Depression:

A Client Based Approach

A Selection of Techniques that Address the Complex Face of Depression

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Depression: Definition and Overview

"Persons experiencing depression are shot through with sadness, feelings of being helpless, discouraged, and hopeless. Individuals riding towards the far end of the continuum of depression cannot cope with life." (Kennedy & Charles, 2001: 215)

This simple definition, not attributable to any particular school of therapy, already betrays the complexity inherent in working with a client who suffers depression. Depression is not the same for all and, as the quoted authors admonish, "we save ourselves from serious errors by not generalizing from our own experience to the experience of those with whom we work" (Ibid, 2001: 217).

There are general maxims, however, that one can follow when working with depressed clients. All depressed clients require affection, support and understanding. Kennedy and Charles state, however, that the depressed "want more than healing, they want everything back, and this largely unconscious need can become an important dynamic in the counseling process." (Ibid, 2001:227)

As therapists, if we do not give credit to the complexity of depression, and the fact that our role is only one in a partnership towards healing, we may not have sufficient resources to cope with forthcoming anger or disappointment from the client. Without dealing with our counter-transference of possible guilt, or disappointment at failing to "save" our client, we will not be able to provide the unconditional empathy, ongoing support, and gradual letting go that a depressed client will require.

Depending on the severity of the depression, self-harm may be the only means for a depressed person to exercise *any* control. Living on the edge of paranoia may also manifest and result in some suspicion of the therapist or therapeutic process. The client's woe may be fixated on "reap[ing] the dividends of sympathy, concern, or being exempt from the rules" (Ibid, 2001:229). All in all, these possible variations make handling the depressed client a unique challenge that is not solved by a "one size fits all" approach. Many different techniques need to be analytically and intuitively employed in order to do the best work that a therapist can do. We must be versatile in accessing and applying techniques as needed including life-management, cognitive behavioural work, and medical intervention with appropriate medication along with, or alternatively to, psychodynamic approaches and emotional bodywork. Overall, we need to exercise the qualities of presence, patience and willingness to discern and understand the tortured patterns of life through a slow and repetitive unfolding.

In this paper, we outline some useful approaches that we have already used, or will hope to use, in our practice of dealing with the depressed. Our modalities are chosen from our current experience of training and practice in what offers hope to the depressed client. The modalities outlined in this paper, and handled by addressing theory and practical techniques, include Self-Psychology, Jungian Perspectives, Mindfulness Based Cognitive Therapy, Depression in the Character Structures and Bio-energetics preceded by an overview of important practical considerations for the beginning of treatment.

We will more thoroughly outline the bio-energetic techniques for handling depression, since this has been the mainstay of our training, but we are cautious in realizing that the bio-energetic approach, especially with its most active

techniques, is a more aggressive modality that needs to be employed with the utmost caution, in the right time and with the right client. It may be that the client is not yet ready for this journey and therefore it would be irresponsible for the therapist to go down that road with the client at a particular point in time, especially if the client is not willing to do so.

In addressing the modalities, we will use variations of the following format and include:

- the understanding or definition of depression according to particular modalities
- the modality's approach to depression (and the theory behind the approach)
- techniques of the modality with possible examples of therapeutic interventions
- references for further information

It is our hope that this paper will afford the beginning or already practiced therapist with techniques, strategies and compelling rationales for employing a rich variety of therapeutic resources for handling the depressed client.

Practical Considerations for Dealing with the Depressed Client

Diagnosing and Distinguishing Types of Depression

Depression is characterized by the following symptoms, however, it is important for us to distinguish between depression that might do well with psychotherapy alone and depression that might require a doctor's care, medication or a larger team approach. Major depression, obviously, requires more intervention.

Usually the symptoms are similar for mild, moderate or severe depression, however, what distinguishes them from one another is the *length* (duration) and *severity* of symptoms. In Clinical Depression, symptoms are present for most of the day, nearly every day for at least two weeks and do not uplift when something good happens. The severity of a client's state is determined by whether they experience these symptoms a little, some or a lot.

Symptoms of Depression according to Jackson-Triche, Wells & Minnium, 2002, include:

- Feeling or looking sad and down-hearted (disturbed mood, hence, a mood disorder)
- Feeling numb or empty
- Losing interest in things that used to be enjoyable
- Trouble concentrating, thinking, remembering, or making decisions
- Trouble sleeping (falling and staying asleep or sleeping too much)
- Loss of energy and motivation (deeper, more intense fatigue)
- Change in appetite and eating habits (overeating or loss of appetite)
- More irritable, edgy, nervous or agitated
- Feeling worthless or guilty
- Feeling hopeless, including thoughts of death or suicide

- Frequent body aches and pains or digestive problems
- Isolating from family and friends
- Abnormal thoughts and experiences (including paranoia, hypochondria)
- Changes in physical activity (living in slow motion, restless, jittery, jumpy, anxious)

At the outset, a client may be somewhat reassured by having the following common **Myths about Depression** dismissed:

- "It's my own fault. I have done something wrong."
- "Depression is a sign of personal weakness or a character flaw."
- "Religious people shouldn't get depressed."
- "It is shameful to have emotional problems."
- "I have to struggle through this alone because no one can help me."
- "Successful people, people with money and friends don't get depressed."
- "Ending my life is the only solution."
- "Children and teenagers don't get depressed."
- "I shouldn't tell anyone about these feelings."
- "The poor don't have the luxury of getting depressed."

It is good to try to determine the cause of depression, since this will aid in treatment and also help determine if therapy alone is what is required.

While simplified, possible **Causes of Depression** are listed below:

- Chemical changes in the neurotransmitters of the brain (can be hereditary or precipitous)
- Family history (heredity or developmental issues)
- Experiencing bad or catastrophic events or significant loss
- Longstanding difficult life circumstances (poverty, unemployment)
- Medical illness

- Drug or alcohol abuse
- Prescription medications
- Exposure to physical or sexual violence or the threat of it
- Past history of clinical depression
- Hormonal change (including post-partem depression)
- Social isolation or no emotional support
- Depression that comes out of the blue – could also be that unconscious matter is surfacing for one reason or another

Types of Clinical Depression:

Clinical Depression is the general term that describes a broad-spectrum of clinical ailments. All share similar clusters of symptoms but they differ in quantity, quality and duration of symptoms and how these symptoms interfere with the ability to perform routine daily activities. The terminology used follows that of The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a text used by trained medical and mental health professionals to diagnose emotional disorders.

DSM-IV Diagnostic Criteria for Major Depression:

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful)
2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3) significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day
4) insomnia or hypersomnia nearly every day

5) psychomotor agitation or retardation nearly every day (observable by others)
6) fatigue or loss of energy nearly every day
7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Major Depressive Disorder (also called Unipolar Depression)

Two primary conditions needed to make this diagnosis are:

1) the depressive symptoms must represent a definitive change from how a person usually feels in everyday life, and,
2) a person must experience sysmptoms *all day, almost every day*, throughout the same two-week period.

