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### BOOK CHAPTER

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## The metapsychology of depression

*Cyril Couve*

In this review of some key psychoanalytic ideas about depression, I shall be using Henri Rey's (1994b) notion of a depressive psychic organization that constitutes a kind of fabric of the experience that we call depression. This depressive psychic organization has two interrelated elements. First, it emerges in relation to the loss of an object. The term "object" here refers to a person, a loved one, a loved attachment, a relationship, or a country or also to what can be called a self-object, such as an ideal, a standard, or an expectation about oneself (Freud, 1917e [1915]). The second element refers to a sense of personal responsibility, conscious or unconscious, about the loss itself. Without the presence of this psychic organization it is difficult to make the diagnosis of depression. This should not be taken to mean that causes that do not fall within the psychic domain—such as biological causes of depression—are excluded. It is perfectly possible to hold a psychoanalytic view of depression and include other causes. Rather, it should be taken to mean that without such a mental structure it would be difficult to make the diagnosis of depression.

Another point needs emphasis. The connection between loss, separation, and depression is quite accepted today, both within and outside psychoanalytic writings on the subject. However, the connection between loss and depression is not an automatic one. What

determines whether depression follows a loss or a series of losses depends on what the child or the adult has made of the loss and how he or she has reacted to it. Depression is one way of reacting to loss. From within the psychoanalytic tradition, *depression is not seen as a result of loss but, more specifically, as a result of an inability to deal with loss or as a result of an inability to do the work of mourning*. Here, an important distinction emerges between mourning and depression. The capacity to mourn and to grieve is a kind of psychic insurance against depression. Depression is not an automatic consequence of loss. Depressive feelings are usually present in mourning, but they are transient and not fixed.

Freud's 1917 paper "Mourning and Melancholia" is the foundation for the psychoanalytic understanding and formulation of loss and depression. It is a complex paper, which moves on different levels. Freud compared the state of mourning to that of melancholia in order to understand melancholia, by which he meant psychotic depression or manic-depressive psychosis. The state of mind that we call mourning has various features in common with the melancholic state of mind, according to Freud. In both mourning and melancholia there is an extremely painful dejection, a loss of interest in the outside world, a loss of the capacity to turn to new relationships, and a turning away from activity not connected with the lost one. However, Freud was keen to single out major differences between these two states.

In a state of mourning, the mourner is preoccupied, almost exclusively, with the psychic work of thinking about and remembering the lost object. According to Freud the world feels impoverished because the object is no more. By contrast, the loss that has led to the pathological reaction of melancholia is much more difficult to detect. This is due to the disproportion between the nature of the melancholic reaction, which can be quite catastrophic, and the loss itself. Whereas the mourner feels that the world is impoverished without his or her love object, the melancholic is far more preoccupied with the impoverishment of his or her own ego. This impoverishment takes the form of an intense, relentless, and merciless self-castigation and self-hatred, which can achieve delusional proportions. Freud singled out the delusion of self-belittlement as being the crucial distinguishing feature between the state of mourning and that of melancholia. He also pointed out that the melancholic does not hide his self-hatred but, instead, proclaims that he is a sinner, a criminal, that he is rotten, and so forth in a rather exhibitionistic way. So there is a definite narcissistic and

exhibitionistic element to the melancholic's relentless self-depreciation and masochism. In addition, although the dejection of the mourning process is extremely painful, the mourner eventually comes to know that this is a normal reaction that will pass away with time, once the work of mourning has been done. Freud called it the "work of mourning" in order to stress the psychic work and mental effort and energy that goes into the process of mourning.

Freud's conceptual strategy in his paper is very interesting. He puts forward a hypothesis that in the case of melancholia there has been a loss, but the loss is an unconscious one. The way he comes to this hypothesis is very ingenious. He says that if one listens to all the self-accusations and the intense criticisms of the melancholic, they do not seem to apply to the person of the melancholic but could very well be directed to a significant figure in the life of the melancholic. This intense self-hatred, Freud thought, linked once to a hatred of an object outside the self. The crises and anxieties generated by this very intense ambivalence are such that the hated object is taken into the self through a process called "introjection". Through the process of introjection, instead of hating the object the melancholic hates him/herself, now identified with the object. Freud, drawing inspiration from the writings of his colleague Karl Abraham (1924), describes this mode of relating to an object as a very primitive one, whose prototype involved an oral incorporation of an object in fantasy.

