentional kindness. Tim's realization that he had no one other than his parents to turn to when he needed love, support, and assistance was another milestone event in the therapy process. When he voiced the observation that perhaps his caretaking of others contributed to his experience of depression, I knew that a transformation in his consciousness had occurred, and that he would be a bit wiser in his future relationships.

As his mood improved, Tim quickly moved to implement his life plans. While I felt that a bit more time in self-reflection would have been of benefit to Tim, I took my cue from him and supported his need and desire to take action. It was clear that as an extravert Tim's comfort zone was engaging the external world head on. I noted for him that implementing a new awareness takes time, and he reported throughout the last four months of our work together that he had moments of sadness that did not last long. I interpreted from his behavior, especially the need to meet with me less often, that he was ready to reengage his life. In parallel process, I began to let go of my introverted need for psychodynamic processing. I recognized that Tim was done with therapy, and I rejoiced with Tim his newfound excitement for life and love.

Imaginal Structures

How I Was Affected

I looked forward to my sessions with Tim, because I knew that between sessions he had been engaged in his own healing. His outgoing personality style was infectious and I enjoyed our verbal interaction. Tim tackled his depression with a sense of gusto and determination. There was little self-pity or licking of wounds for Tim. Once he understood a dynamic and his position within it, he moved quickly to resolve the problem. There were moments when I wondered what my contributions were to his healing process, as I let him have all the space he needed within the therapeutic alliance, and let him take charge of his own process of self-discovery.

The only tension I felt centered around our differing attitude-types. This was not something I ever brought up for discussion, as this was simply the situation, and as the therapist it was my role to adapt to the client's needs, not the other way around. As an introvert, I have a comfort and a preference for thorough awareness of inner process. I value the contributions to character of genetic, developmental, cultural, and interpersonal history, as well as how these determinants impact the beliefs, choices, and actions that we exhibit today. Internal psychodynamics trumps external world conquest according to my introverted style.

Nonetheless, I received several gifts from Tim's extraverted attitude-type. I learned many things about the social groups and events of the local gay male community, information I have shared with other gay male clients. For instance, I learned that there was a group of gay men that met monthly for social events in each other's homes. I was

gifted with getting to know an extravert who used his attitude-type to good advantage, and who also had the capacity for introverted reflection, even if this introverted reflection was not as deep as my attitude-type would have wanted and preferred. It was a good thing for me to work through my own discomfort working with an extraverted personality type. Halfway through the therapy journey, I believe Tim and I found a middle ground between extraverted action and introverted self-reflection for his healing to occur, and for my own education about what the more balanced extraverted attitude-type can look like.

I was able to observe in Tim's extraverted processing of codependency and the resultant decentering the constellation and resolution of a depression. I let Tim take what he needed from my participation, knowledge, and observations, and reject what he did not need. In taking a more passive observer role than I am used to in the therapy situation, I was able to witness the resolution of his depression. While this truth felt uncomfortable to me at times, it allowed me to see in Tim's process my hunches around decentering and depression, inclusive of my working assumption of the mythic background of depression. To use a metaphor, Tim's self initiative and minimal need from me made it easier for me to have binocular vision, to observe his process while keeping the mythic element of depression in my own awareness.

My Imaginal Structures

One imaginal structure that Tim and I shared was the imaginal structure of the caretaker. One common experience of new immigrants is that children become the bridge between the private family home life and the new dominant culture. For instance, language is a barrier for new immigrants. By the time I started the third grade in the

United States, I had become proficient in the English language. At age 10 I became my family's translator by necessity, and other monolingual Spanish speakers in my apartment complex would seek me out whenever they needed language translation, either verbal or written. A caretaker was born.

The imaginal structure of the caretaker was one I struggled with growing up in another way. My stepfather was an alcoholic who often elicited that he be taken care of, even when he was more than capable of performing certain tasks himself. This neediness is something I came to regard as part of the alcoholic personality style. As I got older, I had to set limits on how much and how often I would take care of his needs, a sometimes painful and confusing process for me. Tim's struggle with Rick's neediness was something that I understood all too well.

The notion of codependency is an aspect of the caretaker imaginal structure, its shadow, and my own imaginal structure around caretaking was constellated in my work with Tim. My work as a psychotherapist implies this imaginal structure. I was able to reflect and articulate for Tim what mature caretaking looks like, and what constitutes a dysfunctional and self-destructive caretaking style.

In examining my work with Tim, and the overall experiences that I have had healing my own depression, it seems important to note again that I have acquired some capacities because of my dealings with depression. One is my capacity to sit in the darkest of places that the depressive imagination can take us. I believe this process – from being wounded myself to attending to the wounds of others in depression – comes from an imaginal structure influenced by the wounded healer archetype. David Sedgwick writes that Jung was of the opinion that only the wounded physician can heal.⁵ Omer says

that through reflexivity imaginal structures are transformed. He states: “Reflexivity is the capacity to engage and be aware of those imaginal structures that shape and constitute our experience.”⁶ Through acts of active engagement and reflexivity, I have been able over time to shift the wounding that I experienced from suffering depressions, to attending to the wounding of others when they are depressed.

The Client’s Imaginal Structures

Tim’s struggle with relationships and codependency was probably influenced by what I believe was an imaginal structure of what a dyadic relationship should be, and perhaps his imaginal structure may have been general to relationships. This imaginal structure for Tim was probably the result of his family of origin experiences. For Tim, a dyadic primary relationship was modeled after his parents’ marriage of over four decades. He always described his parents, and his childhood, in positive ways, and described his family as close knit and always taking care of each other without complaint or hesitation.

This imaginal structure would influence Tim to be committed to making any relationship work; one did not walk away from a partner simply because they had problems. This imaginal structure would also allow Tim to accept that conflict was inevitable, but that it could *always* be resolved. Tim spoke of how his parents rarely argued in front of him or his siblings. He stated that the children could hear them arguing in their bedroom, but that when his parents resolved the issue, it was back to business as usual. The fact that Rick had such poor boundaries was not something Tim was used to,

or knew how to handle. Tim could not understand how Rick could be mean since his modeling for relationship was just the opposite.

The second imaginal structure that I believe Tim exhibited was one that I would term a caretaker imaginal structure. Tim's relationships in general seemed to center around his capacity to take care of other's needs, both in his job, and in his personal life. It was a part of his identity that he seemed unaware of. When I asked him the question of who he turned to for help and support, he realized that outside of his family, there was no one. This is often the situation with caretakers, who stay busy helping others, but do not cultivate being the recipients of caretaking themselves, and may even resist attempts by others to take care of them.

It is a one-way flow of energy. For instance, Tim was unable to express his anger at Rick because he was too busy taking care of Rick to know what he himself was feeling. Tim eventually realized that he was tired of being the problem solver and caretaker within his social group. During one session he expressed some resentment that his friends would assume that he wanted to solve their problems or be their sounding board. They never asked if he were interested in having the conversation, they would start right in with relating their problems and asking for advice. Tim began to practice not offering or eliciting this problem solving conversation with his friends, or when prompted would not engage in the discussion. This was an important learning and practice for Tim.

A third imaginal structure was implied by Tim's reaching out for assistance when he realized he was depressed. While this asking for assistance could have been a part of an imaginal structure related to his parents' long term, committed marriage, that people who love each reach out to each other for help, I will suggest that his reaching out for

help was an aspect of his imaginal structure on how best to deal with depression. Tim had had good results in the past seeking assistance when he had been diagnosed with bipolar disorder, and he anticipated that it would benefit him again to seek assistance. His ability to face his depression and seek assistance closely paralleled my own positions on depression, so that we were able to collaborate on his healing without reservations on either side of the therapeutic relationship.

A fourth imaginal structure for Tim could be the result of his extraverted attitude-type. Extraverts are problem solvers and appear to relish a good challenge. An extraverted-type motto might be: people do, they do not complain. This imaginal structure of independence and stoicism might account for Tim rarely showing depressed symptoms while in session. A mark of comfort for a client sometimes is when they are able to show their deepest emotions in a session, when they trust the therapist enough to be vulnerable in the moment. I never got to see Tim in any vulnerable attitude during sessions. It was more likely that Tim would state his discomfort when he shared moments of extreme emotionality in his life, as when he expressed his anger to Rick in a direct way.

New Learnings About My Imaginal Structures

The Literature Review on depression, across several perspectives, consistently voices the association between depression and relational conflicts/trauma. Working with Tim around his codependency dynamic with Rick, I was reminded of my own history with both relationship trauma (the divorce of my parents during my childhood) and the codependency struggles I had with my stepfather. These early wounds can become so

imprinted in the soul's experience as to feel like they have always been there, especially when depression erupts. I have come to appreciate more acutely how depression and relationships are inextricably linked, how the attachment process of human beings is inextricably linked to the experience of loss and depression.

My imaginal structure influenced by the wounded healer archetype was in the forefront of my work with Tim. By attending to and healing my depressions, I have developed the capacity to assist others in their own healing. I have come to appreciate in a new way that the dark gifts that come from my own wounding can be used in the service of others.

Primary Myth

During my early research looking for myths that might reflect depression, the myth of Persephone and Demeter seemed most appropriate. Jean Shinoda Bolen notes that the Demeter or Persephone archetypes are both likely to deal with depression as a psychological illness.⁷ James Hillman frames a psychology of death where the relationship between Hades and Persephone are crucial images.⁸ The concepts of decentering (rape), loss, depression, and the ritual enactment of death are all central to the myth of Demeter and Persephone. The concepts of renewal and return, as well as the nature of the cyclical quality of depression are found in this myth as well.

Klein's depressive position is reflected in the relationship between Demeter and Persephone, even though Persephone is an adult, not a child. The tearing asunder of the symbiotic mother-child relationship occurs here, with the subsequent depressive response

that follows. After long consideration, the imagery in this myth became central to my re-visioning of the depressive imagination.

My therapy work with Tim challenged me in a way that brought into focus the myth of Cupid and Psyche. The suffering of codependency that Tim brought into the therapy journey seemed to fit somewhat the Demeter and Persephone relationship, but not entirely. During the 1980's when the codependency movement found its stride, I was personally offended by the idea that any and all relationship struggles were ipso facto indicative of codependency as progressive illness. It seemed to me that codependency was the natural state of affairs, as relationship is central to the human experience.