Also, sufferers must have at least five of the previous symptoms, with depressed mood or decreased interest (or pleasure) in enjoyable activities being one of them.

Mild Major Depressive Disorder

Sufferers have five or six of the nine symptoms listed and are able to make it through the day without significant impairment. They feel much worse than usual and, although they are still able to manage household activities and work, they must put forth a tremendous amount of effort to do so.

Moderate Major Depressive Disorder

Sufferers usually have more than five of the nine listed symptoms. The key characteristic is that tremendous amounts of effort no longer work. Taking on new tasks becomes impossible as life slowly unravels.

Severe-Major Depressive Disorder Without and With Psychotic Features

Sufferers can no longer work or manage things at home. Some stop taking care of themselves and neglect things like washing up or getting dressed. Their symptoms are so severe that they really cannot function. In the most extreme circumstances, sufferers begin to hallucinate or have bizarre thoughts about harming themselves or others. Psychosis causes a loss in capacity to determine what is real and what is not.

Postpartum Depression

Postpartum depression is not the same as "Baby Blues" that features weepiness, fatigue, frustration, and discomfort that last a few days to up to two weeks. Postpartum depression is a serious form of clinical depression, identical to those seen in Major Depressive Disorder, that progressively worsens and may include disturbing and frightening thoughts about the baby.

Dysthymic Disorder

This is a chronic form of Clinical Depression that typically has fewer symptoms but is suffered over longer periods. For this diagnosis, symptoms must be present for at least two years and include at least two of the following:

Poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and feelings of hopelessness.

Minor Depression

Minor depressive disorder is less severe with fewer symptoms and appears to cause much less distress and difficulty in keeping up with daily activities. Between two and four symptoms are enough to meet criteria for this diagnosis but symptoms must be present nearly all day, almost every day, for a period of at least two weeks.

Depression Due to General Medical Condition

Generally, this depression is diagnosed when the symptoms of depression can be directly connected to the course of a general medical illness and is a secondary consequence of having a medical disease.

Bipolar Disorder (Manic Depression)

People with this disorder experience both extremes of mood from severe depression to mania. Mania includes feeling smarter or better than others, feeling more energetic, becoming irritable, easily angered even violent, thinking faster than usual, talking much more than usual, sleeping less and/or engaging in risky activities.

Posttraumatic Stress Disorder

This is a disease that develops in some people after they personally experienced or witnessed either a life-threatening event or an incident that threatened serious bodily injury such as violent assault, natural disaster, serious accident or military combat. Symptoms include recurrent thoughts and nightmares about the event where they "relive" the trauma, have trouble sleeping, concentrating and/or can have angry or violent outbursts.

Adjustment Disorders

There is a group of clinical disorders called "adjustment disorders" that can be seen as milder forms of posttraumatic stress. People with this experience stressful or unhappy events but they are not life threatening and do not involve serious physical injury. Depressed feelings typically start within three months of the incident and usually get better or resolve by sic months.

Seasonal Pattern Depression

Some people with clinical depression only experience symptoms at particular times of the year, in accordance with exposure to sunlight. Light therapy is a therapy used to treat Seasonal Mood Disorder (SAD).

In assessing the client and deciding if psychotherapy alone is the appropriate treatment, the therapist should ask questions of the client if sufficient information is not automatically revealed in the first session. Then, in additional to the therapeutic process, the therapist should check with the client regarding practical considerations and what the client can do for him/herself to aid in the treatment of depression.

The following is a list of practical self-help suggestions that the depressed client can do to help him or herself:

1) Have a regular bedtime and routine – establish a regular bedtime and bedtime ritual to condition the body for sleep
2) Get daily, moderate exercise – as little as twenty minutes, three times a week such as walking, swimming, gardening, bicycling. The important thing is to find the time and do it regularly, perhaps having the assistance of an exercise partner or a group.
3) Manage stress – Being alone or without emotional support, struggling with limited finances, living in poverty, enduring troubled family or work

relationships and suffering from serious medical problems can drag anyone down into depression. The following strategies can help:

a. Spiritual Practice – religious groups, spiritual advisors, spiritual practice

b. Relaxation Techniques – biofeedback, hypnosis, yoga, massage, listening to relaxation audio tapes, warm baths, stretching exercises, deep breathing exercises, self-help books, are but a few

4) Avoid being alone for long periods – have contacts with people and develop a support system, even if the meetings are short and casual, like going for a coffee. Otherwise, groups such as drawing lessons, exercise classes and volunteering are good ways to get connected.

5) Keep scheduled appointments – and have a method to assist in aiding your memory and concentration

6) Record and report all medication side effects

7) Eat a healthy diet

8) Avoid taking on new or difficult tasks at work or at home – and avoid all new responsibilities

9) Follow doctor and therapist recommendations – do any assigned "homework" such as listing pleasant and relaxing activity suggestions or people, places or things to avoid

10) Avoid alcohol and illegal drugs

Jungian View of Depression

Now more than ever, we are a society obsessed with achieving unalloyed happiness. Our increasingly desperate attempts to fill a spiritual and emotional void with material wealth are hopeless. So fearful is the culture of its inner shadow that we have developed medications that mask and deny our darker emotions. This obsession with happiness is taught as early as preschool: A Harvard study found that antidepressant use among children was increasing at a rate of 23% annually and that the fastest growing segment of users was among children 0-5 years old. Jungians understand the ephemeral nature of happiness. Rather then seeking a fortune which will inevitably slip away, their goal is to derive meaning from life. Depression is not something to fear and avoid but an essential gateway to spiritual and emotional maturation.

Jung termed the psychology he developed, analytical psychology to distinguish it from Freud s psychoanalysis. Jung believed that the psyche has two levels, the conscious and unconscious, and the unconscious itself can be further divided into two parts: The personal unconscious, a person s individual experiences, and the collective unconscious, which has roots from the inherited past of the entire species. The contents of the collective unconscious are passed from one generation to another as psychic potential. It is not ideas that are inherited but rather innate tendencies that cause us to react in particular ways to particular stimuli. For example, a woman may find herself tenderly loving her infant, even though she may have been indifferent during her pregnancy, as her maternal tendency has now been activated. There are endless numbers of these inherited tendencies that are now part of our biological constitution. They have

developed from being forms without content (Feist, p. 165), into forms with content and express themselves as archetypes.

Described by Feist as emotionally toned collections of associated images (p. 165), archetypes are a key concept to understanding how Jungians make meaning of experience. Archetypes encompass both negative and positive possibilities. For example, the mother archetype encompasses both the kind and nurturing aspects of the mother and the terrible and wicked aspects. Both of these associations exist for the child, regardless of the child s experience of the personal mother. We each have the potential for countless numbers of archetypes and when a personal experience matches a latent archaic image, an archetype is activated, affecting one s personal life.

The archetypes make themselves known through dreams and fantasies. Some archetypes have evolved to the point where they can be named. One such archetype is the shadow and this is where depression lurks (Abrams, p. xix). Depression must be confronted in the darkness so that it can be brought into the light of consciousness to be transformed.

