

# Managing depression – analytic, antidepressants or both?

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## INTRODUCTION

In this paper, the analytic contribution to the understanding and management of depression will be considered, together with clinical illustrations, within the context of every day general psychiatric practice.

Patients with major depression cover the spectrum, in terms of severity of the psychopathology, between those who receive a purely analytic approach, those who may take medication while having analytic psychotherapy, and those seemingly not amenable to other than a physical approach.

The latter group features largely in everyday psychiatry, where general psychiatrists have to run large supportive outpatient clinics, where many patients are prescribed antidepressant medication. However, even in these cases, it does not exclude one from thinking analytically. When trying to understand and relate to the most

severe of psychopathology, Freud and Abraham's seminal papers remain as clinically relevant, today, as when they were first written.<sup>1,2</sup>

Clinical material, taken from a patient who had been in analysis, will be used to illustrate how psychoanalysis informs on the psychopathology of depression. Material will then be presented from patients not amenable to analysis, but showing how analytic insights help both to understand the process through which the patient is undergoing and in providing a supportive framework to the professional carers and relatives, while they are having to endure very difficult periods, where the depression appears to be unremitting in character. Appreciating the dynamic of a pathological superego in depression, taking over the driving seat, and the need to unseat it and foster a more benign superego that strengthens ego development, is a key issue when relating to patients with depression, whether treating with antidepressant medication, psychotherapy or both<sup>3</sup>. In order to understand depressive illness, we also need to distinguish it from other causes of low mood and recognise its special psychopathology. Freud's seminal paper, *Mourning and Melancholia*, helps us to go beyond ordinary

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empathy, through recognising the underlying narcissistic structure<sup>1</sup>. However, his insights are usually not incorporated within general psychiatric training and practice, nor in contrast do psychoanalytic therapists think enough about depression in terms of a psychotic disorder and how medication might be thought about, when needed, in this context.

#### DIFFERENT MEANINGS TO DEPRESSION

The first thing we need to do is to be clear about four quite different ways that we may talk about depression. Edith Jacobson, in her studies on depression, referred to them as normal, neurotic, psychotic and grief reactions<sup>4</sup>.

#### NORMAL DEPRESSION

What Jacobson referred to, as normal depression, is akin to what Melanie Klein referred to as the depressive position. It is essentially a state of health, a capacity to bear guilt, stay in touch with mental pain and emotional problems and bring thinking to bear on situations. In Kleinian terms, we oscillate between our ability to stay with painful situations or seek temporary relief through splitting and projection, returning to the paranoid-schizoid position, or flight into manic idealisations<sup>5</sup>.

#### NEUROTIC DEPRESSION

Neurotic depression or reactive depression can be understood, simplistically speaking, as an exaggerated response to stress due to a weak state of ego strength combined with a failure of the external support system and basically is a cry for help.

For example, an asylum seeker was admitted to hospital after running in front of cars. A flat mate reported how he had tried to jump out of a window until restrained and then took a few paracetamol tablets. He clinically presented in a withdrawn and retarded state, as if undergoing a severe depressive episode, but was fine the next day after we indicated that, if contacted by his solicitors, we would write a supportive asylum appeal letter.

Two conditions, where the differentiation of the underlying nature of the depression is important is in the assessment of suicide and with puerperal depression.. the young and is seen as a wish for temporary oblivion and a cry for help in relation to clear external precipitants, such as a family row or break up with a boy

friend. An initial supportive response from the carers' deals with the immediate crisis and medication is not indicated. In contrast, patients with features of psychotic depression are typically older, there was a real intention to kill themselves, and the treatment typically would involve medication and admission to a psychiatric hospital.<sup>6, 7</sup>

#### GRIEF REACTIONS

In Mourning and Melancholia, Freud movingly described the process of mourning. How, we try to turn away from reality and cling onto the lost object through a hallucinatory wishful psychosis e.g. hearing the voice of our lost loved one. However reality gains the day and we have to relinquish the external object and reinstate its memory inside us and to do this we have to go through the work of mourning.<sup>1</sup>