Given my knowledge of the ideas proposed by Jung and Hillman, I began to contemplate what myth might allude to the archetypal notion of codependency, both from a seeming *dysfunction* as well as *necessary* formulation for the soul regarding romantic relationship. I concluded by the end of the 1980s that the myth of Cupid and Psyche might be the appropriate myth that reflected the often complex differentiations of dependency, codependency, independence, and interdependence within romantic love, and their relationship to depression.

The myth of Demeter and Persephone contains the idea of the depressive position as articulated by Klein. Yet, what I was dealing with in Tim's suffering was something more adult than Klein's formulation. This adult quality of romantic love and the soul's need for romantic love seems best exemplified by the myth of Cupid and Psyche. In this myth, like the myth of Demeter and Persephone, decentering, loss, depression, and ritual enactment of death, renewal, and return also occur. The context however is adult romantic entanglement.

I am of the opinion that both of these Greek myths present the range of object relations theory regarding attachment and loss and the subsequent depressive suffering. Object relations theorists imply that early childhood attachment history has an impact on the adult attachment experience.⁹ This object relations observation is the conceptual bridge linking these two Greek myths vis-à-vis the depressive experience.

The third myth that I have used in understanding the archetypal dimension of depression is that of Inanna. This myth presents a wholly different perspective on the idea of descent and depression that does not include a strong relational dynamic, at least not overtly. Decentering and loss, depression, and the ritual enactment of death, renewal, and return occur within this myth as well. There is directness in the presentation of Ereshkigal's intense mourning that is not found in the other two myths. Ereshkigal's fierceness and Inanna's meeting of that fierceness seem illustrative of the encounter between ego and soul, and life and its foundation in death. This myth seems to imply that depression is survivable only by direct engagement and honest suffering.

Personal and Professional Development

Collaborating with Tim on his therapy journey, as well as immersing myself in the review of the psychological literature on depression, challenged me both personally and professionally. One challenge was my reintroduction to engaging as a psychotherapist and in a therapeutic alliance, and bringing this intimate venue back into my life. The last time I was in the role of psychotherapist was during the years of 1990-1994. It had been a full ten years since I had been in this professional role when I began working with Tim.

I had a certain amount of apprehension as I re-experienced what it felt like to be in the psychotherapist's role. For example, there was the sense that as a therapist I had to make it all better for Tim, and do this as quickly as possible. I struggled with the tension of how much intervention was adequate: do I lead more, or less, in the therapy process? Tim's extraverted style made it both easy and difficult for me at the same time. Easy, because he was clear as to what his treatment plan would be; difficult because our attitude-types were opposite. I had to relearn to trust my intuition as a therapist, which I refer to as listening with a third ear to the client's deeper and sometimes unconscious communication of their experience. I had to relearn that making mistakes, as a therapist was not a bad thing, as long I acknowledged it with Tim, and moved beyond the error.

The therapeutic relationship is unique, and in its own way artificial. Boundaries are important: how available should I be to the client? Do I insist on payment if the client cancels within less than 24 hours? What interpersonal issues are relevant to the therapeutic process, and what issues are simply administrative concerns? How much self-disclosure do I engage in, and to what purpose? These kinds of questions are germane and important, and appear whenever a therapist sees clients. My ongoing supervision with Myron Hays was crucial, as I could discuss these questions and sort out my thoughts and feelings with him.

A second challenge that developed out of my research for the Literature Review and my own theoretical orientation in Imaginal Psychology was this: did I consider myself a clinician, in the medical model sense of that word? This was both a professional confusion, and a personal agony. The medical model of mental illness and the cognitive behavioral perspective in psychology are the two dominant models of human suffering

within schools of psychology as well as treatment organizations. The question of whether *psychologist* is synonymous with *clinician* was something I contemplated deeply as I researched the literature. Ever since my first job in 1983 as a mental health worker in an inpatient psychiatric hospital, I have questioned whether human suffering and dysfunction is reducible to a checklist of symptoms

I have come to accept that the *DSM-IV* is a helpful tool, but that for me it is not the primary tool, or even the preferred tool, in working with clients. There are four reasons why this realization is important for my future practice as a psychologist. First, how I define myself vis-à-vis the *DSM-IV* determines how I work with clients. If I accept depression as it is presented in the *DSM-IV*, then I should treat the depression, and not the person, who, as I have noted, always lives within a story. It is important secondarily, because the medical model is the dominant model in the discipline of psychology today. I have found that my inability to profess allegiance to the medical model makes other psychologists question my abilities, as well as, making them nervous about me as a psychologist.¹⁰ Third, my coming to terms with the *DSM-IV* is important because these diagnostic entities are used for third party reimbursement of services from insurance companies, HMOs, and government entitlement programs such as Medicare. There is a built in incentive to tow the line as a medical model clinician - one's livelihood. Finally, the medical model rendering of human suffering determines the licensure and liability of a psychologist, so that I will have a need to utilize the *DSM-IV* categories in an acceptable way. The licensure requirements includes passing an exam based on *DSM-IV* categories, as well as questions pertaining to biological determinants of mental illness usually referred to by the term neuropsychology.

I have come to accept an uneasy alliance with the medical model of mental illness for the reasons just listed. It is neither a failure nor a deficit that I view psychology and psychology from a differing orientation than the majority of others. I have come to accept myself personally and professionally with the identity of psychologist and I have come to accept that not identifying myself as a medical model clinician has come with personal and professional costs. I have been passed over for jobs I was quite capable of performing. I have experienced isolation as a psychologist in the medical model environments that I have worked in. I have had to defend my imaginal approach to colleague and client alike.

This dilemma is not new. Sedgwick remarks that Jung shied away from using jargon and always theorized in non-medical metaphors.¹¹ Jung used terminology from alchemy, myth, shamanism, and religious healing. In my reading of many of Jung's works over the years, I think he tended to apologize for, and ask for equanimity from, the reader, who I fantasized as scientific medical model types, whenever he introduced some of these non-medical metaphors. On the other hand, what I take from Jung's writings is that the effort at explanation is important, so that differing perspectives and the soul's multiplicity can be honored.

Applying an Imaginal Approach to Psychotherapy

Depth psychology has a history of working with images in a therapeutic manner, so that applying an imaginal approach to psychotherapy is neither new nor foreign to depth psychology. As was illustrated in the Literature Review, the fantasy image was a focus of attention in the depth psychology of Freud, who utilized his patient's fantasies

and dreams to better understand their psychodynamic conflicts. Freud's coining of the phrase *Oedipus complex* implies that he understood the mythic element that is found within the ordinary individual life. His one-time student, Jung developed the idea that the archetypal image was at the core of fantasy material, and Hillman opines that the archetype and its image was the one consistent tenet of Jung's psychology.¹²

Hillman, taking Jung's observation to heart, developed a depth psychology that he called archetypal psychology, whose maxim is that the soul is constituted of images.¹³ A more recent development is that of Imaginal Psychology as articulated by Omer, which embraces these imaginal approaches found within depth psychology and seeks to move beyond the limitations of the culture of the Western imagination. Imaginal Psychology is a distinctly postmodern development in the history of psychology.¹⁴

Tim was focused on symptom relief and goal achievement. My work with Tim was not overtly based on imaginal approaches. The reasons for this are several, based on Tim's personal psychology. Early on in our work together he had attended an Al-Anon meeting where the participants were overtly Christian-based in their 12-Step process, utilizing prayer. Tim was extremely put off by this, and never returned to that particular group. He considered himself an agnostic, and did not feel that he could trust the way people used the notion of God. I interpreted these statements to mean that other ways of imagining experience as well might not appeal to Tim. For instance, he never presented any dream material, nor did he provide any direct imaginal entry into his psychic life: no story telling, or movie image sharing, or reading of fiction. Tim rarely used metaphor in his communication style. His rendering of his life events were always concrete and descriptive – subject, object, verb.

Tim was adept at using words, however, and words are themselves imaginably driven. Hillman writes about the power of words to invoke image and soul: “We need to recall the angel aspect of the word, recognizing words as independent carriers of soul between people.”¹⁵ When Tim spoke images like “big boy drinks,” to describe what Rick drank during his episodes, or when he described his presurgery terror as “a near death experience,” he was conveying an image through words that invoked within me an inner fantasy response. His use of humor as well conveyed images, since it is an image that is invoked within us that makes us laugh in response. When Tim spoke of his near death experience, I interpreted this to mean that the event was deeply terrifying and moving for him, so I elicited further explanation from him, and this in turn led to a serious life review for him that lasted several months. Out of this discussion between us he developed a five-year life plan that was meaningful and comforting to him.

The images found in the myths I have explored above and in the Literature Review provided a conceptual supporting framework for my work with Tim, even though I never felt that he would appreciate this way of holding his experience, so I never shared it with him. I began my work with Tim with some intimations based on the myths I have discussed previously. I suspected that his depression must have a relational component since loss, decentering, and depression is always the potential outcomes when human beings attach psychologically and emotionally to others. I also assumed that somewhere within Tim’s depression, anger would have to exist; and that the archetypal experience of death as an element of depression must be somewhere in his imaginal landscape. I was careful not to lead in any of these directions during our sessions, but instead used the

suggestions found in the myths as images to be held lightly, choosing to be mindful and alert should Tim express them in any way.

I never expected – and was completely surprised – when the images that I held lightly were enacted in an externalized manner! The death theme of the depressive imagination occurred *literally* for Tim while he was being anaesthetized for surgery. Tim believed he was dying. He thought that it was sad that he would die alone since Rick chose not to be with him. This was the relational component of his depression. And he was furious that Rick was not capable of being there, so that the anger element of the depressive imagination came out front and center. This single terrifying event constellated the depressive imagination as nothing else had up to this point in our “rational” work together. It was a singularly potent decentering experience for Tim, knocking him out of his rational mode of experiencing into a deep emotional place that forced him to examine his life more deeply. Two months later, he finally expressed his anger to both Rick and Dennis in a direct way, which appeared to be a significant form of resolution for him with both these men. He could move on with his life at this point, and he was able to step into his future with renewed purpose.

During my work with Tim I learned that the image and the imaginal are always present in the soul’s experience, but it requires purposive attention to the soul’s primary composition, the image, and the soul’s primary way of being, the imaginal, in order to engage in soul-making, as Hillman suggests.¹⁶ Psychotherapy as reenactment of Freud’s talking cure turns to the soul’s necessities as expressed in its images to understand the archetypal story that the person is enacting or identified with, usually unconsciously. The therapist can use image effectively; it does not require a buy-in or belief from the client.