By having the courage to swim in the sea of depression, one has the opportunity to coming closer to soul, wholeness and individuation. Ego pulls us towards anything that will make us feel secure —power, money or relationships. Psyche, however, has a different purpose: the quest for meaning — an understanding of the nature of our existence. Whereas suffering is inevitable, depression is not. Depression occurs only when we fail to see the meaning in our suffering.

The task set to understanding depression is to become aware enough to tell the difference between what has happened to us in the past and who we are now. One can

move forward when one can say, I am not the victimized character of my story; I am its author. When this happens, we create a personal myth. This myth is uniquely ours and is free from the hopes, needs and ideas that have been imposed on us by our parents. Depression must be engaged rather than escaped. However, with all the pressures and responsibilities of modern life, there are many commitments that keep people focused outward and prevent people from exploring their despair. But our darkest moments are an opportunity for slowing down and being alone, allowing the hidden messages of the unconscious to be decoded.

Although there are many ways analysands describe depression, a leaden feeling in the body, hopelessness and the sense that one s spirit, courage and will have collapsed are common to each. This sense of despair is one of the main presenting issues that people report as their reason for entering psychotherapy. These clients are aware of having not met their own or others expectations and feel powerless to change themselves or their environment. They believe that they cannot control their rage and terror, which gives rise to the fear that they are going crazy. They constrict and press their lives into small habitual activities that they see as manageable and shy away from challenges and long term plans. It is as if psychologically they are cowering in a spatio-temporal corner (Rosen, p. 8).

Restoration of lost morale comes through the meaning that is imbedded in the depression. When the analysand comes to understand that his deficit was formed by developmental circumstances and not something that is inherent to him, the depression is transformed.

The healing journey of depression transformation comprises three stages: The first stage is a period of resistance wherein the analysand tests the therapist to see if she is genuinely empathetic and accepting of all expressions of negativity and rage. By supporting strengths and emphasizing assets, the therapist affords the analysand a safe place to confront and abandon deficits and liabilities (Rosen p. 77). Once resistance is overcome, the opportunity to explore and understand parental complexes presents itself.

The second stage is characterized by partial ego death. By analyzing the depression to death, talking about the depression in all its subtly diverse permutations over and over again, the analysand becomes aware of the parental introjects. The analysand can then allow these introjects to die, opening the way for a newly organized ego to be born. As the old way of being dies, the analysand experiences a death within himself and becomes dependant on the therapist who becomes a surrogate mother. The defining characteristics of this stage are anxiety, confusion, despondency and introversion. The presence of these symptoms is the confirmation that the previous ego identity has died (Rosen, p.78).

The hallmark of the third stage in this process is the separation from the therapist. The analysand begins to express himself in a more integrated fashion: By exploring and analyzing the meaning of the depression, the unconscious aspects of the past become activated and are brought into consciousness and the present. Meaning and purpose are restored to life and a rebirth occurs (Rosen, p.78).

Jung contended that the healing journey cannot be successfully traversed if one focuses exclusively on the personal aspect of one s internal conflict. For healing to take place, one must come to understand the archetypes in one s psyche, as they may manifest

themselves spontaneously anywhere, anytime. The three methods that Jungians employ to assist analysands to bring the archetypes to consciousness are active imagination, dream analysis and art therapy.

Active imagination is a meditative-like state that is partly directed by the analyst, allowing the analysand to access images from his unconscious. The analysand uses intuition, sensation, thinking and feeling to elaborate on these images. The process can often result in creative acts of expression (eg. painting, dancing, writing, etc).

By employing art therapy, the analysand is able to make visible a part of the psyche that has been torturing him. The analysand can confront the image, now outside the body, and decide how best to process it. Art therapy helps transform potentially destructive inner energy into constructive outer expressions which can be analyzed as if they were dreams. The analysand gives his personal associations to the work and the analyst amplifies these with archetypal references.

An essential tool in Jungian analysis is dream interpretation. Whereas Freud believed that dream images concealed the actual meaning of the dream due to the dreamer's unconscious censor to hide a repressed infantile wish, Jung saw dream images as revealing the situation in the unconscious as it actually is. He thus paid close attention to the manifest images as the dreamer remembered them. In order to understand why the dreamer chooses his unique language of symbols and metaphors, Jungian analysts encourage their analysands to stay close to the image and describe its historical and/or emotional context in the dream and waking life. This method is referred to as amplification and is the elaboration of dream images to determine their significance.

This is achieved by gaining insight into the dreamer's personal associations with the

image, the cultural significance of the image and the parallels that can be drawn from the symbolism contained in folklore, history, fairy tales, religion and mythology.

Analysands may need to revisit the darkness of depression many times. It is important that they understand that this revisiting is not due to a flaw within themselves; as if knowing better should keep them from going into this state as the rhythms of psyche move their powerful ways quite outside our will (Hollis, p.124). The task is to suffer through each bout of depression and find the meaning which lies therein. Each new sinking into the depths brings new insight, corrective behaviour and wisdom. It is through this difficult process that transformation of depression is ultimately achieved.

Glossary

Ego — A complex factor to which all conscious contents are related. It forms the centre of the field of consciousness. It rests on the unconscious and is influenced by retrievable memories as well as by intrusions of the shadow.

Introject — The process of absorbing the superego from the parents; that is, the child incorporates the attitudes of the parents as his own.

Psyche — This refers to the mind, including conscious and unconscious processes. It is also referred to as Self.

Self — This is the centre and totality of the psyche. It encompasses both the conscious and the unconscious

Shadow — That which is repressed, unknown and often evil about oneself. It is typically projected onto other people and is usually represented as same-sexed figures in dreams.

The self — This refers to the personal being and is concerned with life on a day-to-day basis.

Transformation — This is a change to the nature of the personality be making conscious parental introjects and conflicts. At the core of this process is an archetypal death-birth experience.

Further Reading

Feist, Jess (1985). Theories of personality. Toronto: Harcourt brace College Publishers

Hollis, James (1996). Swamplands of the soul: new life in dismal places. Canada: Inner City Books

Rosen, David H. (1993). Transforming depression: a Jungian approach using the creative arts. New York: G. P. Putman s Sons

Zweig, Connie and Jabrams, Jeremiah (1991). Meeting the shadow: the hidden power of the dark side of human nature. New York: Jeremy P. Tarcher/Putnam

Mindfulness-Based Cognitive Therapy for Depression

Compelling research, conducted and collated by Zindel Segal, J. Mark Williams, and John Teasdale, among others, points to the striking capability of mindfulness-based cognitive therapy to prevent relapse in depression. In further reflecting on the unfortunate reality, that occurrences of depression relapse increase proportionately with the number of past depressive experiences, it seems most appropriate that this technique (MBCT) be given credit in our overview of depression treatment options.