Freud interestingly contrasted mourning with melancholia; the latter would now be referred to as a severe depressive episode<sup>8</sup>. In melancholia, Freud surmised that there must have also been a loss for the patient; however one could not see the loss. He concluded that it therefore must have been an internal narcissistic loss, occurring at an unconscious level, and requiring a separately considered understanding in its own right.<sup>1</sup>

#### PSYCHOTIC DEPRESSION

In modern day terminology, Jacobson's psychotic depression would be termed a severe depressive episode with psychotic symptoms<sup>8</sup>. Depression is, in fact, a very common condition. Some 3% of the population are seeking help at any one time, while another 3% remain undetected struggling on their own in the community. 10% also undergo manic episodes. In manic depression, there is a 15% risk of suicide, and up to 50% of patients may have visited their General Practitioners in the few weeks preceding suicide (Gelder et al., 2001).

Clearly, it helps to be familiar with the clinical presentation, as the patient may not complain of depression but only emphasise one of many commonly experienced symptoms and one may miss realising that the symptom is part of an underlying syndrome. The following are well known typical symptoms familiar to all practicing psychiatrists:

Diurnal mood variation, early morning wakening, and psychomotor retardation – a slowing up of all physical and mental processes

– with resulting loss of appetite and weight, decreased libido, amenorrhoea, constipation and retardation (stupor).

Other features include agitation (a ceaseless roundabout of painful thoughts), poor concentration (depressive pseudo-dementia), agoraphobia, depersonalisation and derealisation, a loss of energy (mimicking anaemia) and hypochondriacal features including headaches, chest pain, stomach pains with associated cancer phobia, and atypical facial pain (depressive equivalents) and suicidal thoughts.<sup>9</sup>

There are compelling reasons why general psychiatrists regard depressive illness as a biological disorder. They see the symptoms of a slowing up of psychological and bodily processes as indicative of a medical disorder requiring physical treatment. Also in depression, common neurotransmitters in the brain are depleted, and anti-depressants work by raising their levels, supporting the view of a biochemical disorder. According to traditional psychiatric teaching there is no place for psychotherapy, other than of a supportive kind, while the patient takes his medication and recovers from the episode.

However, the author's perspective, in writing this paper, is from the position of a practising psychoanalyst, seeing some patients with depression for individual analytic therapy, whilst also working in general psychiatry, which includes prescribing medication. In such a position, one is forced to give further consideration as to why the need for differing approaches, depending on the severity of the depression. One finds that analytic thinking does not stop with the more psychotherapeutically inaccessible cases, on the contrary the curiosity increases as the psychopathology become more extreme.

#### THE PSYCHOANALYTIC UNDERSTANDING OF DEPRESSION

It is impossible, by *précis*, to do justice to what one can draw from the richness and liveliness of Freud's paper, "Mourning and Melancholia"<sup>1</sup>.

Freud points out that, in depression, the dominating internal relationship is with an object demanding total obedience, with the associated illusion of being totally looked after by the object. The absolute identification breaks down when needs arise, but the identification with the idealised object still remains, while the ideal object is being criticised for having let one down.

As Freud put it "an object loss was transformed into an ego loss"<sup>1</sup>. So, when the patient announces to the world that they are useless, they are not really criticising themselves, but a purported ideal that has temporarily let them down. The self-tormenting is then a tormenting of the ideal object that had abandoned them at a time of need. The sadomasochistic process of self-criticism, that so dominates depressive episodes, goes on in a relentless fashion until it has run its course.

Some experienced nursing staff will have no difficulty in intuitively understanding the need to let this process run its course in hospital, without demanding excessive physical interventions.

No true mourning, with relinquishment of the object, can occur because of the unresolved ambivalent dependence on an ideal object. One is left struck how, after months of self-berating, the patient then recovers their former composure without showing the slightest curiosity about their whole recent experience in hospital.