Nor is the therapist doing anything “to” the client as much as being with the client in soul. This way of holding the client is not heroic, which the medical model implies with its talk of potions and cures. It is a way of walking with the client, entering their imaginal landscape while attending to one’s own imaginal landscape, an intersubjective field of images that can be explored through words, but not limited to words.

CHAPTER 5

REFLECTIONS

Personal Development and Transformation

The process of the Clinical Case Study and the specific topic of depression, inclusive of the imaginal approach to understanding depression, became, quite unexpectedly, a situation about my identity as a psychologist. During the last stages of the Literature Review, I interviewed for a psychologist position at a local medical center. There were many reasons for a lack of fit between the department, the responsibilities of the job, and me, but one main concern on both sides of the interview process was my inability to articulate the medical model of mental illness with any ease.

The usual process involves a written hypothetical client case from which I had to extrapolate appropriate diagnostic categories from the *DSM-IV*, rule out other possible diagnoses, formulate a treatment plan, and deduce any legal or ethical considerations. I felt I achieved this particular test and was confident of my overall analysis, yet I found myself in an awkward situation. While I knew the appropriate medical model words to use, I found resistance within myself to pathologize this hypothetical client in medical model parlance. I found myself choosing words carefully, choosing different words with the same meaning.

I consciously interviewed myself out of a job. I left and proceeded to feel inadequate for several hours after the interview. I spoke with Dr. Hays who reassured me

that my professional skills were sound. I thought back on the fact that this was the fourth time in about 20 years that I had interviewed for and been turned down for, a mental health clinician's job.

This time I felt that I had made a *choice*, and I chose to accept that this particular rendering of psychologist as medical model clinician is not my particular identity. I came to accept that I should not work in an environment where mental health or mental illness is viewed from the germ theory of disease. When I spoke to my potential supervisor during a second follow up interview for the job, she acknowledged that the work environment was indeed medical model, and proceeded to share that she had been admonished because she had forgotten to use the *DSM-IV* diagnosis as part of a summary note on a patient, an issue connected to accreditation in a primary medical care setting.

The Merriam-Webster Collegiate Dictionary defines the word *clinical* as an adjective that means “of, relating to or conducted in or as if in a clinic; as involving direct observation of the patient or diagnosable by or based on clinical observation.” A second definition given is “analytical or coolly dispassionate.”¹ The dictionary defines *clinician* as a noun, “a person qualified in the clinical practice of medicine, psychiatry, or psychology as distinguished from one specializing in laboratory or research techniques or in theory.”² Both these definitions together imply that in the general clinician is a practitioner who uses direct observation of the client to assist the client in getting better.

This parsing of words may seem unnecessary, but as Hillman has suggested, words are the carriers of soul between persons. *Identity*, sometimes referred to as individuality, is an aspect of personality development, and professional identity is no less important than personal identity. I came to realize that this issue of professional identity

is what makes medical model practitioners so uncomfortable with my process and my implied criticisms of the medical model.

I have come to see that my struggle during the doctoral process has been to come to terms with how my personal identity has merged with my professional identity.

Omer's concept of *core identity* comes to mind here, which he defines as the following:

“Core Identity refers to the unique endowment of particularities that unfold, mature, and guide transformations of identity through the life span.”³ There is a suggestion in Omer's statement that core identity guides the individuation process. Concerning individuation, Whitmont writes: “There appears to be a compelling urge to adapt to what one is meant to be – one's inner truth - which may have little or nothing to do with one's conscious ideas or purposes. Jung has called this the individuation urge.”⁴

In retrospect, my struggle with the identity of psychologist has been a lifelong process, which leads me to assume that this particular struggle is associated with my own core identity. While an undergraduate at the University of Connecticut with a major in psychology, I was extremely put off by the idea of experimental psychology, which was a large component of the psychology department's emphasis. I was reading R.D Laing and Thomas Szaz, both early authors who had published criticisms of mainstream scientific psychology. I had already read many of Carl Jung's works, and I appreciated that Jung used metaphorical language to describe the soul's experience.

For me, there was a disconnect between what I experienced in my life, and my observation that experimental psychology limited the soul's experience. I recognized as well that my own non-Western identity was not found within mainstream psychology's orientation. My religious promptings and beginning religious practices were not held in

any way by experimental psychology's emphasis on measurement of experience. How does one measure a religious epiphany? Finally, I remember taking an abnormal psychology class and reading a list of deviant sexual preferences. Homosexuality was listed last, after pedophilia and necrophilia. I remember feeling outraged, stunned, and betrayed.

Many decades later, I can finally accept that my professional development and my core identity are mutually defining. After the job interview and its aftermath, when I finally sat quietly with myself, it seemed simple to me, but nonetheless important, to recognize that given who I am – and where I have come from – a European, Western, scientific, medical model approach to the soul's experience is not an environment that I can live within for too long. It was odd to, in a way, forgive myself for not being someone I could never become and never have been. Sometimes the simplest explanation is the hardest to recognize.

As I finish the doctoral process, I have to reexamine as well what kind of work I would prefer to do with clients. I have initiated this conversation with my supervisor in my private practice Myron Hays, who continues to be supportive of my professional individuation process. It is a conversation that we will both continue to have as the private practice continues.

Imaginal Psychology allows for the movement between competing images and ways of imagining experience for the soul. The process of researching and writing this Clinical Case Study has challenged me to better understand my professional identity, and how this ties to my personal identities. I am beginning to get comfortable with how I am

compelled to practice psychology and I am confident that this new sense of identity as psychologist will benefit future clients.

Impact of the Learnings on My Understanding of the Topic

I started the Clinical Case Study on depression with the assumption that Klein's depressive position was a key concept to understanding the necessity of depression to the soul. Klein was the only theorist I had encountered at the beginning of this writing who found depression to be meaningful within the overall developmental context of the person. I suspected that Klein's depressive position was paralleled in the myth of Demeter and Persephone. I was excited about developing this connection from a mythic perspective.

The notion of the decentering of the subject from its experience and the resultant depressive position/depressive imagination was confirmed for me, both from actual work with Tim, as well as, by the overall literature on depression. For example, Healy proposes that circadian rhythm disruption may be the precursor to depressive episodes.⁵ He makes a strong case as to why social and biological rhythm disruptions might result in a case of depression. I would suggest that he is describing another form of decentering of the subject from its experience.

I am grateful that I had Klein's notion to either support or refute while doing the Literature Review on depression. The overwhelming negative judgments against depression by medical model proponents like Kramer, or cognitivists like Beck, required that I persevere and read the literature and the studies. It was a significant finding for me that critiques of the medical model of mental illness rarely come from within the

profession of psychology. Healy is a rare psychiatrist who is able to hold onto both the benefits of antidepressants and their limitations. The critiques found in the book *The Loss of Sadness* come by way of Allan Horwitz, a sociologist, and Jerome Wakefield, a social worker.

My work with Tim was confirmation that an imaginal approach to treating depression was possible, while not denying the medical model categorization of mental illness. The medical model was a good starting point in our work together. Tim did not want to take medications, nor was he interested in psychodynamic theories to explain his depression. No cognitive behavioral approach for him; he wanted results, and engaged his life in a direct and admirable and honest way.

Another aspect of my collaboration with Tim was confirming the idea that depression has a purpose in a very personal way. While the medical model can be helpful to start a treatment plan, the *DSM-IV* contains little in the way of formulating why a depression constellates, or how it can be healed. Despair is never far behind for a sufferer of depression if they do not believe there is a significant cause, or a purpose to their suffering. I refer to this situation as suffering without dignity.

Both the medical model of depression and the cognitive model of depression minimize the cause, meaning, and purpose of the depressive imagination. Both of these models assume errancy, dysfunction, and dysregulation in the experience of depression, and the implied judgment of this viewpoint reduces human suffering to having little dignity, and some shame. I am not suggesting that suffering is noble, only that suffering without dignity is ignoble. What I learned is that the medical model of mental illness inclusive of the *DSM-IV* does not impair my ability to assist the client in finding the story

that allows them to move forward in their depression, to find the dignity implied in their suffering.

Mythic Implications of the Learnings: The Depressive Imagination

The mythic largeness of depression is reflected in the psychiatric nosology of the *DSM-IV*, where new disease clusters describing depression are still being created, because, I believe, the mythic and archetypal ground of depression's being can never be fully captured by psychiatric disease modeling. The mythic quality of the soul's experience reflects the intentionality of the images that the soul lives. Hillman believes that all things desire to return to the archetypal originals of which they are copies and from which they proceed. This notion of reversion implies that the soul's suffering has archetypal roots, that there is indeed a purpose to the soul's descent into the depressive imagination. Klein and Ogden articulate this intention of depression, as do many depth psychologists.

Myths are stories that embody the universal constants of the human experience. As far back as written human history, depression as an aspect of loss appears in the *Epic of Gilgamesh*. When sharing his story with an innkeeper Gilgamesh exclaims: "Enkidu, whom I love deeply, who went through every hardship with me, the fate of mankind has overtaken him. Six days and seven nights I mourned over him and would not allow him to be buried until a maggot fell out of his nose."⁶ This image of the maggot shocks Gilgamesh into recognizing the tragic loss he has suffered, and he sets out to learn the secret of immortal life. There is often a story akin to what Gilgamesh describes to the

innkeeper, which a client wants to tell and share, when they come for treatment. The story that moves their depression forward is already present.

The myth of Demeter and Persephone formed the thematic background to my work with Tim. I worked under the assumption that the myth of Demeter and Persephone contains the idea of the depressive position as articulated by Klein. I assumed that Tim's resolution of his depression should contain some key themes found in this myth, and held this assumption lightly, as a participant observer. I was surprised when Tim's therapy journey reflected these themes, in moments unimagined, as in his near death experience during his presurgery. Or when he "lost it" and expressed his hidden rage to his two previous lovers within the same week.