What is additionally persuasive is that mindfulness-based cognitive therapy is more effective in preventing relapse than therapy or medication alone or combined therapy and medication. This is supported by much clinical evidence (Segal, Williams and Teasdale: 2002). Therefore, there is value in combining cognitive therapy approaches (changing thinking) with mindfulness practice (observing and accepting the body-self) in that this is a winning combination that protects those most vulnerable to recurrent depression.

According to the researcher authors, there is observable patterning in those that suffer from repeated depression. While negative thinking (e.g. "I am a failure") does affect mood, in those who have experienced depression, the phenomenon of learned association is prevalent ("mood activated reinstatement of negative thinking patterns") and, conversely, causes mood to affect thinking. The depressed client can easily fall into negative "mental grooves" that further deepen with persistent rumination and self-perpetuating modes of mind.

Decentering, a typical CBT skill, works (by examining evidence, testing hypotheses, doing experiments, etc.) to help the depressed client *see* his or her thoughts in a wider perspective (as simply reflecting "thoughts" and not necessarily reality). The aim of these strategies is to distance the client from his or

her own narrow negative and destructive perspective. Add detachment (a meditation concept and state) to this CBT skill, whereby the client practices and learns to experience his thoughts and feelings more as passing events (as in "I am not my thoughts") and you have a reinforcing combination that works to prevent a client from falling into the vortex downward spiral of depression. Finally, the benefits of *choosing focus* correspond to the reality that "information processing take[s] up space in a 'limited capacity channel'" of the mind. One can learn to use to advantage that the mind can really only be in one place at one time.

Jon Kabat-Zinn, designer of mindfulness based practice for therapeutic purposes, defines mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn,1994:4). It was Kabat-Zinn's work in his stress reduction clinic in Massachusetts that contributed greatly to the advancement of MBCT work for depression. The same practices that have helped sufferers of physical pain and mental stress find relief can be applied to the alleviation and elimination of depression.

As the practitioners of MBCT summarize, "mindfulness appeared to offer a number of possibilities for approaching relapse prevention. We saw it as providing alternative methods for teaching decentering skills, training patients to recognize when their mood was deteriorating, and using techniques that would take up limited resources in channels of information processing that normally sustained ruminative thought-affect cycles." (Segal, Williams & Teasdale, 2002:42). Proponents of this approach believed that "the key was whether people could learn to take a decentered perspective on their patterns of thinking. If this were true, then there was no need to change the content of people's thoughts, but only how they related to this content" (Ibid, 2002:45).

The drawbacks to this method and program, since it is actually an eight-week (two and a half hour a session) series of group instruction and practice program, are that two conditions are necessary to be met. Firstly, participants could not be involved in the program if they were in an active depressive state. They need to be in remission from depression since depression precludes one's ability to focus that is so necessary for the mindfulness work. Secondly, the candidate must be sufficiently self-motivated to complete the homework practice (both written and meditative) on a weekly basis. In practice, there was a substantial drop out rate particularly in the first three weeks of the program because of these significant demands. Finally, what could be considered to be an additional drawback to this program is that the practitioner/teachers of this program have to be actively practicing mindfulness based meditation themselves for 40 minutes per day (as would be expected of the participants). All in all, when looking at the outstanding statistics related to the prevention of relapse, the demands are worth the high payoffs of success that participants experience.

The Program

The first four weeks of the program consists of *attentional control training* whereby mindfulness practice enables patients to increase their awareness. MCBT prioritizes learning how to pay attention, on purpose, in each moment and without judgment. Sessions 1 – 4 include daily life attention, awareness of how quickly the mind shifts and how to bring the mind back to single focus (taught with reference to the body and to breathing) and becoming aware of how mind wandering can allow negative thoughts and feelings to occur. There are three positive consequences to this: 1) awareness would enable patients to notice

when they were about to undergo dangerous mood swings, 2) awareness would take up those scarce processing resources that might have been supporting rumination, thereby weakening it, and, 3) patients could then de-centre or exit from their more automatic depression-linked patterns (automatic pilot) of thought that these moods habitually brought to mind.

An example of the practice is as follows. When patients said they felt sad or afraid or that they had judgmental or hopeless thoughts, they were simply encouraged to bring these difficulties to awareness and to breathe with them, allowing their difficult thoughts and feelings simply to *be* there in a kindly awareness, adopting a more "welcoming" than a "need to solve" stance. While CBT skills could allow patients to deal with the negative thoughts that any sad moods might re-activate, the key is to slowly and steadily change one's relationship to thoughts, feelings and bodily sensations. This approach is about teaching people a new way of relating to experience that is not about avoiding, fixing, ruminating, fighting against or seeing problems as the enemy but is about cultivating and allowing a gentleness or friendly awareness posture towards all experience.

MBCT helps a client see how negative thoughts and feelings are expressed through the entire body. This awareness of the effect of negative thoughts and feelings in the body gives participants another place to stand, another perspective from which to view the situation. This awareness discourages avoidance of difficult or painful thoughts, feelings or body sensations. Instead it suggests a measured and reliable way of "turning around" and "looking into" these experiences. It also suggests that breathing or a neutral focus in the body could be used as a base or center from which to steady oneself if the work of

looking at one's experience becomes overwhelming. On might call this approach a "radical acceptance" which is aimed at normalizing and bring peace to the suffering client.

MBCT is an experiential program that supports a client in creating a habit of mind whereby new experiences for the mind and body are provided over and over again that will eventually accumulate to create an alternative pattern and move the client from "doing" to "being" mode. The re-patterning replaces the rumination of the mind going round and round in a hopeless attempt for the client to think their way out of their problem. The core skill of mindfulness, taught in a formal and repetitive manner, provides the client with the ability to recognize and disengage from mind states (when thinking/doing mode is triggered) characterized by self-perpetuating patterns of ruminative, negative thought. This is a departure from the classic CBT focus on changing thought content to a focus on process with the intentional use of attention and awareness. More traditional CBT techniques can also be used as additional coping strategies to help a client respond even more skillfully to negative emotion derived from "bad" thinking.

In Sessions 5 to 8 of the training program, clients are taught how to respond to negative thoughts or feelings that arise by simply *being there* before taking steps to respond skillfully by using specific strategies. This is done by initially taking a "breathing space" for a minute or two before expanding attention to the body as a whole. Then, the client may choose to deal with the thought or feeling directly (then or later) by seeing it as simply a thought or feeling and watching it as it passes (as in meditation practice) or she may choose to deal with it by noting the part of the body affected and bringing awareness to that part of the

body using the breath to open and soften to the sensation rather than tighten and brace around it. Finally, the client may choose to deal with the difficulty by taking an action specifically chosen for its ability in the past to bring some pleasure or sense of mastery to bear on the unpleasant situation.

What causes the hold of old patterns of negative thinking? They are based on old, well-practiced, automatic cognitive routines (often ruminative) that are motivated (ineffectively) by the goals of escaping/avoiding depression or problematic life situations. These unhelpful routines persist because the person remains in a cognitive mode characterized by automatic pilot and is driven by the overriding wish to get rid of the negative mood with a strong attachment to the goal of feeling happy. Constant monitoring and comparison of the current state with the desired state and reliance on "verbal" problem-solving techniques does not solve anything but, on the contrary, further embeds the problem.