The following serves as an amusing example of recovery from a major depressive episode and how we can be fooled into thinking that we have been dealing with a neurotic disorder. After months in hospital in a withdrawn depressed state, a woman started to recover. She then complained that her husband worked all day and then went to the pub in the evening leaving her on her own. We felt incensed on her behalf that his non-supportive behaviour was a significant contributory factor to the length of her depression and invited the husband up next week for enlightenment to his wife's needs. When he arrived her attitude had completely changed. She said that he worked very hard during the day and was entitled to have a drink in the evening before coming home! She had shifted her criticism, after many months in hospital, from herself having failed to live up to the ideal, onto her husband, and then quickly restored him to be the all-providing object. She was then in a mental state ready to leave hospital but not in the least bit interested in why she had been so long in hospital.

Freud emphasised the oral roots to the psychopathology of depression, with regression to oral narcissism, as evidenced by a patient's refusal to eat, when in a severely depressed state<sup>1</sup>. Expanding on this theme, Abraham<sup>2</sup> brilliantly and succinctly summarised the dynamic factors underlying depression, as follows:

A constitutional factor of an over accentuation of oral eroticism.

1. A special fixation of the libido at the oral stage.
2. A severe injury to infantile narcissism.
3. Occurrence of the primary disappointment pre-oedipally.
4. Repetition of the primary disappointment in later life.

The following clinical material, taken from a patient who was in analysis, confirms Abraham's points.

Mrs A was a woman in her fifties, who came to analysis because of troublesome feelings of depression, isolation and lack of identity. She had an autistic son with whom she struggled for years to get specialist help for him. When she stated to improve she turned to her own needs.

Psychiatrically speaking, she exhibited typical features of depression, with early morning wakening, diurnal mood variation, lack of energy and hypochondriasis, experiencing headaches, which she felt might have been indicative of a brain tumour. She felt her life was not her own, especially feeling demands from her elderly mother and her autistic son.

For both parents it was their second marriage. Her father was elderly, eccentric but warm hearted. Her mother was quite dismissive towards him.

When Mrs A was born, her mother had a depressive breakdown. For three months, Mrs A was sent away to a nanny. The nanny was reported to have neglected her and she was ill with jaundice and gastro-enteritis. It took three months for the neglect to be discovered and for her to be returned home.

Throughout her childhood, her mother remained predominantly in a withdrawn state in bed. However, she remained very dominating and ridiculing in manner to her daughter.

The grandmother would instruct Mrs A not to upset her mother. Mrs A had a very lonely childhood, living in the countryside and would befriend animals and plants.

Her one talent was painting. Her mother was so envious of any challenge to her authority that she put kitchen rubbish on a painting of Mrs A that won a prize in her adolescence.

Mrs A's husband was supportive but often abroad on business. When her autistic son was born, it was a precipitate labour. He cried day and night for months on end. She went to stay at her mother's but her mother couldn't tolerate her baby's persistent crying, so she went back

home on her own. She described being in a depressed state for two years, but receiving no treatment. It took two years before she was able to get the first specialist assessment of her son. It was several years later before she had her second child, a healthy daughter.

Mrs A's opening remark to the analysis was striking, "I want to be a calm sensible person with no feelings." Since her mother spent her time in a manic omnipotent state ridiculing separate thinking this comment represents Mrs A's wish to conform to her mother's requirements. However this statement underlines the central dynamic to understanding depression, for with the desire for identification with an ideal object, there is no room for separate thinking or expression of needy feelings. All tensions related to ones own needs and how the idealised object is ignoring them gets projected and then experienced somatically. I will return further to this point in relation to the use of medication.

The lack of availability of a containing mother was graphically illustrated in a dream, where she went to get food from a supermarket. There was no basket and she came out, arms full of tin cans. Suddenly, an aunt (mother's sister) shouted from a house window: "Where is your mother?" She dropped the cans and opened her mouth to speak. It was full of blood and bits of glass.

The oral origins of the psychopathology are very apparent, with the brittleness of the breast and the aggressiveness to it. When badly depressed, Mrs A would also report a sensation of having swallowed two tablets of stones that lay heavy on her stomach, i.e. the unresponsive stone breasts of mother. Also it reminds one of the Ten Commandments, two tablets of stone not to be disobeyed.

This history confirms all of Abraham's points. The constitutionally inherited family history of depression, her mother having a breakdown when she was born; The fixation of the libido at the oral level, with the sensation of having swallowed the tablets of stone breasts when depressed and also the oral aggressiveness, with the cut glass in the mouth.