Myths contain images that are archetypal in nature. If the mythic is reflective of an archetypal lens, then a case study such as this should betray the lens that shapes it. The lens of depression runs throughout this Clinical Case Study, not just in the learnings, nor only in the myths being deconstructed. Hillman provides a truth that has sustained this Clinical Case Study from beginning to end: "If archetypal images are the fundamentals of fantasy, they are the means by which the world is imagined, and therefore they are the modes by which all knowledge, all experiences whatsoever become possible."⁷

Depression is inherently mythic and mythical. The decentering aspect of depression appears repeatedly in human experience and therefore in the mythic spinning of the soul's imagination, in story and myth. I would like to share some themes that I believe appear repeatedly in the mythic presentations of depression. If even a few of these themes appear consistently within myths from different times and places and

peoples, then depression would appear to be archetypal, in the sense of Jung's definition of the archetype as a consistent way of apperception of experience.

When I reflect on the three myths that have been summarized, the literature on depression as a whole, and the learnings from my work with Tim, some common themes appear. These themes are not given in any particular order, nor is a particular order suggested. Each theme is vital to the understanding of the other themes, so that they amplify each other in a meaningful way. What I present is not meant to be exhaustive or definitive, but is offered as a way to find the language that best describes the depressive imagination. It is an imaginal approach to an imaginal landscape. The archetypal themes described are soma, decentering, Hades, mirroring, negation, liminality, loss, return, and devotion.

Myth being sacred, the sacred can be found in the mythic suffering of the soul. This is an approach to myth that sees in the myth a ritual enactment that contextualizes suffering within the realm of the particular God from whom the affliction proceeds. One must then go before the appropriate God and make the appropriate sacrifice. The modeling for this approach comes from the beautiful maiden Psyche herself, who realizes that the only healer she can turn to, is the very Goddess from whom her fate is decreed.

Soma

The word for the body in Greek is the word *soma*. The body is the spatial metaphor within which depression happens. It is in corporal enactment that depression is first seen, the outer manifestation of an invisible force, or lack of force, for the soul, *anima*, that which animates, has left one, and left one bereft.⁸ Inanna becomes the image

of rotting meat, and as rotting meat she is treated by Ereshkigal. This is Solomon's "walking-death quality of depression," the suspicion that something vital has left the body, or left the body in a weakened state.⁹

This body state is part of the *DSM IV* list of vegetative symptoms of depression, which include: "anhedonia or inability for or disinterest in pleasure, weight loss or gain, insomnia or hypersomnia, fatigue, and psychomotor retardation or agitation."¹⁰ Demeter is awash in vegetative symptoms. She wanders aimlessly, she will not eat, she will not bathe, she will not drink, and she will not sleep. Persephone mirrors her mother's bodily symptoms by refusing to eat. Psyche wanders the earth far and wide, distraught, her body unable to stop moving. This is the image of the undead, the not-quite living, and all three of our myths hint at the fact that death is not far away and is in fact the telos of the story.

The cognitivists' model of depression lists biology (body), thought, emotion, and behavior as the four aspects of depression needing attention, yet cognitivists bypass emotion and the body in favor of thought and behavior.¹¹ Within the medical model of mental illness the body is referred to as symptomatic, the bearer of symptoms, ignored until it asserts its errant ways. Psychology's response to the body has often not been gentle or compassionate, no light holding or loving touch.

In the history of psychology, depression has been treated by the body being given antidepressants to correct brain chemistry. The body has been operated upon surgically. For a time insulin was used to induce diabetic coma, and with some success. Individuals have been immersed in ice, or hot water, or both. ECT, electroconvulsive therapy, appears to work best in the most severe forms of vegetative depression, intriguingly, has the greatest efficacy among the body treatments available.¹² One consistent finding in

treating the body is that none of the body treatments work immediately, requiring weeks to show an effect.

It could be that when the depressive imagination is taken literally, literal treatments are in order. Imaginally, without judgment as to whether these body treatments work or do not work, it seems that humanity has tried to shock back into the body, that which has left it behind. For some indigenous cultures the symptoms of depression are attributed to the loss of soul and our myths confirm this observation. The soul is away, on a journey, toward the land of the dead.

Decentering

The depressive imagination is the result of the decentering of the subject from its own experience, both what one sees and how one sees it. In my view, depression can be a creative act of integration, a move to put the subject back into the center of its own experience. Since the soul contains multiple subjectivities, a question that needs to be asked is: which subject is being decentered and disintegrated? Through this process of disintegration (death) and integration, the soul engenders greater capacities for holding the complexity of its own experience.

This idea of emergent soul capacities is seen within Omer's definition of an imaginal structure, which is both content and process.¹³ Omer suggests that disidentification from an imaginal structure is one of the steps in transmuting that imaginal structure, and this transmutation results in emergent and enhanced capacities; for example, the turning towards the experience of injustice calls forth fierceness as a response.¹⁴ I will suggest that one result of disidentification from an imaginal structure is

the depressive position, and that the depressive imagination is constellated as part of this process of transmutation. The subject is decentered from itself. If only briefly, the subject is set adrift.

Hades

The ancient Greeks referred to the land of the dead and its king with one word, Hades, often said in a whisper, if said at all. Hades is the Invisible God, the Hidden God, that unknown mystery that is the foundation of life. The Greeks equated Dionysus with Hades, and there were great festivals to Dionysus, this God that rules the invisible point where Life and Death meet. In my view, our particular Western culture does not honor death. The current frenzy of embryonic stem cell research can be seen as the latest example of our turning away from death.

All three of the myths explored have as their endpoint Hades, Death. Inanna goes there voluntarily. Persephone is abducted into its realities and becomes its Queen. Psyche is the enactor of the dance of death, although ignorant to this truth. The very idea that she is attended to by invisible hands and that her husband chooses to remain invisible hint at the fact that Cupid has a secret relationship to Hades, The Invisible One himself. How else could Cupid have brought Persephone back from the dead?

Psyche resolves to commit suicide no less than three times, and each time is given the counsel she needs to complete the impossible tasks that Venus has laid out for her. Psyche confuses literal death with the ritual enactment of death. It seems more than coincidence that at each place she contemplates suicide, a helper steps forward to guide her towards ritual enactment and not literal extinction.

Psyche in Greek also means soul. Psyche enacts ritual moments of death throughout her story because it is to the land of the dead that the soul turns to in order to find renewal. The disintegration and integration of the depressive position occurs in this landscape.

Psychology and psychologists are well aware that suicide can be the extreme result of an untreated depression. It is every psychologist's nightmare and the alarm is sounded often and repeatedly in the risk assessment of any client, as it should be. While psychologists worry about the suicidal risk of their clients, they sometimes miss the other ritual enactment of death: murder. Women drown their children. Men murder their spouse, their children, and then kill themselves. Young men enter a school campus and kill innocent bystanders. In my view, this is the externalizing pole of the Call to Hades, a complement to the internalizing pole of the suicide.

The weekly psychotherapy hour between client and helper is a container for death, for the ritual enactment of death. What does it say, then, that psychotherapy *per se* is constantly under the gun by medical model psychologists, insurance companies, and managed care? Could it be that psychology's secularism and categorical models of depression contribute to the suicidality of our clients? Is psychology itself depressogenic? These are questions worth asking for the responsibility for those of us who would be doctors of the soul – psychologists – is great.

But what purpose does the ritual enactment of death serve for the soul? Inanna provides one clue. Unlike Psyche, referred to in the narrative as an ignorant girl, Inanna chooses to enter the underworld: "From the Great Above she opened her ear to the Great Below. From the Great Above the goddess opened her ear to the Great Below. From the

Great Above Inanna opened her ear to the Great Below.”¹⁵ It seems instructive that it is her ear that she opens, for vision in a place of shadows and shades would be pointless. The Dead speak in whispers and from the dark. Inanna has a plan and she executes it, having faith in her ability to survive, and cleverly, understanding that her survival depends on the love of others.

Inanna upon her return to life chooses her husband Dumuzi as her replacement in the land of the dead. She turns on him the eye of death and pronounces judgment, *just as Ereshkigal had done to her*. By undergoing the ritual of death, Inanna now has the power of death itself. She is now the Queen of Heaven, Earth, *and* the Underworld. Perhaps the emergent capacity found within the depressive imagination is the power of death, an understanding of its archetypal necessity to the experience of the soul, death’s inherent potential for renewal and the living of a more passionate life.

Mirroring

Father Enki, the God of Wisdom, understands what psychologists today refer to as complicated grief. He fashions Mourners, neither male nor female, whom he sends to Ereshkigal as witnesses. The Mourners repeat each of Ereshkigal’s laments without judgment:

Ereshkigal was moaning: ‘Oh! Oh! My inside!
 They moaned: Oh! Oh! Your Inside!
 She moaned: Ohhhh! Oh! My Outside!
 They moaned: Ohhhh! Oh! Your Outside!’¹⁶

Ereshkigal, whose awesome gaze has the power to kill, in gratitude for the mirroring shown by these creatures, hands over Inanna’s corpse as they request.

Mirroring is a concept developed by the object relations theorists, as Klein implies. The infant not only has its biological needs met, but is mirrored back to itself by the mother and other caregivers. As human beings, we continue to mirror each other throughout our lives and it is safe to say that this mirroring is at the core of the human aspect of being a social being.

There are parallel mirroring processes within our three myths. Demeter and Persephone mirror each other in their separateness. Persephone expresses her anger directly and refuses to eat. Demeter sublimates her anger and wanders the Earth. At the end of the myth there is a switch, Demeter rages and takes her power while Persephone relents and accepts her fate. It is as if, though separated, the mirroring is happening empathically. Inanna is the victim of Ereshkigal and upon her return she is the perpetrator against Dumuzi. Psyche chooses physical death but instead performs a ritualized enactment of death. Psyche is the mirror of Venus, and vice versa, and their fates are intertwined.

The notion of mirroring is important to the care of depression. We do this by using Freud's talking therapy, the power of speech, which is the servant of mirroring. This is why Inanna turns her ear to the Great Below, for the finely tuned ear is crucial to talk therapy, this ritual of death. The therapist mirrors back to the client, without judgment, the depth of their despair. The therapist takes on the role of Father Enki's Mourners. This is a very different approach than the heroic one, where eradication of the depression is the goal: take this pill, do this fire walk, get back to work.

The client requires from us this mirroring as they become thin, as they become spectral. We therapists are the counterweight, the reality function, Demeter's quiet raging

to Persephone's helplessness. If the depressive position is about disintegration, then there is a moment when death happens, and as attendants, we – Hecate, Psyche, Ninshubur – must be there to chop the wood and carry the water that the client cannot. These myths show us how.