The core skill of stepping out of this pattern is "letting go" that is repeatedly practiced by the body awareness exercises and moving on from one body part to another (body-mindfulness meditation). The aim of the program is freedom not happiness, relaxation and so on. Participants learn concentration; awareness/mindfulness of thoughts, emotions/feelings, bodily sensations; being in the moment; decentering; acceptance/nonaversion, nonattachment, kindly awareness; letting go; being rather than doing, non-goal attainment, and that there is no special state to be achieved (either relaxation, happiness, peace, etc.). All this work happens *in* the body.

Only when people learn to take a different stance in relation to the "battleground" of their thoughts and feelings will they be able in the future to recognize difficult situations early and deal with them skillfully.

Selected Resources:

Beck, Aaron T., A. John Rush, Brian F. Shaw & Gary Emery. **Cognitive Therapy of Depression.** The Guildford Press (1987)

Brach, Tara. **Radical Acceptance: Embracing Your Life with the Heart of a Buddha**. Bantam Books (2003)

Kabat-Zinn, Jon. **Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.** Bantam Dell Pub Group (1990)

Kabat-Zinn, Jon. **Mindfulness Meditation Audio Tapes**. Simon and Schuster (2002)

Kabat-Zinn, Jon. **Wherever You Go, There You Are: Mindfulness in Everyday Life.** Hyperion (2005)

Segal, Zinden V., J. Mark G. Williams, & John D. Teasdale. **Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse.** The Guilford Press (2002)

Self Psychology and Depression

How de we develop a sense of self; that structure that represents the core of our personality? Some people grow into confident, capable adults, while others are wracked by insecurity and self-doubt. Even siblings develop differently from each other, in spite of sharing a common environment. What accounts for these differences? Researchers in infant development have found that the relationship between mother and baby has a profound impact on the baby's psychological development. In order to organize experience and make meaning, the emerging self needs the presence of others (objects). How these objects respond to the self (termed selfobject experiences or selfobjects) will determine whether it is maintained as a cohesive and vigorous structure or a self that is easily fragmented and feels empty (Wolf, p.11). Positive selfobject experiences are required throughout life.

Contemporary society demands more of women than in the past and as a consequence they are less available to their children. Also, the importance of extended families is shrinking, leaving the child without the potential for positive selfobject experiences from grandparents, aunts and uncles. Daycare centres and nursery schools have not proven themselves to be adequate providers of "sufficient stimulation and psychological nourishment" (Wolf, p.25). All of these considerations together, leave the child "feeling uncared for and unresponded to" (Wolf, p.25). This lack of positive selfobject experience has left children vulnerable to many self disorders, including depression. Self psychology views depression as a rupture in the developmental spiral stemming from inappropriate (unattuned) responses of caregivers (Basch, p.28). This breach can be mended through the relationship between therapist and client. Because self

psychology is a psychodynamic relational approach to psychotherapy, as each client brings his wounded inner child, a new opportunity for healing the gap presents itself.

Depression is a fundamental reaction to poor attunement, usually by the mother. Because the infant needs to be loved and recognized as good, he becomes angry at not having this expected need met and begins to hate the selfother. Because the infant fears that his hatred will destroy the very person that he needs, his anger and hatred are turned inwards and result in depression and despair. Depression, therefore, is seen as a problem caused by a sense of inner badness. The self becomes paralyzed because of its inability to cope with the outer danger of not being empathically seen. The state of depression contains a tendency to deny life and leads to the statement, "I am bad, a horrible person, guilty" (Guntrip, p.24).

Self psychology divides depression into three types: Preverbal depression is characterized by apathy, a sense of deadness and diffuse rage and is related to trauma experienced in early life. Those suffering from empty depression experience a depletion of self-esteem and vitality due to "a lack of joyful selfobject responses." Guilt depression results from a lack of positive experiences with a calm, idealized adult and its symptoms are feelings of self-rejection and blame (Wolf, pp 185-186).

The cornerstone to healing in self psychology is the understanding of transference. Transference occurs when the client views the therapist as a significant person from the past and responds to the therapist *as if* she were that person, usually the mother or father. Transference is the result of fears, defenses and distortions that become structured in the body and become habitual. By reactivating these in the container of the therapeutic relationship, the client can express his legitimate childhood needs and wishes in the

present. It is his hope that he will now find a good object in his therapist who will provide him with longed for and missed selfobject functions. It is also his dread that the frustrating experiences of the past will be repeated (http://www.columbia.edu/~wd16/glossary.htm).

By being empathetic to the client's needs and wishes, that is, by finding the way into his feeling experience, the therapist can gather data which will help her to understand the nature of the transference. In this way, the therapist assists the client to move through developmental breaks and grow the self.

Self psychology defines three types of transference. The first type is mirroring transference. The mirroring transference is the need of a person to be remembered, noticed and admired. This transference is essential to the development of healthy self-esteem and for achieving higher forms of expression, like humour, creativity and healthy ambition (White, p.11). In the idealizing transference, the client needs to imbue the therapist with absolute perfection and power, so the client will be able to internalize some of these qualities. Through her idealization of the therapist, the client makes known her secret fear: "Will you be there when I need you? Are you strong enough to deal with my despair and help me to learn to cope with my depression so that I won't fall apart (White, p.8)?" In the twinship transference, the client needs to know that she is part of the human race; that she and the therapist share abilities, traits and qualities (e.g. I also like reading mystery novels). This transference stimulates the development of talents and skills which help the client carry out goals (White, p.106). Each of these types of transference may be seen during the course of a therapy. By deciphering which transference the client

requires at a given time, the therapist is able to provide the client with the appropriate response and helps the self to see itself in a new way.

In order to repair the damage to the self and help it move towards the understanding of its own competence, the therapist must be empathically attuned to the client's feeling states. When the therapist enters the client's inner world, it enables the client to experience and express unconscious emotions. This can be accomplished not by asking "how does that make you feel?", which may leave a client feeling misunderstood, but rather by finding a way into the client's emotions with statements such as I can sense that..., I can see how you might resent..., I can understand how you would feel... Breaks in attunement by the therapist are experienced as threats to the self, much as they were in childhood. By allowing the client to use her as an internalized selfobject, the therapist helps the client to make meaning of the client's life.

Analysis of a Session

The following session is an example of how transference can lead to a break in the empathic attunement. The repair of that break can lead the client to an awareness of a deeply held, denied affect and the deepening of the idealizing transference, thus loosening the hold of the depression.