Freud's paper is a foundation paper, a pioneering paper, but also one that is full of gaps and uncertainties. Nevertheless, it contains many implicit and explicit truths that are very important. First, it establishes a clear link between the state of depression and the internalization of an object or figure that is relentless, punishing, and merciless. In other words, it establishes a very important relation between depression and the sense of responsibility or guilt, which can take extreme forms such as persecutory guilt in cases like melancholia and severe depressive states. Second, it is also implicit in Freud's paper that the introjection of the hated and hateful object inside the self means that the object has not been let go and remains within the self, with terrible consequences. In contemporary psychoanalytic theory these primitive introjective identifications, with their omnipotent character, would be understood as functioning as a defence against separateness and loss. Third, what is also interesting about "Mourning and Melancholia" is that although Freud uses the parallel with melancholia to understand melancholic despair, he ends up with a dynamic view of severe depression and

still very little insight into what constitutes what he calls the work of mourning. Freud quite candidly pointed out that the reason why the work of mourning should be so difficult actually eluded him.

He understood the work of mourning as a conflict between a part of the self that, through memory and through a revisiting of memories about the object, kept the object alive and a part of the self that had the capacity to submit every one of these memories to the judgement of reality. Reality says the object is no more; it is dead or is lost. Freud conceived of the work of mourning as a process of maintaining attachments to the object through memory while at the same time detaching oneself from the object by a process of reality testing. After a while, the reality ego prevails over the pleasure ego. While this is interesting, it leaves us, in the main, with an economic view of mourning regarding quantities of attachment and abilities to detach, but not with a fully fleshed-out psychodynamic view of the process of mourning.

### *The depressive position*

This is where the work of the psychoanalyst Melanie Klein on the depressive position is of great interest and value. Klein's theory of the depressive position allowed her to provide a structural explanation for states of mind present in severe psychotic/melancholic depression, but also for the state of mind associated with normal mourning. According to Klein, the situation of loss and mourning revived the conflict of the depressive position and is an occasion to continue the working-through of such conflicts. The state of mourning, according to Klein, is a transient "depression", with a crucial difference: *in successful mourning, it is possible to bear guilt, it is possible to engage in reparation proper, and it is possible to re-establish a good relation with the loved object and good internal object.* Although Klein established a rapprochement between the work of mourning and the state of depression, she also maintained a very important distinction between the capacity to mourn and the incapacity to mourn, which led to depression. While Freud hinted in the direction of this distinction, I suggest that he was unable to give us a dynamic explanation for it.

Melanie Klein referred to the depressive position as a major structure in infantile life inaugurating a new mode of relating to objects, a new psychic reality, a new experience of the world, and the emergence of what she called depressive anxiety—a new form of very primitive anxiety, with its own group of defences. A mixture of internal and external factors allows the very young infant to negotiate some of

the conflicts of the earlier paranoid–schizoid position, which Klein thought occurred during the first few months of life. According to Klein, the paranoid–schizoid way of relating to the object means a relation to part-objects. The splitting mechanisms are such that the object that gratifies—the “good” object or the idealized object—is kept wholly separate from the object that frustrates. The frustrating object is hated and, by projection, becomes hateful and persecutory: the “bad” object. The crux of the paranoid–schizoid mode of relating is that idealized and persecutory objects are kept wholly separate, so that both the object and the ego are split. This results in a part-object mode of relating, and in such a world there is no place for loss. The anxiety that dominates is that of being persecuted by the bad object and contains fears of psychic dissolution, of disintegration into bits in relation to bad objects. The omnipotent possession of the idealized object is a desperate defence against this awful state of persecution.

If the infant has been properly contained and mothered and has internalized a sustaining object, then there is movement to whole-object relating. This means that the loved object is also the object who is hated and attacked. When development goes well, there is an increased capacity on the part of the infant to bear frustration (e.g., when the mother is absent), depending on whether a sustaining object has been introjected. This enables an increased capacity within the infant to feel separated from his or her objects such that there is more of a distinction between him/herself and others. In this entry into the depressive position, emotional ambivalence is experienced towards the object, together with an enhanced capacity to integrate feelings of love and of hatred stemming from the same self, initiating emotional whole-object relating. This inaugurates a new psychic reality: the anxiety of loss of the object that is loved.