Negation

Negation is the saying of the word, “No!” Negation is not the *opposite* of something as we wait for a reversal, the reprieve promised in white light scenarios. Negation is *absence*. Beck notes that the depressed individual negates all things life oriented. He writes: “The overall behaviors of the depressed patients – verbal and nonverbal – seem to contradict the most hallowed notions of human nature.”¹⁷ The depressive will not eat, sometimes desiring death, negating the instinct of self-preservation. The depressive will not relate, negating the procreative instinct. The depressive will not have pleasure, negating the call of the body. The depressive will not parent, negating the call to care for the most vulnerable.

One emotion behind negation is found within our myths. Hatred and murderous rage, which tears apart and tears down, come easily to Ereshkigal. Venus rages and wants nothing else than the death of Psyche. Demeter's rage is more layered, more nuanced, a bit more complicated. She accepts the will of Zeus, the God of Above, and turns her anger against herself. It is an errant way for anger; but as a result of this sublimation she founds the Eleusinian Mysteries, hinted by Greeks to be ritual enactments of death and rebirth. This still does not change her situation. It is only when she accepts her murderous

rage, and paradoxically decrees what is in her power to take away – the negation of vegetative life – that her daughter is returned to her.

Negation has a hand in the dialectical tension between hatred and love of Klein's depressive position, the injury and the reparation, the disintegration and the integration. Cupid and Psyche embody the mirrored, negating, dialectical sides of the depressive position. Cupid is the invisible one, hinting at his relationship to Hades, death, he is also son of Venus, the personification of Love. Psyche is fated to weave in and out of this tension; she is one moment the servant of Venus, love, and the other moment the servant of Persephone, death.

Negation leads us to Inanna's nakedness, to being a piece of rotting meat on a hook. It is in the darkness and deprived of all things human, the measure of the human, that the Invisible source of the soul is to be found. Solomon writes about his three depressions, deep suffering that changed his life irrevocably:

There is someone or something there stronger than chemistry or will, a me that got me through the revolt of my self, a unionist me that held on until the rebel chemicals and their consequent ideation had been brought back into line.¹⁸

The task of the therapist, when the client is deep in the experience of negation, is to mirror to the client the "unionist me" that Solomon writes about, so that the impulse towards the literal enactment of death is seen through, and the painful ritual enactment of death can proceed.

Liminality

The word liminal comes from the Latin word *limen*, which means threshold, so that liminality is the state of being between two realms, neither here nor there, neither this

nor that, absence in presence. A threshold is the beam above a door, connecting above with below, the place we are told to stand during an earthquake, implying certainty in uncertainty. A doorway is a good image for liminality since one is neither in this room nor that one, while simultaneously being in both rooms. Another image for liminality is the antechamber to a temple where one prepares before entering a sacred space; or the anteroom where one waits before being announced, the experience of every client in every waiting room in every psychologist's office. It is to a liminal space that the subject enters whenever that subject is decentered from its own experience.

The myths tell us that ritual is the creator of liminal states, is the vehicle for liminal states, and is the way out of liminal states. Inanna has to enter through seven gates, which are then locked behind her. Obversely, there is a procession that follows her as she leaves the underworld. Psyche has a treacherous route to take to retrieve Persephone's beauty, past Charon the ferryman and over the river Styx, and past Cerberus the hound that guards the place of death. Her return journey is identical but in the opposite direction.

All experiences of depression have rituals, if we attend closely. Often the soma aspect of depression is the key to the ritual: too much eating, not enough eating, too much doing, or no doing at all. Ritual is not static, even though it is considered a noun. A ceremonial act is act first, ceremony second. There is a doing involved, as in the process of psychotherapy, but the first task in psychotherapy is the building of the antechamber, the purification place, for the realm of the dead is sacred ground. This is why depth work in psychology takes time and ritual, as the Seven Gates are traversed, first into, and then out of, the place of Hades.

Loss

Psychologists, modeling Freud, have argued over the distinction between mourning and depression, whether depression is exogenous (reactive) or endogenous (internal). Beck, who is an astute observer of the depressive, writes: “The depressive’s conception of his valued attributes, relationships, and achievements is saturated with the notion of loss - past, present, and future.” Beck also observes that the experience of a loss sets up a chain reaction that can eventually lead to a depression.¹⁹

It is difficult to know if thoughts of loss or an actual loss leads to a depression, and Beck is implying both. If we accept these observations as true, then a case can be made for the experience of loss as being elemental to the depressive imagination. There is no need to argue whether it is mourning or melancholia.

Contrary to what Beck and Kramer believe, that depression has no evolutionary benefit, Horwitz and Wakefield contextualize depression as an aspect of loss.²⁰ Loss is a result of the biological and psychological mechanisms of attachment, as is seen by the distress exhibited by a mammalian infant when it loses contact with its mother, as well as the distress exhibited by the mother at the loss of her infant. While arguments can be made as to whether a depression is normative or dysfunctional, loss as an aspect of attachment processes has been established across scientific and academic disciplines.

Relationship has as its complementary horror loss. The experience of loss is somewhere in the mix whether mourning or melancholia, as Freud concluded. Ereshkigal is grieving the loss of her husband, is inconsolable. Persephone and Demeter have their perfect mirroring, symbiotic-like relationship shattered. Psyche at first has nothing to lose since in a way she is at a loss from the very beginning. Once she falls in love with Love

himself, her true awakening into life begins for she now has lost what she once possessed. There is an aspect to this primal kind of loss that is idyllic.

Return

For some individuals, depression is not a one-time event, but a cycle between adaptive functioning and extreme suffering. The notion of return speaks to the cyclical nature of depression. Persephone, who shuttles between four months of living with Hades below, and eight months of living with her mother in the world above, images this cyclical nature of depression. Persephone's return is the occasion of the flowering of Spring, and in the story, Spring and Winter are a necessary tandem.

The extremeness of cycling is found in bipolar disorder as described in the *DSM-IV*, which describes the ecstatic manic states that are followed by depression. Many clients I have worked with who do not have bipolar disorder describe a cycle of up and down, and learning the cues to when these cycles indicate the depressive pole helps them better prepare for the downturns. Seasonal Affective Disorder, which is the colloquial term used for the *DSM-IV* Seasonal Pattern Specifier to Major Depression, is another rendering of the cyclical nature of depression.²¹ This specifier notes that for some individuals depression occurs in a yearly seasonal pattern, usually beginning in Fall and Winter, and remitting in Spring. The nature of cycling speaks to the experience of depression as being dynamic and changing, even when clients report the overall intractability of their suffering.

Devotion

Devotion is expressed openly between Demeter and Persephone, and Cupid and Psyche. Several of the themes found within the depressive imagination offered so far, and some of the images attendant to them, denote elements of devotion. Coming to therapy weekly and other rituals as a response to the landscape of depression speak to a devotional aspect of the depressive imagination. Devotion in this context is religious enactment, as well as dedication and loyalty to depressive suffering as having telos, or an ultimate end.

The devotional element of the depressive imagination implies that within the depressive imagination there is an Eros, an element of love both emotional (Demeter and Persephone) and erotic (Persephone and Hades, Cupid and Psyche). This Eros is necessary within the context of psychotherapy since the first step in coming to terms with depression is to create a relationship to it that accepts the necessity for its being, and a compassion for oneself as wounded subject. It is the ultimate dilemma, embracing depression as a way to get over it by going through it. This is treatment of depression by understanding it, and oneself within it, as opposed to attacking it and eradicating it.

Significance of the Learnings

It has been my hope that the writing of the Clinical Case Study, in particular the learnings, would support a rationale that depression is a functional, adaptive process that may at times slip over an invisible line into dysfunction and dysregulation requiring a more aggressive approach to treatment. This is the view held by Horwitz and Wakefield as already noted, two professionals outside the discipline of psychology. The dominant

viewpoint within the biological model and its encroachment into the discipline of psychology is that depression is a disease, and both Kramer and Beck assume no pertinent evolutionary benefit to depression. The development of this viewpoint may be traced to observations of the most severe forms of depression, and the disabling nature of these occurrences. There is general agreement that this extreme form of depressive suffering appears to have little benefit to the sufferer, or those closest to them.

Opinions become split once this agreement of immense suffering is noted. Solomon, who has suffered the severity of depression, makes a move to understand depression and its meaning in his own life. He is articulate in voicing both the despair and the need to find meaning within his agony, because these were *his* depressions, engendered and lived through his subjective awareness. For him, depression is not some disease entity that runs consistent in all places and at all times. For Solomon, depression has a specific time, a specific place, specific people, and is grounded in his soul. To do violence against depression is to judge his suffering as meaningless and devoid of necessity. This is a definition of despair. Solomon demonstrates by example that the human being is a maker of meaning, even when the event is the abject terror of deep depression.

The tension within psychology of biological determinism of suffering, versus soul (psychodynamic) causation of suffering, runs deep and is long in history. Freud and Jung, medical doctors immersed in the biological model at the beginning of their careers, wrote about their observations that some symptoms in their patients were the result of psychological distress. Jung in particular writes consistently about the adaptive nature of neuroses, which he states, "...are also attempts at a new synthesis of life – unsuccessful

attempts, let it be added in the same breath, yet attempts nevertheless, with a core of value and meaning. They are seeds that fail to sprout owing to the inclement conditions of inner and outer nature.”²² Both of these men – based on their work and observations – moved away from an absolutist biological determinism of suffering, creating psychodynamic theories that address etiology as well as resolution of psychopathology from a psychological perspective.

Klein offers a way to view depression that gives depression a necessary role in human development, and describes an inner process of integration that allows for the development of the capacity to love, among other abilities. Bowlby, borrowing the observations of other disciplines such as ethology, documented how loss and sadness are the necessary distress responses to attachment between children and parents, or any two human beings. Horwitz and Wakefield more recently support some of Bowlby’s observations. Healy offers the opinion that dysregulation of circadian rhythms may be the causation of depression. Turning to myths, there is evidence that as far back as written history with the *Epic of Gilgamesh* depression and loss have been consistent experiences in human consciousness.

One consistent notion in many of these observations and theorists appears to be the notion of the decentering of the subject from its experience resulting in the constellation of the depressive imagination. This was certainly the situation with Tim when he came to therapy. The learnings from this Clinical Case Study, both theoretical and practical, support the decentering observation: the decentering of the subject from its own experience, the depressive position, leads to activation of the depressive imagination

as a process of integration. Depression can be a creative act of integration, a move to put the subject back into the center of its own experience.