The client expressed feelings of sadness, loneliness and hopelessness. Nothing in her life was going well; neither work, nor personal relationships. The therapist could say nothing right and she felt as if she were offering platitudes. The client rejected everything and said "Can't I just feel bad?" The therapist realized that she had been caught in a transference of her own feelings of despair and had been trying to save her client from the same feelings. The therapist then repaired the empathic break by telling

the client that of course she was free to express all her feelings. The client breathed deeply and went into her body:

CLIENT: I hate you. I don't really but it feels good to say it.

THERAPIST: Maybe you *do* hate me now and its okay to say it. Why do you think you might hate me now?

CLIENT: I don't know.

THERAPIST: Maybe because I don't have all the answers to make things better in your life.

CLIENT: Yeah. Wave your magic wand and make this all go away.

The client began to scream but did not seem connected to the sounds.

THERAPIST: Are you angry?

CLIENT: It feels like that's what I should be doing. The sounds are coming out but I don't feel connected to them.

THERAPIST: Don't force anything but lie quietly and breathe.

CLIENT: I'm aware of a monster opening my abdomen and eating my organs. Others are pulling my skin back to allow it easier access to my insides.

THERAPIST: Everyone's always wanted a piece of you – They reached right in and took what they wanted – There were no boundaries.

The client elaborated on the abuse her father had inflicted on her. At the end of the session, the client hugged the therapist warmly and thanked her for giving her what she had needed. She turned back when she was outside the door to blow the therapist a kiss.

Even though the therapist had initially denied the client her feelings, she then allowed the client to express her hatred. This showed the client that the therapist was strong enough to receive her difficult feelings and knew that she could trust the therapist

to be there for her, thus enhancing the idealizing transference and allowing the client to express her anger towards her father.

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The field of psychotherapy has no hard and fast rules. It is a field of intuition, nuance and flexibility. With nothing tangible to hold onto, what is it that the psychotherapist who practices self psychology does when she is concerned with the client's feeling state? She is empathic to feelings of fear, hopelessness and anger and she understands that to the client, joy can never exist. The therapist stays in the moment. The awareness that someone is empathically attuned to him, probably for the first time, opens the gateway for him to believe that he is a person who is valued and this lays the foundation for the growth of the self (White, p. 174, pp 177-178).

Glossary

Empathy (vicarious introspection) - A process of gaining access to antoher's psychological state by feeling oneself into the other's experience. Empathy is not sympathy or kindness. Nor is it an affective attitude. It is a method of data collection.

Self – This refers to the core of the personality which is made up of various parts that emerge into a coherent and lasting configuration based on nature and nurture with the child's experience of it's earliest selfothers.

Selfobject - This is a subjective aspect of a self-sustaining function performed by a relationship of self to objects who by their presence or activity evoke and maintain the self and the experience of selfhood. The selfobject relationship refers to an intrasychic relationship between the self and other objects. It denotes the experience of imagoes that are needed for sustaining the self.

Further Reading

Basch, M. (1988). *Understanding psychotherapy: the science behind the art.* USA: Basic Books.

General psychotherapy glossary. (n.d.). Retrieved April 17, 2005, from http://www.columbia.edu/~wd16/glossary.htm

Guntrip, H. (1975). *Schizoid phenomena, object relations and the self.* Madison, CO: International Universities Press, Inc.

Stern, D. (1985). *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology.* USA: Basic Books.

White, M., & Weiner, M. (1986). *The theory and practice of self psychology.* New York: Brunner/Mazel Publishers.

Wolf, E.S. (1988). *Treating the self: elements of clinical self psychology.* New York: The Guilford Press.

A Bio-energetic Approach

To the Understanding and Treatment of Depression

A Bio-energetic Understanding of Depression

While a full variety of feeling states, from ecstasy and joy to disappointment, sadness and sorrow (and all the feelings in between) is to be expected as part of the course of normal life, depression is characterized, according to Alexander Lowen, as the condition of being "unable to respond" (Lowen, 1972:18). It is this deadening of an ability to feel, accompanied by inner emptiness and inaccessibility of real pleasure, that distinguishes depression from unhappy or unpleasant human states. Thus the depressed individual, in blocking feeling, comes to wear an expressionless mask, complete with locking in the jaw, dullness in the eyes, strained vocal production and bodily rigidity, which is the best façade that he or she can muster for the outside world.

Despite the downhearted and discouraged nature of depression, the inability to feel also excludes expressions of grief, anger, rage and similar feelings that are usually associated with deep unhappiness. In the depressed person these feelings are trapped within and guarded against with great amounts of personal energy going towards containing these feelings. So, the work of the bio-energetic therapist is to bring life back to this lifeless state thus freeing the depression. As we bio-energetically know, shallow breathing is a way of avoiding feeling and the method to counteract this is for the therapist to create a safe environment where deep breathing can be encouraged and the feelings can start to flow. With conscious attention to breathing, other techniques (to be outlined in the next section) can also be applied in order to loosen the body and free up trapped feelings.

Lack of feeling reveals an inability to be in the present and this confirms the bio-energetical understanding that early childhood trauma is implicated in depression whereby the depressed person makes a commitment to an unreal future (holding unrealistic expectations) because she is held hostage by her past where early needs were thwarted.

Lowen elucidates this common phenomenon:

> When a person has experienced a loss or trauma in childhood that undermines his feelings of security and self-acceptance, he would project into his image of the future the requirements that it reverse the experience of his past. Thus an individual who experienced a sense of rejection as a child would picture the future as promising acceptance and approval. If he struggled against a sense of helplessness and impotence as a child, his mind would naturally compensate this insult to the ego with an image of the future in which he is powerful and controlling. The mind in its fantasies and daydreams attempts to reverse an unfavorable and unacceptable reality by creating images that exalt the individual and inflate his ego. If a significant part of a person's energy focuses on these images and dreams, he will lose sight of their origin in childhood experience and will sacrifice the present to their fulfillment. These images are unreal goals and their realization is an unattainable objective. (Lowen, 1972: 25, 26)

When a depressed client is out of touch with her own body, as is evident in the inability to feel, the alternative ways of being become in the head – governed by the ego structures of thought, will and wishful thinking - and living in the future, where the ideals of redemption and wholeness are projected. For example, the oral character structure, prone to depression, may fantasize and long for romantic love as a remedy for unhappiness instead of speaking personally and acting responsibly from a place of self-awareness to note that shallow breathing or chest tightness indicate a need to listen to the body, open up and self-nurture.

Depression, according to Lowen, is both a dire consequence of blocked feeling, yet it can be seen as an opportunity for healing where a person can begin to

make a shift from being outer-directed to inner directed. Depression occurs in epidemic proportion today in large part due to societal values and rampant consumerism which focus on finding fulfillment outside of the self – in wealth, success, fame and other inadequate substitutions for the authentic human needs of love, self-expression and freedom. The former unreal goals are embedded with unrealistic expectations that are never deliverable because they are counterfeits for our true needs. The Jungian sense of a spiritual/psychical reality is congruent with this assessment of contemporary life. The call of depression – to "call a halt to senseless waste of energy" (1972:33) is an opportunity for the bio-energetic therapist to get a client back to living and feeling in his or her own body which starts with the fundamentals of breathing, grounding, sensing, feeling and expressing.