The severe injury to infantile narcissism was evidenced by her mother's unresponsiveness. The first disappointment pre-oedipally, starting at birth with being left with the neglectful nanny; with the repetition of the primary disappointment in later life, with her mother's lack of support at the time of the birth of the autistic child.

Over the years, I endeavoured to support

the growth of a separate sensitive independent thinking self, but the pull to be the calm sensible person with no feelings predominated. In the transference-counter-transference, this took the form of a superficial quality to her speech, in which I was left feeling that I was an object that never took anything in, but expect to be regarded as the authority with nothing to learn. This was the idealised object, with which she wished to identify.

In her paper on Manic Depressive States, Klein comments on this clinging to the pathological early severe superego as “the idea of perfection is so compelling as it disproves the idea of disintegration” (p.270).<sup>10</sup>

The experience with this patient helped me in starting to arrive at an understanding of the role that medication played in treating other patients. Freud initially referred to melancholia as a narcissistic neurosis, later to be revised, with his introduction of the structural model, as a disease of the critical agency or superego<sup>11</sup>.

In his paper “On Narcissism”, Freud compared the healthy state of taking in mental food from parental figures, the anaclitic state, with a self centred state in which no development occurs, the narcissistic state<sup>12</sup>. In depression, the narcissistic state predominates and takes the form of a delusion of being at one with an all providing primitive godlike superego, but also living in fear of being cast out, like from the Garden of Eden, if any questioning or curiosity develops.

If one develops any need emotional or physical, such as a bout of flu, it is a criticism of the primitive god-like superego, who should have prevented it happening, or oneself for not following the correct path to prevent getting ill in the first place and this may trigger another depressive episode of self-berating.

The commonest symptom of depression is one of extreme agitation, as at the moment of curiosity or questioning, one feels separated from being at one with the godlike superego. This results in a feeling of being completely unheld, like a newly born baby left on a changing mat shaking with the “Moro reflex”.

This central insecurity, experienced on the slightest separation from total submission to the narcissistic object, accounts for anxiety being the most prominent of all symptoms of depression, and why general psychiatrists often use the overall term “agitated depression”.

In her paper “On mourning and its relationship to manic depressive states”, Klein also emphasised a central theme of insecurity in depression, explaining it in terms of having

been unable in childhood to establish their good objects and so feel secure in their inner world<sup>13</sup>.

Bion’s insights on the container add further depth to our appreciation of the nature of the agitation. “Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother, the infant feels that it is dying is stripped of such meaning that it has. It therefore reintrojects, not a fear of dying made tolerable but a nameless dread” (p.116)<sup>14</sup>.

In fact, each of the various symptoms of depression invites consideration from a dynamic perspective. The separation from the idealised identification may link to developing a fear of going out, as having any separate identity would bring down the wrath of a jealous god, resulting in agoraphobia. *An analytic patient of mine when depressed, would develop agoraphobia, linked to fears of having developed a shape to her body, as if this represented individuality and would draw hostile notice to her.*

The loss of the ideal object, leads to symptoms akin to mourning, with both the self (depersonalisation) and the outer world (derealisation) feeling unreal. Patients with depression typically wake early and feel worse in the morning, feeling better as the day goes on. Biological psychiatry has unsuccessfully tried to explain these features in terms of diurnal variations in steroid levels, but the symptoms can be also considered at an analytic level.

A man with severe unrelenting depression, whom I saw supportively for a year, came weekly to out patients accompanied by his wife. After I had left, he was admitted and received ECT, but sadly then took his own life. His problem was that he could not come to terms with, during the war, having killed in a fit of rage a Japanese soldier who was on the point of surrendering, because the Japanese had recently killed his friend, whom he had found with his head smashed open. He would wake up early from a recurring nightmare. In the dream, a man had been shot in the head. His skull was open and he was dying. The patient was holding him, waiting for the doctor to come. The man died just before the doctor came.