An imaginal approach sees through any depression into the purposeful activity of the soul to put things aright. This is the intuition that clients in my experience are unable to articulate fully. What clients bring to the therapy hour is their sense that their suffering contains meaning.

The Application of Imaginal Psychology to Psychotherapy

The image has been an integral area of focus within the discipline of psychology, in particular depth psychology.²³ Imaginal Psychology as a distinctly postmodern development integrates and continues the long tradition of using the image as an aspect of psychotherapy, since every experience is at core imaginal. This Clinical Case Study has provided a demonstration of how Imaginal Psychology can guide a psychotherapeutic process. The re-visioning of depression as one of the soul's imaginal landscapes, as opposed to concrete fact, is supported by the way Imaginal Psychology makes a turn toward the soul and its images. The theory of decentering and the constellation of the depressive imagination, as suggested and articulated throughout the Clinical Case Study, is consistent with Imaginal Psychology, which places images and the imaginal at the center of psychological inquiry.

I have suggested and developed the proposition that how we imagine depression, psychologically, determines our response to it. The repertoire, complexity, and consistent expression of human experience and behavior are not entirely explainable by behavioral learning theories, or by purely biological processes, or by cognitive structures alone.

Affect is rarely addressed by the dominant theories of psychology that are in play today.

By claiming the soul and the image as psychology's main concern, Imaginal Psychology makes an integrative move: structurally, as to the nature of the soul, as well as bringing within psychology's purview all those areas the soul inhabits, where the archetypal dimension of the soul's experience is most apparent.²⁴ The inclusiveness and integrative capacity of Imaginal Psychology allows for openness to all the ways in which depression is imagined and experienced. As an imaginal psychologist I can invite my client to bring their total experience to the session. I am not compelled to argue whether medication is better than cognitive therapy, or whether cognitive therapy is better than psychodynamic psychotherapy. I do not have to choose whether biology, or cognition, or behavior, or emotion is the preferred target in the course of treatment, but instead look to each as they contribute to the overall subjective experience. Imaginal Psychology allows me the freedom to treat the individual as opposed to treating the depression. I am free to help the client imagine into their depression, to help them keep the symptom and its context in relationship to each other and in relationship to their unique experience.

Bridging Imaginal Psychology

There some natural entry points that a psychotherapist can utilize when bridging Imaginal Psychology to mainstream care settings and clients. Bridging domains is the role of the psychotherapist. The psychotherapist by profession and role provides a bridge between many experiential domains, such as self and other, inner fantasy and outer events, engagement in the client's process and outside witness, simultaneously. Ogden

notes that the subjects of analysis are created within dialectical relationships, such as the intersubjective space between therapist and client.

Imaginal Psychology places the soul as the primary concern of psychology.²⁵ A subject has a story, and with stories come images. This case study has articulated the necessity to the client of having a myth, a story to move forward with their depression, something often lacking in the medical model approach to mental illness. I have found that clients struggling with depression are quite open to sharing their story, their subjective ways of making meaning – *they insist on sharing their story*. This entry point of story and subjective participation allows an Imaginal psychologist access to the client's subjective material, the images that their soul is living. Once this trust and rapport is established, clients can be open to imaginal approaches to healing. Often, it is the client that wants to explore “nonspecific” avenues to heal themselves.

Imaginal Psychology is welcoming of the many domains of the soul's expression, another entry point to bridging Imaginal Psychology with clients. A person's religious practices, the cultural and social contexts they inhabit, creative acts such as poetry and music, historical events, all these can be given value and welcomed into the therapeutic setting. Racial and ethnic inheritances are important imaginal landscapes that can be welcomed and embraced. A client seeks both – validation of the lenses through which they live, and freedom from the embeddedness and limitations imposed by those imaginal structures – a paradox that the therapist must navigate with the client. Imaginal Psychology, with its discipline of recognizing, engaging, and transforming the soul's imaginal structures, is uniquely positioned to hold both the client and therapist in these paradoxes of experience.

Areas for Future Research

Healy and his observations on the nonspecific factors that may cause and may heal depression suggest one area of future research on the topic of adult depression. I suspect that some of the ideas presented in this Clinical Case Study, for example, the subjective nature of the soul's experience, are implied in the notion of nonspecific factors that contribute to, and heal depression. Neither experimental psychology nor psychiatry have explanations for the placebo effect, something that consistently appears in randomized controlled trials, where up to one-half of participants in some depression drug trials get better without benefit of the tested drug. The placebo effect suggests that even when biological determinants of mental illness are documented, the complexity of the soul's processes may require other modes of observation.

One question that should be asked in regards to the theory of decentering and the constellation of the depressive imagination is whether decentering as dialectical process between the paranoid-schizoid position and the depressive position, as suggested by Ogden, necessarily leads to depression and the activation of the depressive imagination in all circumstances? In other words, can an individual develop psychological strength over time so that the movement between the positions when decentering occurs happens smoothly and effortlessly? Can integrations between the positions become adaptive events unencumbered by dysfunction or dysregulation? The evidence for biological and environmental contributions to depression seems to indicate that *sensitivity* to depression is a more reasonable explanation than direct one-to-one causal relationships. Sensitivity may be the more reasonable approach when examining the decentering theory of depression as well.

Concerning the psychology of depression, an area for future study is the notion of codependency and the myth of Cupid and Psyche as it amplifies adult romantic love and the depressive imagination. Had Tim moved towards a better understanding of his relationship imaginal structures vis-à-vis his depression and codependency experience, I might have been offered the opportunity to explore this mythic connection further. Instead, Tim moved quickly towards resolution and moving towards reengagement with his life and goals, something I supported wholeheartedly as the client-centered thing to do. The examination of the mythic connection of romantic love and its loss to the onset of depression would be helpful in the understanding of adult depression.

APPENDIX

APPENDIX 1

INFORMED CONSENT FORM

To [client's name]:

You are invited to be the subject of a Clinical Case Study on depression. The study's purpose is to better understand how depression mediates necessary change in a person's life.

For the protection of your privacy, all of my notes will be kept confidential and your identity will be protected. In the reporting of information in published material, any and all information that could serve to identify you will be altered to ensure your anonymity.

This study is of a research nature and may offer no direct benefit to you. The published findings, however, may be useful to persons struggling with depression and may benefit the understanding of the treatment of depression.

The Clinical Case Study does not directly require your involvement. However, it is possible that simply knowing you are a subject of the study could affect you in ways which could potentially distract you from your primary focus in therapy. If at any time you develop concerns or questions, I will make every effort to discuss these with you.

If you decide to participate in this Clinical Case Study, you may withdraw your consent and discontinue your participation at any time and for any reason. Please note as well that I may need to terminate your being the subject of the study at any point and for any reason; I will inform you of this change, should I need to make it.

If you have any questions or concerns, you may discuss these with me, or you may contact the Clinical Case Study Coordinator at the Institute of Imaginal Studies, 47 Sixth Street, Petaluma, CA, 94952, telephone: (707) 765-1836.

I, _____, understand and consent to be the subject of the Clinical Case Study written by Luis Alvarado, M.A., on the topic of depression. I understand private and confidential information may be discussed or disclosed in this Clinical Case Study. I have had this study explained to me by Luis Alvarado, M.A. Any questions of mine about this Clinical Case Study have been answered, and I have received a copy of this consent form. My participation in this study is entirely voluntary.

I knowingly and voluntarily give my unconditional consent for use of both my clinical case history, as well as for disclosure of all other information about me including, but not

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4. David Healy, *The Antidepressant Era* (Cambridge, MA: Harvard University Press, 1997), 218.

5. Aftab Omer, conversation with author, November 7, 2006.

6. Sigmund Freud, "The Dissolution of the Oedipus Complex," in *The Freud Reader*, ed. Peter Gay (New York: W. W. Norton & Company, Inc., 1995), 665.

7. Jay R. Greenberg and Stephen A. Mitchell, *Object Relations in Psychoanalytic Theory* (Cambridge, MA: Harvard University Press, 1983), 22. The authors further write: ". . . indicate that he [Freud] thought of the mind as existing in physical space."

8. Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans are all diagnostic tools to look non-surgically inside the body. They are all based on the fact that certain things happen to atoms in our bodies when they absorb energy and release energy, which is then captured by the particular scan in use.

9. John Preston, John H. O'Neal, and Mary C. Talaga, *Handbook of Clinical Psychopharmacology for Therapists* (Oakland, CA: New Harbinger Publications, Inc., 1997), 7.

10. David Bjerklie et al., "The Year in Medicine from A to Z," *Time* 168, no. 23 (2006): 73-94.

11. J. P. Docherty, "Barriers to the Diagnosis of Depression in Primary Care," *Journal of Clinical Psychiatry* 58, Suppl 1 (1997): 5-10.

12. M. Olfson et al., "National Trends in the Outpatient Treatment of Depression," *JAMA: Journal of the American Medical Association* 287, no. 2 (2002): 203.

13. Ibid.
14. Charles A. Kaufman, Janet E. Johnson, and Herbert Pardes, "Evolution and Revolution in Psychiatric Genetics," in *Genetics and Mental Illness*, 5-10.
15. Ibid., 12.
16. Ming T. Tsuang and Stephen V. Faraone, "The Inheritance of Mood Disorders," in *Genetics and Mental Illness*, 88.
17. Ibid.
18. Peter McGuffin, Randy Katz, and Joan Rutherford, "Nature, Nurture and Depression: A Twin Study," *Psychological Medicine* 21, no. 2 (1991): 329-35.
19. Kenneth S. Kendler and Carol A. Prescott, *Genes, Environment, and Psychopathology: Understanding the Causes of Psychiatric and Substance Use Disorders* (New York: Guilford Press, 2006), 22-26.
20. Ibid., 52.
21. Ibid., 56.
22. Tsuang and Faraone, "Inheritance of Mood Disorders," 91.
23. Ibid., 99.
24. Donald F. Klein and Paul H. Wender, *Understanding Depression: A Complete Guide to Its Diagnosis and Treatment* (New York: Oxford University Press, 2005), 70. "Depression is twice as common in women as in men, while manic-depression is equally common in both sexes."
25. Kendler and Prescott, *Genes, Environment, and Psychopathology*, 172-74.
26. Ibid.
27. Peter McGuffin and Anne E. Farmer, "Are There Phenotype Problems?," in *Psychopathology in the Genome and Neuroscience Era*, ed. Charles F. Zorumski and Eugene H. Rubin (Washington, DC: American Psychopathological Association, 2005), 65-84. "Therefore we strongly suspect that although clinicians in the United States and elsewhere would say that they apply DSM-IV-TR in their daily practice, there is often an element of self deception in asserting this, because many of the criteria for common disorders are so complex that they are not easily adhered to in a way that is meticulous or precise."
28. Kathleen R. Merikangas, "Bridging Genetics and Epidemiology of Mental Disorders," in *Psychopathology in the Genome and Neuroscience Era*, 6.
29. Ibid., 7.
30. Laura Lee Hall, "The Human Implications of Psychiatric Genetics," in *Genetics and Mental Illness*, 166.
31. Wayne C. Drevets, "Brain Structural Abnormalities in Mood Disorders," in *Psychopathology in the Genome and Neuroscience Era*, 119-52.