It is important to point out that, for Klein, entry into the depressive position is not dyadic in nature: it is triadic. With an increased awareness about the mother as a separate person, the new object world that is entered into involves the mother’s relationship with a third object. The object who is hated and attacked is not simply the mother but, rather, the mother’s link with others. In her work with young children, Klein showed with great clarity the concrete nature of the child’s fantasy. Here, the fantasies about triangularity and the triangular psychic space have as their new object the mother’s body and what is inside the mother’s body. In terms of the contents of mother’s body, this can include milk, other babies, and also some link with father, a very primitive type of father, which Klein calls the father’s penis.

Since it is the link to objects that is attacked, it also means that the anxiety is very great, because it is all the objects that are attacked. The depressive position is particularly poignant emotionally because it is triangular, which also means that it is not only one object that is attacked or split, but it is all the objects that are damaged in phantasy. Hence, she refers to the notion that in the depressive position the object world is in chaos. She pointed out that while the anxiety is of a more persecutory or paranoid nature (i.e. there is a fear that the objects that have been attacked will retaliate, hence leading to a considerable amount of persecutory anxiety), it is also depressive in nature in that it inaugurates a fear of loss, a concern for the object who has been lost or damaged or whose loss is feared, and guilt because it is the same loved object or objects that are also hated and attacked in fantasy. So, in the depressive position, the child or the adult in later life has to confront both paranoid anxiety and depressive anxiety. The coexistence of paranoid anxiety and depressive anxiety leads to a structure in which guilt can easily become tinged by a very persecutory quality. If paranoid anxiety is still dominant, then guilt will tend to achieve a more persecutory character. The major defence against this new form of anxiety is what Klein calls the group of manic defences. While there are other defences in the depressive position, such as the important obsessional defences, I shall focus on some essential aspect of the manic defences.

#### *Characteristics of the manic defence*

1. There is omnipotent denial of need and dependency. Since need and dependency occasion an exposure to the pain of being separate and also to the pain of exclusion in the new triangular relations, this can lead to a very conflictual relationship to the world of objects. Need and dependency are omnipotently denied and omnipotently triumphed over.
2. The triumph over need and dependency is also achieved by a triumph over the object. The importance of the object is devalued, belittled, and demoted, as a way of avoiding what Klein calls "the perils of dependency".
3. It is not sufficiently understood that the triumph over need and over one's object is absolutely central to what Klein calls omnipotent or concrete reparation. One way of attempting to restore the damaged object is to omnipotently rid oneself of one's needs for objects and one's dependency on objects that occasioned conflict

and destructive attacks in the first place. Fantasies of manic repair are often expressed in terms of omnipotent and narcissistic fantasies of self-sufficiency, whereby the need for the object and the importance of the object is demoted or radically denied because one has all the resources oneself. By being perfect, big, and omnipotently grown up and resourceful, the self avoids the risk of ambivalence and destructive conflict, which lead to depressive anxiety and depressive despair.

4. Under the pressure of the manic defence, a splitting of the object and of the self between alive and dead takes place. The damaged object is dreaded and, instead, the alive part of the self and of the object are idealized. Manic states are usually characterized by grandiosity and overactivity and a forceful but brittle liveliness; they can also be highly sexualized states to ensure the triumph of aliveness over the dread of deadness.
5. The problem with manic defences, which are essentially triumphant and defeating, is that they themselves constitute attacks on the object and on the self, which leads to more guilt and to more persecution. In working with a person in a manic state, the change from a feeling of being completely devalued to one in which one is intensely concerned for the brittleness of a patient can be quite startling. Mania protects the patient against the feared experience of depressive despair, of psychic pain, and of persecutory internal figures.

The psychic task of the depressive position is gradually to be able to bear guilt and to engage in what Klein referred to as “reparation proper”. Reparation proper means that one cannot put absolutely right the damage one has caused to the object in phantasy. But excessive guilt and despair give way to the emergence of concern, of love, or of pining for the objects lost. In other words, reparation proper allows the self to reinstate a good and loving internal relationship with the lost object. This can only come about when depressive guilt can be faced and not fled from with omnipotent defences, denials, and mechanisms. For Klein, reactions to loss will depend greatly on the way the conflicts of the depressive position have been worked through and negotiated. If loss mobilizes persecution and despair, then melancholic states or severely depressive states will most probably result.