Living with an outer directed posture is linked to the earlier mentioned phenomenon of not being with oneself and in the present. Since we fundamentally live in the body and, despite our worldly successes, "life is still lived on a very personal level" (1972:30), ego satisfaction never can fully address our underlying needs. Anthropologist Joseph Campbell echoes this truth in stating his belief that humans do not seek meaning in life (as many would think) as much as they seek the experience(s) of being fully alive.

Being fully alive is intrinsically connected to life in the body and is manifested (and thus is capable of being read by the therapist) in the eyes, voice and bodily movements. These bodily manifestations are clearly constricted in a depressed client. As self-authentication and self-reliance is not enabled, the body registers this lack of being at home as a disconnected way of being and outward seeking (or ultimately giving up) stance. Anecdotal history and disclosures from the client confirm a thwarting of natural needs set in motion in early childhood and the

subsequent futile quest for fulfillment in the outer world. A theory of character structures can assist the bio-energetic therapist by pointing to specific exercises that would help the client tap into and release blocks. In therapy the therapist creates an existential present where "what is" (a client's emotional and bodily content) is encouraged to come to the surface for the purpose of re-patterning.

A compelling quote by Lowen on the subject and true nature of love, helps to elucidate the goal of treating depression that is all about reconnecting to the self – feeling the self, experientially knowing the self, grounding the self, having faith in the self and engaging in authentic self-love. Lowen says "being loved is important only in so far as it facilitates the active expression of our own love. People don't get depressed when they are the loving ones. Through love you express yourself and affirm your being and identity" (1972:27)

Depression and Bioenergetic Psychotherapy: The Importance of Being Grounded

Many of us are forgetting to live our lives. We are either grieving the past and what could have been, or we are rushing into the future in the pursuit of an illusion that we believe will surely make us happy. What has happened to the present moment? It has gotten lost just as we have lost connection with our selves. By living in the past or the future, we are unaware of the feelings and sensations that are within us at this moment. We are not in our bodies and this leaves us vulnerable to depression because we cannot see our essential nature and the connection we have with the Earth. We need to find our way back to the present so we can be in touch with our inner world of feelings and the ground beneath our feet.

Bioenergetic psychotherapy is the study of personality in terms of the energetic processes of the body. How much energy a person has and how he uses it reflects in how he feels in his life. This relationship between energy and personality is most clearly seen in people suffering with depression. Studies have shown that depressed people make many less spontaneous movements than do those who are not depressed, indicating a decrease in all energetic functions: breathing, appetite and sexual drive are all depressed. Because the depressed person does not have the energy to get himself going, he must rely on the therapist's energy to help him get started. The therapist accomplishes this by guiding the client into simple exercises that deepen the breath and put pressure on the body. By increasing respiration and body sensation, the client's energy level is lifted (Bioenergetics, pp. 47-48). The principle process employed to achieve this end is grounding. Through grounding, the client is brought home to the body and what is happening in the now.

People who are not grounded are undercharged in the lower part of the body, and as such, cannot make contact with the ground. This is due to an unconscious fear that there is no ground to stand on and no support to hold onto. This results in the energetic charge being pulled into the body's midsection and prevents a free flow down into the legs. The belief that there is no support available causes insecurity and the feeling that one is empty; that one does not have the guts to stand up in a crisis (Depression and the Body p.48). As the discharge of energy is a function of the lower half of the body (eg sexual activity, movement in general), if one is not grounded there will be no place for this energy to go. The equilibrium of energy input and output will be disrupted, as the person will still be taking in energy in the forms of food, oxygen and sensory stimulation. This energetic imbalance results in depression.

Depression reduces one's ability to feel pleasure and efforts to reach out become limited. Breathing becomes restricted, food intake is reduced and interest in life begins to decline. The flow of life nearly comes to a stop.

Grounding provides the means for a person to come back to life. As he feels the vibration build in his legs and feet, he senses the connection between the Earth and himself. Grounding the body releases excess energy. This is experienced as pleasurable as the tension has been dissipated and energetic equilibrium has been restored. Through the pleasurable sensations of being grounded, the client feels encouraged to seek more energetic charge in all areas of his life as he begins to connect with others, knowing that he can support himself and is supported.

Bioenergetic psychotherapy describes several physical exercises to guide clients into their bodies and ground them in their feet, legs and belly. The following are two basic grounding exercises that are most helpful at the beginning of a therapy:

Exercise 1

With knees slightly bent keep your feet parallel and about six inches apart. Balance the weight of your body between the heels and balls of the feet. Keep your upper body straight and let your arms hang loosely at your sides. Keep your mouth slightly open so you're your breathing can develop easily and fully and your belly can relax. Hold this position for 2 minutes if possible (Lowen, p. 62).

Exercise 2

Keep your feet about 8 inches apart and your toes turned inwards. Flex your knees and bend your torso forward until your fingertips touch the ground. Release your head. With your fingertips on the ground, gradually straighten your knees but do not lock them. .Notice if some vibration develops. Support your weight on your feet as your fingertips serve only as points of contact. Inhale and exhale deeply through your mouth. Hold the position for one to two minutes, never allowing it to become painful or tiring (Lowen, pp 63-4).

Variation of Exercise 2

After holding the position of exercise 2 for one minute, bend your knees all the way and hold your hands straight out, just off the floor. Pitch the weight of your body forward and keep your heels on the ground (Lowen, p. 71).

These exercises bring awareness to the legs and feet as sensation builds in them. The legs may begin to vibrate or shake and this is an expression of the flow of feeling in the body. If this becomes painful or the legs feel like they will collapse, change to the next position.

Even as bioenergetic psychotherapists work to help their clients to become grounded, they must be aware of their client's unconscious fear of doing so. The client may associate being grounded with falling and this keeps the energy directed upwards. Many people associate falling with helplessness and vulnerability and so holding on becomes an

expression of individuality. People often believe that to fall is to be left behind. Hidden beliefs such as these reduce a client's capacity to surrender to love or to fall into deep sleep(Lowen, p.69). The following exercise addresses the fear of falling:

- Stand on one leg and bend the knee as far as it will go while keeping the whole foot on the ground. Extend your other leg off the ground. Extend your arms and rest your hands lightly on two chairs placed alongside you(the chairs are for balance, not support). Place a folded blanket six inches from your foot and hold the position for as long as possible. Breathe deeply and fully and feel the weight of the body on the foot (Lowen, pp 67-8).

When the position can no longer be maintained, the client is asked to let himself fall onto the blanket. This exercise is repeated twice on each leg. On the fourth time, the client can be asked to say "I give up" as he falls. Realizing that he can fall and let go without being hurt, relieves anxiety and the client may begin to cry. Lying on the ground, he can feel secure in its support and can abandon the struggle against gravity and the need to do something.