32. Ibid., 150.
33. Preston, O'Neal, and Talaga, *Handbook of Clinical Psychopharmacology*, 35-36.
34. Ibid., 36-37.
35. Ibid., 37-38.
36. Klein and Wender, *Understanding Depression*, 93-96.
37. Ibid.
38. F. Scott Kraly, *Brain Science and Psychological Disorders: Therapy, Psychotropic Drugs, and the Brain* (New York: W.W. Norton, 2006), 91-95.
39. Healy, *The Antidepressant Era*, 168.
40. The current available SSRIs are Prozac, Paxil, Zoloft, Celexa, Lexapro, and Luvox.
41. Peter D. Kramer, "Makeover," in *Listening to Prozac* (New York, NY: Viking, 1993), 1-21.
42. These traits are the subjects of the various chapters of Kramer's book and are listed here as a convenient summary.
43. Kramer, *Listening to Prozac*, 259.
44. Madhukar H. Trivedi et al., "Evaluation of Outcomes with Citalopram for Depression Using Measurement-Based Care in Star*D: Implications for Clinical Practice," *American Journal of Psychiatry* 163, no. 1 (2006): 28-40.
45. Group Hypericum Depression Trial Study, "Effect of Hypericum Performatum (St John's Wort) in Major Depressive Disorder: A Randomized Controlled Trial," *JAMA: Journal of the American Medical Association* 287, no. 14 (2002): 1807-14.
46. Ibid.
47. B. Timothy Walsh et al., "Placebo Response in Studies of Major Depression: Variable, Substantial, and Growing," *JAMA: Journal of the American Medical Association* 287, no. 14 (2002): 1840-47.
48. Ibid.
49. Ibid.
50. Healey, *The Antidepressant Era*, 109.
51. Ibid., 110.
52. Klein and Wender, *Understanding Depression*, 1-7.
53. Ibid., 6.
54. Peter D. Kramer, *Against Depression* (New York: Viking, 2005), 30-41.

55. Ibid., 28-29.
56. National Council on Disability, "The Well Being of Our Nation: An Inter-Generational Vision of Effective Mental Health Services and Supports," (September 16, 2002), 2-10.
57. Ibid.
58. Kramer, *Against Depression*, 12. "I took my disgust as a sign that I fully accepted depression as disease."
59. Hall, "Human Implications of Psychiatric Genetics," 167.
60. Beck, *Depression: Causes and Treatment*, 228.
61. Morton M. Hunt, *The Story of Psychology* (New York: Random House, Inc., 1993), 588-88.
62. Aaron T. Beck, *Cognitive Therapy and the Emotional Disorders* (New York: International Universities Press, 1976), 2.
63. Ibid., 234.
64. Ibid.
65. Beck, *Depression: Causes and Treatment*, 228.
66. Ibid., 228-40.
67. Beck, *Cognitive Therapy and the Emotional Disorders*, 3.
68. Albert Ellis, "Rational-Emotive Therapy," in *What Is Psychotherapy?: Contemporary Perspectives*, ed. Jeffrey K. Zeig and W. Michael Munion (San Francisco: Jossey-Bass Publishers, 1990), 147.
69. Ibid.
70. Ibid., 148.
71. E. Thomas Dowd, "History and Recent Developments in Cognitive Psychotherapy," in *Clinical Advances in Cognitive Psychotherapy: Theory and Application*, ed. Robert L. Leahy and E. Thomas Dowd (New York: Springer, 2002), 17.
72. Johh Cloud, "The Third Wave of Therapy," *Time* (Feb 05, 2006) [journal online]; <http://www.time.com/time/magazine/article/0,9171,1156613,00.html>; Internet; accessed 15 January 2008.
73. N. S. Jacobson et al., "A Component Analysis of Cognitive-Behavioral Treatment for Depression," *Journal of Consulting and Clinical Psychology* 64, no. 2 (1996): 295-304.
74. Ibid.
75. Jacqueline B. Persons, Joan Davidson, and Michael A. Tompkins, *Essential Components of Cognitive-Behavior Therapy for Depression* (Washington, DC: American Psychological Association, 2001), 22. The authors note that Beck et al.'s recommendation in their 1979 book *Cognitive Therapy of*

Depression is to begin with using behavioral interventions when the patient is severely depressed and ending with schema change interventions as the patient's functioning improves.

76. Aaron T. Beck, "Cognitive Models of Depression," in *Clinical Advances in Cognitive Psychotherapy: Theory and Application*, ed. Robert L. Leahy and E. Thomas Dowd (New York: Springer, 2002), 21-69. The six smaller models utilized by Beck in this essay give a nod to the biological, social, stress-vulnerability and evolutionary theories regarding depression, among others.

77. *Ibid.*, 34.

78. Persons, Davidson, and Tompkins, *Essential Components of Cognitive-Behavior Therapy for Depression*, 22.

79. E. Thomas Dowd and Karen E. Courchaine, "Implicit Learning, Tacit Knowledge, and Implications for Stasis and Change in Cognitive Psychotherapy," in *Clinical Advances in Cognitive Psychotherapy: Theory and Application*, ed. Robert L. Leahy and E. Thomas Dowd (New York: Springer, 2002), 325-27.

80. *Ibid.*, 326.

81. Dowd, "History and Recent Developments in Cognitive Psychotherapy," 20.

82. *Ibid.*, 19.

83. Dowd and Courchaine, "Implicit Learning, Tacit Knowledge, and Implications for Stasis and Change in Cognitive Psychotherapy," 325-26.

84. Richard Moore and Anne Garland, *Cognitive Therapy for Chronic and Persistent Depression* (Chichester, UK: Wiley, 2003), 89.

85. *Ibid.*, ix.

86. *Ibid.*, 14-15.

87. Persons, Davidson, and Tompkins, *Essential Components of Cognitive-Behavior Therapy for Depression*, 8.

88. Dowd, "History and Recent Developments in Cognitive Psychotherapy," 24-25.

89. Persons, Davidson, and Tompkins, *Essential Components of Cognitive-Behavior Therapy for Depression*, 9.

90. *Ibid.*, 11-12.

91. Neil S. Jacobson and Andrew Christensen, *Integrative Couple Therapy: Promoting Acceptance and Change* (New York: W. W. Norton & Company, 1996), 89-90.

92. M. M. Linehan et al., "Cognitive-Behavioral Treatment of Chronically Parasuicidal Borderline Patients," *Archives of General Psychiatry* 48, no. 12 (1991): 1060-4.

93. T. R. Lynch et al., "Dialectical Behavior Therapy for Depressed Older Adults: A Randomized Pilot Study," *American Journal of Geriatric Psychiatry* 11, no. 1 (2003): 33-45.

94. James P. McCullough, *Treating Chronic Depression with Disciplined Personal Involvement: Cognitive Behavioral Analysis System of Psychotherapy (Cbasp)* (New York: Springer, 2006), viii.
95. J. D. Teasdale et al., "Prevention of Relapse/Recurrence in Major Depression by Mindfulness-Based Cognitive Therapy," *Journal of Consulting and Clinical Psychology* 68, no. 4 (2000): 615-23.
96. Ibid.
97. Dowd, "History and Recent Developments in Cognitive Psychotherapy," 15-28.
98. Dowd and Courchaine, "Implicit Learning, Tacit Knowledge, and Implications for Stasis and Change in Cognitive Psychotherapy," 326. "Because cognitive structures operate at a tacit level, they cannot generally be explicated by individuals, even with external assistance. Thus, in many ways they resemble what are commonly thought of as unconscious processes, although, without the elaborate explanatory structure and metaphorical constructs characteristic of psychoanalytic thought."
99. Morton M. Hunt, *The Story of Psychology*, 564.
100. Whitmont, *The Symbolic Quest*, ix.
101. Hillman, *Archetypal Psychology*, 1.
102. Aftab Omer, conversation with author, November 7, 2006. "The term psychological multiplicity refers to the existence of many distinct and often encapsulated centers of subjectivity within the experience of the same individual."
103. Klein's formulation of the depressive position is not linear, but is described over several of her essays. The two most notable essays are "Notes on Some Schizoid Mechanisms" and "A Contribution to the Psychogenesis of Manic-Depressive States (1935)".
104. Greenberg and Mitchell, *Object Relations in Psychoanalytic Theory*, 38.
105. Ibid., 39.
106. Ibid., 40.
107. Ibid., 40-41.
108. Ibid., 10.
109. Harry Guntrip, *Psychoanalytic Theory, Therapy, and the Self* (New York: Basic Books, 1971), 21.
110. Greenberg and Mitchell, *Object Relations in Psychoanalytic Theory*, 150-51.
111. Ibid., 146.
112. Melanie Klein, "Notes on Some Schizoid Mechanisms (1946)," in *The Selected Melanie Klein*, ed. Juliet Mitchell (New York: Free Press, 1986), 176.
113. Melanie Klein, "A Contribution to the Psychogenesis of Manic-Depressive States (1935)," in *Selected Melanie Klein*, 116.

114. *Ibid.*, 121.

115. *Ibid.*, 141-42.

116. Klein, "Notes on Some Schizoid Mechanisms (1946)," 178.

117. *Ibid.*, 189.

118. Melanie Klein, "Mourning and Its Relation to Manic-Depressive States (1940)," in *Selected Melanie Klein*, 172.

119. Thomas H. Ogden, *Subjects of Analysis* (Northvale, NJ: Jason Aronson Inc., 1994), 14.

120. *Ibid.*, 40-41.

121. *Ibid.*, 34.