The work of mourning is difficult because the loss re-evokes the conflicts of the depressive position—that is, the loss of a loved one



re-evokes the guilt occasioned by one's own death wishes and attacks on one's early objects vital for psychic survival and development. If these conflicts are still virulent, then mourning cannot take place and a pathological reaction to loss is likely. If the conflicts are less intense and more attenuated, then the loss of a good internal object is only temporary, transient, and the trust in the individual's capacity for concern and capacity to face guilt, along with a capacity for reparation proper, leads to the reinstatement of good and loving feelings towards one's own internal objects. This, according to Klein, is the crux of the work of mourning: to be able to restore a loving relationship with one's internal good objects.

*Clinical illustration:*

*Twenty-session psychotherapy with Mr D*

The difficulties experienced in the work of mourning can be seen in the following psychotherapy treatment with Mr D, a patient whom I saw for twenty sessions, who was unable to fully mourn a tragic loss. D was in his early sixties and had been prescribed a variety of antidepressants over the previous five years. He had become dependent on them, even though they didn't help his depression. As a builder, he moved around and managed to obtain medication from a variety of GPs until he met a psychologically minded GP who fortunately felt he needed psychotherapy and not just medication.

The narrative I am going to give is a result of the twenty sessions and was not obtained in one go. D's attendance and punctuality were very erratic, especially at the beginning. Whenever he started to tell me about the loss, he would sob very painfully, which often meant he could not carry on telling me what he had started. As a result sessions were very disjointed, especially at the beginning. D told me that he had lost his wife seven years ago in the most tragic of circumstances. They had been married for over twenty years, a very close couple, both Catholics, and had three children, now in their twenties and late teens. As Catholics they used natural contraception: abstinence, or coitus interruptus during ovulation. His wife had become anxious because of a lump in her breast. She consulted two different GPs and was reassured that the lump was benign and did not need to be removed. His wife went along with the diagnosis but was not entirely reassured by it. One night they made love, unprotected, and then he ejaculated inside her. It was

a mistake. His wife told him jokingly at that moment: "now this is it, you have killed me." Things then happened very fast. She fell pregnant, the tumour was malignant, and, with the pregnancy, the cancer spread and she developed a secondary. Tragically the pregnancy bought life and death at the same time. I think that the juxtaposition of these two extremely contradictory and antithetical events of life on the one hand and death at the same time most probably complicated the process of mourning considerably.

Mrs D was placed in an intensive care unit for much of the pregnancy. In a desperate attempt to save the mother, they had discussed abortion, if this might help. But it was too late. And anyway, even if this could have helped, their Catholic principles would have made them decide against it. My patient saw his wife die gradually. However, some of the memories of them together in the hospital bedroom were recounted with an extraordinary vividness and presence and with an unbearable sadness that made me feel close to tears. Their son was eventually born a healthy baby, and before her death two weeks later his wife had asked him: "Promise me you will look after our baby as I would." He had promised.

D received no bereavement counselling but was told by a consultant who had worked on the case that he should not think of making any new or major move in his life for at least nine months, for his own and also for the baby's sake. Interestingly, he followed this advice to the absolute letter. I felt, as therapy developed, that he had heard it and had reacted to it as if it were a kind of edict or an injunction. He gave himself exactly nine months, not a day more, not a day less, and then moved his entire family to a region just north of London. Building work was abundant there, so he could make good money and give everything he had promised he would to his children and the baby.

He worked hard during the day, and also at night, when he would look after his infant son. During the day, childminders were used to help. Despite the hardship in his life, he felt that he was doing pretty well and that he was overcoming the loss of his wife. However, when he could make better use of his sessions, he also presented the other side of him that did not cope so well. He described states of utter exhaustion, culminating in moments of total impatience with his crying young baby at night, sometimes shaking him angrily to try to get some sleep, expressing considerable

guilt in depending so extensively on his elder daughter to help care for his little son.