*There were of course many striking aspects to the presentation, including the inability for reparation, as the patient could never forgive himself for having committed his murderous attack. However the point that I wanted to highlight here was the patient's waking early*

*with the recurrent nightmare and then feeling worse in the morning, improving as the day went on i.e. his symptoms of early morning waking and diurnal mood variation.*

We have an internal as well as an external world, and this helps to make sense of the patient's experience at a psychological level. The patient wakes up early to get away from a terrifying and critical internal world. Patients with depression feel worse on waking as they find themselves totally dominated by their unforgiving internal world. As the day progresses they start to feel better as the external world is a far more humanly responsive one than their internal world. Consideration of this dynamic may also introduce a way of talking with the patient and his relatives about the internal experience.

#### THE PLACE FOR MEDICATION

Since all feelings are to be repressed (the calm sensible person with no feelings), they may be projected into the body and felt only as physical sensations, referred to as 'depressive equivalents'. While depression raises fascinating questions of the relationship between the mind and bodily experiences, as transmitted through neuronal networks, at the end of the day, we may be left with a patient with no insight seeking relief from very distressing physically experienced symptoms. This is where antidepressant and anxiolytic medication enter the picture.

A patient gave a history of being a corporal in the army many years ago. When age 30, he had an attack of pericarditis. This destroyed his delusion of immortality. He held onto this belief by projecting his anger at such a loss into his body. He became consumed with hypochondriasis complaining of pain in every organ. If visitors came round to see his family, he would dominate the conversation and talk of pain from his big toe to his testis, abdomen, chest and head.

*If it became too much for the family he would be admitted to give them respite and he would receive medication or ECT. I inherited him when he was in his sixties. On admission, he again talked incessantly about his symptoms. However, I was struck by how he managed to chase the female nurses round the ward with his walking stick, in a sexually provocative way. Interestingly on the morning of his birthday, his mind temporarily returned to his head. He behaved normally, in a patient's group, inquiring as to other patients' welfare. He then reverted to*

*his former ways. To speak to him one would have needed to know what part of his mind was located in his big toe! This patient lacked any insight and all treatment inevitably remained at a physical level. However, it does not stop ones analytic interest in the way his mind was functioning.*

One therefore has to accept that, for some people, the severity of their psychopathology is such that one is left only being able to treat them at a physical level. Others psychopathology might not be so severe and, while taking medication, come for psychotherapy, while others may opt purely for a psychotherapeutic approach.

In some patients in psychotherapy, medication can reduce the intensity of symptoms when threatening to become incapacitating, for example when rendering the patient unable to get up in the morning to make their analytic sessions or in lessening suicidal feelings when threatening to become overwhelming. The doctor prescribing the medication, whether the general practitioner or specialist, could work in harmony with the analytic psychotherapist, provided there was a mutual understanding of how ill was the patient and there was agreement on the purpose of each aspect of the treatment plan.

Including the marital partner in management is most important in all cases of severe depression. The partner needs support and education in the dynamics of the disorder in order to endure extended periods where the patient will not listen to their advice.

In this context, an understanding of transference and counter-transference issues presenting in depression, may help the patients, their relatives and professionals in understanding and coping with the experience.

#### THE TRANSFERENCE AND COUNTER – TRANSFERENCE IN DEPRESSION

##### *The Transference*

If one considers a major depressive episode in terms of a psychotic episode, then one cannot rely on ones ordinary empathy, but has to tune into a particular wavelength to make sense of the disorder and understanding the transference phenomenon.

There is an expectation that things should never have gone wrong. The object relationship is to a god-like figure. If anything goes wrong, someone is to blame because it could have always been prevented from happening in the

first place. There is no desire for understanding, only in returning to a previous trouble free state.

*An example would be the story of the man driving a car who knocks over another man riding a motorbike. The motorcyclist is lying on the floor unconscious. His motorbike is in flames. The driver gets out of his car and beats himself on his chest saying to himself, look what a terrible person you are for what you have done, but does not lift a finger to help the motorcyclist.*

This leads onto the counter-transference experience for those trying to help the patient whether psychiatrists, analytical therapists or relatives.