This exercise should always be followed by a relaxation exercise:

- Place both of your knees on the ground and bend your elbows. Place one forearm over the other, flat on the floor and rest your forehead on your hands. Push your buttocks back as far as possible and hold the position for two minutes (Lowen, p. 70).

In this position, the head is close to the ground and the breath can come fully into the deep abdominal cavity, awakening this area (Lowen, p. 71).

In all bioenergetic exercises, it is important to breathe through the mouth because these exercises put the body under stress and one needs as much oxygen as possible. Breathing through the mouth allows the jaw to relax, diminishing the tension that is normally present when the mouth is closed. In addition, there is an energetic connection between the jaw and the pelvis and as the jaw relaxes so does the pelvis. Full and deep breathing

charges the body and promotes vibrations in the legs. As the muscles begin to tire, their ability to hold against the tendency to collapse weakens and tight muscles begin to relax. Feeling can then flow into the lower part of the body (Lowen, p. 72).

The aim of these exercises is to ground the client in the reality of the body and of the Earth. This surrender will become pleasurable as the client realizes that he is surrendering to his life.

Because our culture is on guard against continual crisis and we hold our bodies to withstand these crises, it is important that we find ways to let down through the body. If we do not find this way, we will find ourselves dropped into depression.

Depression in the Character Structures

Individuals who have the schizoid characterlogical makeup have experienced a death of the self. They mourn the loss of what could have been and the loving relationship that did not happen. Depression is common, and is the least suppressed affect of this structure. It is not deeply felt, however, and is often seen as a longstanding or periodic, chronic condition. The depression is expressed more by withdrawal and whining discomfort than by deeply felt grief. In order to persevere, the "hated" child had to deny this feeling as he did all others. Depression, accompanied by suicidal ideation, the termination of self care, and the recognition that one is unable to feel anything else is the presenting complaint of people with this character structure (Johnson, p. 82).

Because this structure cannot identify with life in the body, their energy is pulled into the mental realm and they find comfort from life in seeking an idealized illusion – ideas, religion, drug states, etc. They have a great need for external approval and attempt to find self-acceptance through achievement. When the outside world does not reflect back to them who they are, or if they feel that they have fallen short in their endeavors, the result may be depression, suicidal thinking and behaviour (Johnson, p. 84).

The needs of those with the oral character structure were never met by their caregivers. Because of this ongoing frustration, they shut down their own needs and told themselves, "If my need makes me hurt, I will stop needing". In order to not feel the need, the oral character limits breathing activity and energy output. This strategy does result in the need for less input but as expression is suppressed, it leads to low-level, chronic depression.

The oral character is caught in the trap of the feelings of love and hate being directed at the same person, the mother. Each feeling has blocked the expression of the other and because the energy of hate has become locked in the body, depression results. (Johnson, p.119). Depression in the oral is a defense against these aggressive and hostile feelings and it also serves to protect him from experiencing his grief at his deprivation and the loss of the self. Very often, this character structure is invested in his self-sacrificing nature and sees himself as loving and caring. Uncovering the unconscious beliefs and working with the physical blocks will lead the way out of depression (Johnson, p. 118).

The psychopathic character structure has experienced a deep wound to the real self because the message he received as a child was that he needed to be something very different from something that he was, "Don't be who you are, be who I need you to be and I will love you" (Johnson, p. 156). Because of this, the person with this history tends to objectify his experience and those of others and in his compensated state, displays a "striving for power, a lack of humility, and an inability to accept failure (Johnson, p. 185)". This state is difficult to maintain, and when it breaks down, the person is sensitive to criticism and prone to depression. He senses that he has sacrificed himself for others and often hides his disagreeable qualities under a blanket of depression. He is haunted by thoughts of worthlessness. He is conscious of these symptoms but is unaware of their relationship to the grandiosity (Johnson, p. 172). If he is unable to maintain his grandiose position, then the dreaded feelings of panic, void, and fragmentation rise to the surface. To avoid these feelings, he deadens himself in depression. This serves to protect the expectations of the false self because it allows the person to believe that he if weren't so

depressed or ill he could certainly accomplish whatever he sets his mind to (Johnson, p. 180).

Depression is a signal that the needs of the real self are not being met, and as the client comes to see the depression as an opportunity for healing, he will be unwilling to continue to "martyr the real self for the non-sustaining nutriments that the false compensation provides" (Johnson, p. 185).

Those whose early development have led them to a pattern of self-defeating behaviour in social, emotional, and work life embody the traits of the masochistic character structure. Social masochism arises from a history of defeat where the "child's will has been persistently, intrusively, and often sadistically beaten into submission (Johnson, p. 193). They can be recognized by the absence of any pleasure in life and present as overburdened people who are making maximum efforts but are getting no where. They suffer from chronic depression from which they believe there is no escape. In spite of this, they keep going and have found a way of winning through losing (Johnson, p. 216). In therapy, they appear compliant and grateful, but self-defeating behaviour such as depression, never seem to change. They tend to not feel deeply, and even their depression, which can be profound, is never keenly felt. They endure their lot and suggestions for change elicit a reflexive response of "it won't work, there is something wrong with it, I've tried it before, it's dangerous" (Johnson, p. 219).

Because the masochistic character is intent on defeating the other, including the therapist, a deep therapeutic alliance cannot be established. Until he can shift in responsibility and see that he has different choices, nothing in therapy seems to help. When this shift does occur, therapy can help him to understand how he has become

"programmed to maintain a depressive self-defeating life style" and "learn why he works to maintain this state" (Johnson, p.225). Through the interpretation of his affects, behaviours, and cognitions, he can explore how his patterns play out in his relationships, and he will develop greater self awareness of his use of others to maintain his depressive condition.

Family patterns that include a seductive father and a presence of rivalry between mother and daughter for the father's attention result in the rigid character structure (Johnson, p. 235). Those with this personality style are often seen as being over emotional. Because a deep feeling of her personal problems will cause the rigid woman to experience an emotional overwhelm, she deletes information and blocks her thought processes, as this keeps her safe from fully feeling her underlying issues.

Rigid issues represent exploitation of human need, sexual interest, and normal rivalry (Johnson, p. 237). Studies show that a majority of these women suffer from major depressive symptoms. They fluctuate between thinking of themselves as good girls, in the idealized role of daddy's princess, or as bad girls who were "little temptresses who had aroused their father's interest and their mother's jealous hostility" (Johnson, p. 245).

When these unconscious concepts of "rivalry, feared retaliation, and guilt for injuring the mother figure" break through, they often cause depression. Because a part of her sees herself as having colluded with the secret relationship with her father, the rigid character believes she has done something wrong (Johnson, p. 251-252). Very often, these depressions are a defence against the more deeply disturbed feelings of exploitation. An initial therapeutic objective is to assist the client to gradually let go of the depression defence.

Further Reading

Lowen, A. (1975). Bioenergetics. USA: Penguin.

Lowen, A. (1972). Depression and the body: the biological basis of faith and reality. New York: Penguin.

Johnson, S.M. (1994). Character styles. USA: W.W. Norton and Company.