After one year of being in London, he met a woman, herself a relatively young widow with two children. They became friends, and lovers, and soon decided it would be better to live under the same roof with their combined families. It was from this point on that he started to feel badly depressed, constantly tormented by thoughts telling him that he should commit suicide. The very fact that such thoughts came to him increased his sense of guilt because of his Catholic morality. He did not get these thoughts when at work. Usually they came at night when he could not sleep or on his way to or from work. As he downed his tools, he would be invaded with guilt and fear about what he may do while driving back home. These depressive moods and thoughts descended on him, and he felt that he would be condemned to live this kind of misery for ever. He would think about his wife and her death and would sob uncontrollably but without much relief. When he was prescribed antidepressants, he soon became addicted to them. When I saw him, he was taking the pills at will to try to stop his depressive and suicidal thoughts. As soon as he would have them he would take an antidepressant. Antidepressants helped him a bit initially, but after five years he was still depressed and afraid now that he had become addicted to medication. By the time I saw him he also mentioned that his sexual relation with his new partner had become virtually non-existent, and this worried him a great deal in case she thought he was just with her to replace his dead wife. (This narrative makes it sound simple and self-evident, but it was not. Information came in very disjointed bits.)

When we started treatment my patient was very sceptical about how talking to me could help him. He felt that he had remembered all the details of his wife's death so often, and had gone through them so often, that it was not as if there was anything he was hiding to himself. So how could talking to me help him? Whereupon in the session he would tell me something about his wife and then start to weep and to sob uncontrollably. The pain and sadness were so intense that he could not carry on telling me what he had started to talk about. When the session would end, he often was in a heap and would leave in a state of despair. I was left feeling terrible, caught up with the devastating pathos of his tragic loss, but also with a sense of impotence and anxiety about how he would cope

with such sadness over the next week. I was never seriously worried that he would commit suicide. But he evoked in me great concern about his state over the following week until his next session. After a while, by using and listening to my countertransference, I started to understand how this man could get antidepressant medication from his GPs, because he very subtly evoked in one a combination of intense sympathy and caring and also a kind of helplessness and anxiety at the same time. This helped me start to think about the distinction between what was pathos in this man—and there was plenty of pathos because of the tragedy—but also to consider what was pathological.

For example, after a while I started to perceive increasingly that when he remembered with such intense vividness the memories of his wife's illness and death, he was perhaps keeping it alive in memory, in the manner that Freud (1917e [1915]) suggested, and that this vividness could be a way of defending against the guilt he felt about his wife's death. The question that came to me was: what kind of tears was he having when he cried so uncontrollably in the session?

I also remembered one of the first things that D told me. He said, "I did not know anything then. . . . All I ever had is my hands", which he showed me, builder's hands, well worn by work. "If only I knew then what I know now." And then he showed me his hands again and said, "These are all I've got." Increasingly in the course of our sessions I came back to this communication and started to see it as a very condensed communication with different layers of meaning, a bit like a dream. On the one hand, it sounded like an apology, the protestation of innocence: "If only I knew this, it would not have happened, but I did not because I am an honest worker who doesn't know much, and the proof is there in my hands. I am an honest worker with honest working hands. My hands are clean." Now clearly this was both an admission of guilt and a protestation of hard-working innocence and ignorance.

Gradually he started to miss sessions or to come late, and I started to perceive a more negative aspect to the transference with me and a kind of subtle arrogance about the lateness when he failed to ring to tell me he couldn't come, hardly excusing himself when I saw him again. He seemed to behave as if all this was par for the course, that there was no sense of loss, that it didn't mean much to come

or not to come to a session, while on the other hand he remained plagued by despair, by suicidal, intrusive thoughts, and also by this dependence on antidepressants, which he was very unhappy with. I started to take up the way he mistreated his sessions, the way he made no allowance for any sense of loss in missing his session, or the way he seemed to be subtly contemptuous about his need for my help and about the help that I could give him. I interpreted how he took refuge in his work instead, which provided him with very good excuses for not attending his sessions and not attending to his depression. I started to see a different meaning to his "all I've got are just my hands". His hands, his zealous activity at work, his doing very well financially—all of this was part and parcel of manic defence. It was also a way of denying that he had a mind and that things happened in his mind, a way, too, of denying the possibility of knowing what took place in his mind and the fact that he needed me to help him understand what had gone on in his mind leading to his depression.

D did much of the reconstructing by himself of what had happened. At times I would also help him to put things together about what had happened to his wife and what he felt in relation to her. Gradually he started to treat his sessions much more seriously, and after the tenth session he did not miss any of the subsequent sessions.

I shall now list what felt like some important landmarks in the progress D was making in his brief therapy once he had become more reconciled with his real needs as a patient. In his ninth session he told me that he had decided to stop the antidepressant medication and was surprised at how easy it had been. I think he was able to cast off his unhealthy dependency on medication because he understood that a more healthy emotional process had begun in his therapy which allowed him to make better contact with his very unresolved grief. In other words he had begun to trust the value of his sessions.