#### *The Counter-transference*

The first issue to be appreciated is the clash of interest between the patient and the carers. Whilst the patient is not interested in gaining insight, just wanting to regain a previous illusion of perfection, the therapist or relative is trying to persuade the patient not to be so demanding and critical of themselves and take a more reasoned, forgiving and understanding approach.

The counter-transference for the carer becomes one of frustration and irritation, as anything that is offered in terms of helpful advice is rejected, while the patient persists in remaining in a troubled state.

While the process of self-berating goes on, it feels for the professionals and carers that there is no sign of light at the end of the tunnel and that the process will on forever. Often the patient will ask also if their state of depression will ever end. The carers need help to appreciate that the self berating over the loss of the illusion of perfection, is an internal process that will go on with a momentum of its own until it abates, and the carer may need help not to take rejections of their offered help, by the patient, in a personal way.

Of course, the issue of support for the relatives becomes much more pressing when manic states arise, where there is a component of triumphing over the object of dependency, which is projected onto the nearest relative, with acting out behaviour of verbal abuse and sexual affairs. This has potentially a very destructive on relationships and a later real risk of suicidal behaviour, once the patient has come down from the manic state. In such circumstances, it is even more important to help and support the relatives in understanding and coping with their counter-transference feelings

(Lucas, 1998).

I will conclude the paper with an elaboration about the two superegos, a mature benign reflective one, and the ego destructive superego taking over in depression, as it provides an overall framework to our approach to depression.

#### THE SUPEREGO IN DEPRESSION

Freud's introduced the term 'Superego' in "The Ego and The Id"<sup>11</sup>. He described how one part of the Ego sets itself over against the other and judges it critically. The superego incorporated his previous concepts of the dream censor, special agency, ego ideal and unconscious sense of guilt<sup>16</sup>.

Klein described an early pre-oedipal stage to the formation of the superego, with a very harsh superego in evidence at the oral stage, which becomes modified over time, with experiences, to becoming more benign, less demanding and more tolerant towards human frailties<sup>5</sup>.

Freud commented on the particular nature of the superego operating in relation to Melancholia, noting an "extraordinary harshness and severity towards the ego" in both obsessional neurosis and melancholia (p.53)<sup>11</sup>. However, it was more dangerous in Melancholia where it was "a pure culture of the death instinct (which) often succeeds in driving the ego into death" (p.53).<sup>11</sup>

Klein also referred to an early very harsh superego that stood apart and was unmodified by the normal processes of growth, leading to consideration of a different superego operating in depression<sup>17, 3</sup>.

Bion outlined the characteristics of this ego-destructive superego in the following way, "It is a super-ego that has hardly any characteristics of the super-ego as understood in psychoanalysis: it is 'super' ego. It is an envious assertion of moral superiority without any morals" (p.97)<sup>18</sup>. He further comments, "In so far as its resemblance to the super-ego...shows itself as a superior object asserting its superiority by finding fault with everything. The most important characteristic is its hatred of any new development in the personality as if the new development were a rival to be destroyed" (p 98)<sup>18</sup>.

*The following serves as a telling example of the extraordinarily murderous quality to the ego-destructive superego. A patient with a long history of depression had reached mid-life. There was no previous history of self-harm. He*

*had never worked and lived with his mother until she died two years previously, when he went to live with his single brother, who went to work. He spent his days visiting different sisters who remained very loving and supportive. He had recently become some-what more agitated, but persistently denied suicidal feelings, including on the very day that he actually killed himself by multiple stabbing with a kitchen knife, with his brother returning from work to find him dead.*

His family needed help to make sense of it all, and how their loving feelings had been appropriately directed in supporting a dependent part that had never been allowed to develop by the ego-destructive superego. When reaching mid-life and faced with having to account for its destructiveness in never having allowed the patient to develop a life, the murderous part turns on the ego and kills it. It was interesting that in the discussion afterwards with the relatives, a sister recalled how months previously, the patient had said that his body was tired of living, suggesting that the ego was located in the body awaiting to be attacked by the superego.