122. *Ibid.*, 40.

123. Hanna Segal, *Introduction to the Work of Melanie Klein* (New York: Basic Books, Inc., 1973), 69.

124. Ogden, *Subjects of Analysis*, 42-48. Ogden analyzes the idea of projective identification as proposed by Klein and elaborated upon by Bion and H. Rosenfeld. In summary, Ogden proposes that the process of projective identification is the vehicle whereby the subject interpersonally is decentered from itself and instead is to be found within the dialectical relationship between self and other.

125. Kramer, *Against Depression*, 244-60.

126. Beck, "Cognitive Models of Depression," 29-61.

127. *Ibid.*, 43-46.

128. Freud, "On Mourning and Melancholia," 251. "After all, the person who has occasioned the patient's emotional disorder, and on whom his illness is centered, is usually to be found in his immediate environment."

129. Robert L. Karen, *Becoming Attached: First Relationships and How They Shape Our Capacity to Love* (New York: Oxford University Press, 1998), 54. "But beneath the antisocial attitudes Bowlby saw a profound and unreachable depression, as if, when they lost their loving universe, a switch turned off in them that could not be turned back on. 'Behind the mask of indifference,' he wrote, 'is bottomless misery and behind the apparent callousness despair.'

130. Kendler and Prescott, *Genes, Environment, and Psychopathology*, 136-37. "One reason for this is a conceptual one: Although twins have the same parents and (are assumed to) receive the same type of parenting from them, they may react to the parenting in different ways. If the twin's reactions are guided in part by genetically influenced characteristics (e.g., temperament), then parenting effects would show up in twin models as genetic, not shared environmental effects. Another reason is statistical: Our standard twin modeling is not a sensitive method for detecting small shared environmental effects, particularly in the presence of moderate degrees of heritability [between 1 and 4 percent]."

131. *Ibid.*, 129-46.

132. Ibid.
133. Ibid.
134. Ibid., 148-65.
135. Bonnie Moradi and Cristina Risco, "Perceived Discrimination Experiences and Mental Health of Latina/O American Persons," *Journal of Counseling Psychology* 53, no. 4 (2006): 411-21.
136. Leilani Greening and Laura Stoppelbein, "Religiosity, Attributional Style, and Social Support as Psychosocial Buffers for African American and White Adolescents' Perceived Risk for Suicide," *Suicide and Life-Threatening Behavior* 32, no. 4 (2002): 4-4-17.
137. Ly Nguyen et al., "The Influence of Race and Ethnicity on Psychiatric Diagnoses and Clinical Characteristics of Children and Adolescents in Children's Services," *Cultural Diversity & Ethnic Minority Psychology* 13, no. 1 (2007): 18-25.
138. Horwitz and Wakefield, *The Loss of Sadness*, 33-37.
139. Ibid., 43-46.
140. Paul J. Watson and Paul W. Andrews, "Toward a Revised Evolutionary Adaptationist Analysis of Depression: The Social Navigation Hypothesis," *Journal of Affective Disorders* 72, no. 1 (2002): 1-14.
141. Ibid., 12.
142. John Steadman Rice, *A Disease of One's Own: Psychotherapy, Addiction, and the Emergence of Co-Dependency* (New Brunswick, NJ: Transaction Publishers, 1996), 6-7.
143. Ibid., 7.
144. Beattie, *Codependent No More*, 42-53.
145. John Bowlby, *Attachment and Loss*, vol. 3, *Loss* (New York: Basic Books, Inc., 1982), 250.
146. Karen, *Becoming Attached*, 405.
147. Institute of Imaginal Studies, *Course Catalog 2007-08*, 4.
148. Hunt, *The Story of Psychology*, 198-200.
149. Greenberg and Mitchell, *Object Relations in Psychoanalytic Theory*, 10.
150. *The Complete Works of C.G. Jung*, Bollingen Series 20, trans. R.F.C. Hull, vol. 8, *The Structure and Dynamics of the Psyche* (Princeton, N.J.: Princeton University Press, 1969), 136-7.
151. Whitmont, *The Symbolic Quest*, 27-8.
152. Jung, *The Structure and Dynamics of the Psyche*, 212.
153. *Complete Psychological Works of Sigmund Freud*, vol. 1, *Pre-psycho-analytic Publications and Unpublished Drafts* (London: Hogarth Press, 1966), 252.

154. *Complete Psychological Works of Sigmund Freud*, vol. 6, *The Psychopathology of Everyday Life* (London: Hogarth Press, 1966), 196. "As a small child he had been strongly attached to this doctor; and a brief self-analysis enabled him to discover that at the age of three and a half he had had a double phantasy concerning the birth of a younger sister-namely that she was the child, firstly, of himself and his mother, and secondly, of the doctor and himself. Thus in this phantasy he played both a masculine and a feminine part."

155. *The Complete Works of C.G. Jung*, Bollingen Series 20, trans. R.F.C. Hull, vol. 7, *Two Essays on Analytical Psychology* (Princeton, N.J.: Princeton University Press, 1975), 65.

156. Aftab Omer, conversation with author, November 7, 2006.

157. Ibid.

158. Ibid.

159. Ibid.

160. Ibid.

161. Jung, *The Structure and Dynamics of the Psyche*, 95-98.

162. Jung, *Two Essays on Analytical Psychology*, 44.

163. Ibid., 57-58.

164. Hillman, *Re-Visioning Psychology*, 101.

165. Diane Wolkstein and Samuel Noah Kramer, "From the Great above to the Great Below," in *Inana, Queen of Heaven and Earth* (New York: Harper & Row 1983).

166. Thelma Sargent, *The Homeric Hymns: A Verse Translation*, 1st ed. (New York,: W. W. Norton & Company, Inc., 1973).

167. Apuleius, *The Transformations of Lucius: Otherwise Known as the Golden Ass*, trans. Robert Graves, The Noonday Press ed. (New York: Farrar, Straus and Giroux, 1979).

168. Diane Wolkstein and Samuel Noah Kramer, "From the Great above to the Great Below," in *Inana, Queen of Heaven and Earth* (New York: Harper & Row 1983), 52-73. The summary that follows is taken from this chapter.

169. Thelma Sargent, *The Homeric Hymns: A Verse Translation*, 1st ed. (New York,: W. W. Norton & Company, Inc., 1973), 2-14. The summary that follows is taken from this translation.

170. Apuleius, *The Transformations of Lucius: Otherwise Known as the Golden Ass*, trans. Robert Graves, The Noonday Press ed. (New York: Farrar, Straus and Giroux, 1979), 96-143. The summary that follows is taken from this translation.

171. Hunt, *The Story of Psychology*, 242-79.

172. Ibid., 278.

173. Horwitz and Wakefield, *The Loss of Sadness*, 7.

174. Solomon, *The Noonday Demon*, 29.

Chapter 3

1. Beattie, *Codependent No More*, 36.

Chapter 4

1. Whitmont, *The Symbolic Quest*, 139.

2. Ibid., 140.

3. Rice, *A Disease of One's Own*, 8-11.

4. Beattie, *Codependent No More*, 42-53.

5. David Sedgwick, *The Wounded Healer: Countertransference from a Jungian Perspective* (New York: Routledge 1994), 15. "Jung returns to the 'wounded healer' archetype in his last major work, *Mysterium Coniunctionis* (1955-56), and in his autobiography, where he says with some finality, 'Only the wounded physician heals.'"

6. Aftab Omer, conversation with author, November 7, 2006.

7. Jean Shinoda Bolen, *Goddesses in Everywoman: A New Psychology of Women* (New York: Harper & Row, 1984), 218-19.

8. Hillman, *Re-Visioning Psychology*, 207.

9. Greenberg and Mitchell, *Object Relations in Psychoanalytic Theory*, 182-83. The authors present here a summary of Michael Balint's belief that primary object love is found in the beginning of infant experience and continues for the rest of the lifetime.

10. This is an inference on my part, based on the feedback I have received when I have applied for clinical positions in strongly medical model environments. The feedback is usually something to the effect that the interviewers do not believe that I could handle the "pace" or the "demands" of the work setting.

11. Sedgwick, *The Wounded Healer*, 8.

12. Hillman, *Archetypal Psychology*, 1-3.

13. Ibid., 6. "The image was identified with the psyche by Jung ('image is psyche' – CW 13, §75), a maxim which archetypal psychology has elaborated to mean that the soul is constituted of images, . . ."

14. Institute of Imaginal Studies, *Course Catalog 2007-08*, 5.

15. Hillman, *Re-Visioning Psychology*, 9.

16. Hillman, *Archetypal Psychology*, 26-28. "The underlying aspiration of its work archetypal psychology has called 'soul-making,'"

Chapter 5

1. *Merriam-Webster's Collegiate Dictionary*, 10th ed., s.v. "clinical."
2. *Ibid.*, s.v. "clinician."
3. Aftab Omer, conversation with author, November 7, 2006.
4. Whitmont, *The Symbolic Quest*, 48-9.
5. Healy, *The Antidepressant Era*, 260-61.
6. Kovacs, *The Epic of Gilgamesh*, 85.
7. Hillman, *Archetypal Psychology*, 12.
8. Hillman and Jung, *Anima*, 51-70.
9. Solomon, *The Noonday Demon*, 38.
10. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 327.
11. Moore and Garland, *Cognitive Therapy for Chronic and Persistent Depression*, 140.
12. Healy, *The Antidepressant Era*, 243.
13. Aftab Omer, conversation with author, November 7, 2006.
14. *Ibid.*
15. Wolkstein and Kramer, "From the Great above to the Great Below," 52.
16. *Ibid.*, 65-66.
17. Beck, "Cognitive Models of Depression," 52.
18. Solomon, *The Noonday Demon*, 81.
19. Beck, *Cognitive Therapy and the Emotional Disorders*, 106, 28.
20. Horwitz and Wakefield, *The Loss of Sadness*, 27-52.
21. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 389.
22. Jung, *Two Essays on Analytical Psychology*, 46.

23. Please refer to the Literature Review, the section “Imaginal Perspectives on Depression.”

24. Imaginal Psychology turns toward the following domains of the soul’s expression for a better understanding of the soul’s images: spiritual traditions, somatic practices, creative arts, mythology, indigenous wisdom, literary and poetic imagination, deep ecology, and social critique.

25. Institute of Imaginal Studies, *Course Catalog 2007-08*, 5.

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