Soon after, he made a very interesting self-observation: he said that he had thought about his wife at the weekend and had cried. But it was different this time, because after he had cried he felt relieved, whereas usually when he cried he felt depressed and little relief. This insightful self-observation, which confirmed my sense that D had up to then suppressed his capacity to think and understand out

of his unconscious tormenting guilt, indicated that he was beginning to understand by himself the important distinction between the pathos in his situation and the pathological in his depressed state. Depressed tears serve to evacuate mental pain and guilt but do not relieve the patient, whereas tears born out of sorrow follow the reinstatement of love for the lost object and bring relief to the mourner who can now let go of the lost loved one.

One month later he told me he had been able to take his new partner over to Ireland on the anniversary of his wife's death. This was the first time he had been able to bring her directly on one of his trips to his wife's grave and in this way bring his two partners together instead of hiding the one from the other out of guilt. Shortly afterwards he voiced for the first time his concerns for his youngest son's emotional state. I learnt that the latter had been experiencing difficulties at school and recently had been statemented. D wanted me to help refer him and his son and the whole family to a child guidance clinic. I saw this as an acknowledgement of the damage and mess he realized his manic denial had left behind and had caused to his son, who was not properly looked after in his early years. With the acknowledgement of his need for help there was a decrease of omnipotence along with an increase of more truly reparative urges and tendencies: he was feeling more able to face his guilt and put it right instead of fleeing away from it like a haunted man. Finally, in the penultimate session he announced to me that he was planning to marry his partner, which he had avoided all this time because of his guilt.

### *Some psychodynamic features of this case*

In conclusion, I shall outline some of the more salient psychodynamic features of D's inability to mourn the loss of his wife and how this brief spell of analytic therapy allowed him to begin to face internally and externally his tragic loss. The effectiveness of this brief psychotherapy is in itself a testimony to the fact that D had no severe underlying personality problems which usually complicate both the experience of loss and can cause a more protracted and complex depressed state that is less accessible to psychotherapy.

D felt that unconsciously he had killed his wife. The loss of a loved one inevitably evokes the unconscious ambivalent feelings that the mourner has had towards his primal objects of infancy and childhood.

One's guilt at the damage caused to these objects is revived by the more current loss. This brief psychotherapy precluded an understanding of these more unconscious factors. However, what seemed clear was that D felt that his impulsive sexual desire and the unprotected sex had killed his wife. His sense of guilt was most probably exacerbated by his own Catholic morality and attitudes about sex. But the words of his wife had become absorbed by his internal tribunal, which proclaimed that indeed "he had killed her".

It is possible to see how this internal tribunal was active in the way he heard both his wife's wish and the recommendation made by the consultant who treated his wife. He heard both as edicts or strict injunctions that he felt he had to follow to the letter, in the manner of a sentence without parole passed by a tribunal.

Pitted against such a sense of guilt and inner torment, he tried to escape and protect himself by relying on a manic state of mind. He attempted too quickly to replace his wife and to deny his own needs for her as a husband and a father of a baby boy.

He worked zealously, seeking a new beginning and acting as if he could be both father and mother at the same time. He cleansed his builder's hands by making more money than he had before and in this way by looking after his family as if there had been no loss and limitations. But internally his sexual hands felt guilty and persecuting. I think D felt devastated but also angry with his wife for leaving him through her death. His anger and resentment exacerbated his already strong sense of guilt and his reliance on manic overactivity and omnipotent fantasies of self-sufficiency. Later he could acknowledge his guilt towards his daughter for his overreliance on her and indeed recognize that he had not done a very good job on parenting his young son. If mania protects against loss and depression, the omnipotent denial at the heart of mania creates more damage and guilt.

D's sense of guilt emerged in the form of suicidal thoughts when he actually began to replace his wife with a new woman friend and partner. It was only then that his inability to mourn emerged with greater clarity. The suicidal thoughts were the internal sentence passed for his attempts to replace her too quickly, which itself was fuelled by unbearable guilt. His unhealthy dependence on antidepressants was also part of his manic flight into self-sufficiency and an avoidance of his true psychic pain.

After two months of therapy, D began to give up his contemptuous and devaluing attitude towards his treatment and towards his