Bion's hypothesis<sup>19</sup> was that the pathological superego arose out of early failures in communication between the infant and mother. In depression, the ego-destructive superego will occupy the driving seat and attack the self. In such a situation, O'Shaughnessy summarises, "No working through can take place, only an impoverishment and deterioration of relations, with an escalation of hatred and anxiety that results in psychotic panic or despair. In this dangerous situation, the significant event for the patient is to be enabled to move away from his abnormal superego, return to his object, and so experience the analyst as an object with a normal superego" (p.861).<sup>3</sup>

To end on a more positive note, in contrast to the previous example, there are also cases where patients may actively seek help through analytic psychotherapy.

*A young woman came to therapy with a five-year history of disabling depression. She had been hospitalised early in the illness and had been on antidepressant medication for a number of years. She came from a strict religious background. Her wish was to develop her own mind, while facing up to the guilt of developing a different attitude to her parents. She was determined to come off medication. She described the feelings in therapy as going round and round over painful events; however it was like a spiral coil, so that there was a forward*

*movement. The active involvement of the therapist on the side of a mature reflective superego, helped lessen the effects of the ego-destructive superego and support the development of her own mind.*

## CONCLUSION

In this paper, I have endeavoured to draw attention, with clinical illustrations, to certain key issues when thinking about the management of depression and why in some cases patients may receive analytic psychotherapy, in others antidepressant medication, and in some a mixture of both.

It is important to distinguish major depressive episodes from other ways that we think of low moods. If we regard major depressive episodes as manifestations of an underlying psychotic disorder, then it means that we need to make a special effort to tune into the wavelength of the psychopathology in order to understand it and become empathic to the ongoing process.

Psychoanalysis as well as biological psychiatry has much to contribute in the understanding and management of depression, and it is suggested that a biological and a psychoanalytic approach are not necessarily mutually incompatible.

Analytic theory in describing the presence of an abnormal ego-destructive superego, operating in depression, suggests an overall framework of approach to treatment. The priority in treatment, whether through medication or analytic psychotherapy, would be to unseat the primitive ego-destructive superego, which has usurped the driving seat that otherwise would have been occupied by a more mature and reflective superego. Only when the reflective superego is back in place can any meaningful analytic work go on towards strengthening the ego or individuality of the person.

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#### ABSTRACT

*Patients with depression cover the spectrum, in terms of severity of psychopathology, between those receptive to analytic psychotherapy and those that require treatment with medication. In this paper, the author demonstrates how a psychoanalytic framework of understanding has a place in the latter group, and can aid general psychiatrists in relating to their depressed patients. The notion of a pathological ego-destructive superego taking over control in depression is explored, with the need to unseat it and replace it*

*with a more mature superego providing an overall framework of approach to treatment.*

*Keywords: Depression, medication, psychoanalytic framework, ego-destructive superego.*

#### RESUMO

*Pacientes com depressão abrange um espectro, em termos da severidade da psicopatologia, entre os que se tratam com psicoterapia psicanalítica e os que recebem tratamento medicamentoso. Neste artigo o autor demonstra como o referencial psicanalítico tem lugar no segundo grupo e pode ajudar o psiquiatra clínico a tratar seus pacientes deprimidos. A noção da patologia autodetrutiva do superego é explorada no controle da depressão com a necessidade de atingir a um superego mais maduro promovendo uma estrutura à abordagem do tratamento.*

*Descritores: Depressão, medicação, referencial psicanalítico, superego autodestrutivo.*

*Título: O manejo da depressão – análise, antidepressivos, ou ambos?*

#### RESUMEN

*Pacientes con depresión abarca un espectro, en términos de la severidad de la psicopatología, entre los que se tratan con psicoterapia psicoanalítica y los que reciben tratamiento medicamentoso. En este artículo el autor demuestra como el referencial psicoanalítico tiene lugar en el segundo grupo y puede ayudar al psiquiatra clínico a tratar sus pacientes deprimidos. La noción de la patología autodestructiva del superego es explorada en el control de la depresión con la necesidad de alcanzar un superego mas maduro promoviendo una estructura al abordaje del tratamiento.*

*Palabras-clave: Depresión, medicación, referencial psicoanalítico, superego autodestructivo.*

*Título: Gerenciando la depresión – analítica, antidepressivos o ambos?*

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