Depression: rethinking diagnosis and treatment

Far from requiring treatment, writes **Darian Leader**, depression is often a good sign in therapy, an indication the work has challenged the patient and something has changed. As therapists we should not try to 'cure' depression but instead seek to understand it

Photograph: Angus Muir

If the term 'depression' was rare some 50 years ago, today it is everywhere. Personalities describe it, TV shows feature it, and GPs diagnose it with astonishing frequency. According to the World Health Organization, it will be the second largest health problem in the West by 2020. And yet in the early 1960s, it was deemed to affect less than 0.5 per cent of the population.[1] Has there been an epidemic of depression, a refinement of diagnostic tools or, on the contrary, the successful marketing of a new category?

It would be unwise for clinicians to ignore these questions, as we work in a culture permeated by the term and we hear it every day in the mouths of our clients. Historians of psychiatry and of general practice medicine have been rather unanimous in their verdict here. Depression, as a clinical category, was created and marketed after the collapse of the benzodiazepine market in the late 1970s. Faced with irresolvable problems due to new data on dependency and addiction, the vast marketing budgets of drugs companies found a new focus: depression was now the name to designate the malaise felt by urban populations, and an active campaign was established to rebrand anxiety as depression.

At the same time, new regulatory frameworks meant that drugs had to specify active ingredients, outcomes sought, and the time period in which these could be delivered. This meant a more reductionist model of human suffering, in which the name of a 'disorder' had to be produced and linked with a cause and a treatment. What was once a bacteriological model of illness came to dominate much medical thinking about psychical problems, and the receptor models that have enjoyed such popularity in recent decades, despite no real scientific evidence, simply perpetuated this. As the historians have pointed out, there was a confusion of scientific and regulatory standards here, which we have still found no way out of.

These developments had their advantages and disadvantages. They certainly managed to expand markets, selling lots of drugs, and they gave some people access to treatments that they might not otherwise have had. But they failed to distinguish surface symptoms – such as fatigue, insomnia, loss of libido, low mood – from underlying structure. The old psychiatric distinction between behavioural phenomena and deep structure was progressively eroded, as now the surface symptoms actually came to constitute the diagnostic category. Having those symptoms was just equivalent to depression, rather than seeing them as effects that could have a variety of different causes.

Yet a differential clinic is crucial here. Failing to recognise whether we are dealing with a neurosis or a psychosis with depressive states can have serious consequences. In the form of psychotic depression that we call melancholia, the person is rigid in their self-castigation, and they search for a tribunal before which they can blame themselves. This is usually quite vocal, yet in some cases remains masked behind so-called substance abuse. The person's speech will revolve around a fixed idea of bodily, spiritual or moral ruin, and they are certain that they are responsible for this, not anyone else. Complaints about difficult life situations or body image problems will eventually reveal a more profound and unchangeable accusation directed at the heart of their being: they should never have been born, they are the cause of all the sin in the world etc. There is no innocence here.

In contrast, neurotic depressions are less inert and tend not to centre on a single theme or accusation. There is the possibility of movement, and we find with great frequency problems with the ideal image. A critical comment from one's boss, a lover's perceived coldness, a parental rebuke can all trigger a questioning of one's image as lovable. Yet, equally so, the marks of worldly success: a promotion, a romantic conquest, a business achievement. The athlete who breaks a record will be more likely to enter a depressive state than the one who fails. In these cases where an ideal is attained, desire is cancelled out. Ideals are often used to regulate desire, and when an ideal is removed – through either a change in the way one imagines one is seen or through attaining it – then life itself can feel depleted, as if there is nothing to keep desire going.

The search for satisfaction

Our interest in the world around us was once an important research area for psychoanalysts. Without going into the details of the different theories, the most obvious point to make is that reality becomes interesting for us when something is missing from it. The creation and registration of a lack means that we will search for satisfaction outside ourselves, through work, through relationships, through projects and passions. If we are satisfied, we won't, and hence lack of satisfaction is one of the key motors for our pursuits in life. Desire, we could say, protects us from a certain void or feeling of emptiness. As my colleague Paul Verhaege puts it, the denominator of neurotic depressions is either 'I have no desire' or 'I am not desired.'[2]

But what exactly is the context of this desire? Infants tend to become interested in things around them when someone else is also interested in them. Child analysts and psychologists have shown repeatedly how the mother or caregiver's interest in every aspect of care will resonate with the child. If they have no interest in anything beyond their child, it will be very difficult for that child to establish an interest, in turn, for the world beyond their caregiver. Much of the work of therapy is about charting and exploring how the interests and passions of our patients have been formed in relation to those of their parents. As Winnicott said, there is no such thing as a baby, only a baby in the context of those around it.[3]

The most basic human functions and rhythms of life are all set down and created within this context: how we eat and sleep will depend on what is happening in the field of these relationships, and it is not surprising that these vital functions are often the first to be deregulated during depressive episodes. Rather than seeing this as proof that depression is an essentially biological problem, we should allow it to return us to the original sense of the term 'biology', to include within it our relation to others; recognising this is not merely academic to the clinician, as it means that the articulation of their own interest can have significant effects in the context of a therapy.

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The ego ideal and the ideal ego

This link to others can be elaborated, in part, by distinguishing the ego ideal and the ideal ego. The ego ideal is the image of who we want to be: the great athlete, the movie star, the tramp, the success or the failure that has taken on a value for us in our childhoods through the complex dynamic with those around us. Depressive states might seem to be established when these images are compromised or attained in some way, but in order to grasp how they have crystallised, we need to situate them in relation to the ego ideal, the point from which the image takes on its value. We might want to be an athlete, for example, because of the value we believe this image has for someone else. It will depend on the internalised look of the Other. And it is when this look changes that depressive states so often arise.

Think of Nick Leeson, the man who brought down Barings Bank. He strove to attain the image of golden boy trader, and we could call this a form of the ideal ego for him. When he began losing vast sums of money, he was worried but not in any kind of depressive or anxious inertia. The key is to ask whom the image of golden boy trader was produced for. It was only when he knew that the bosses in London knew about his losses that his symptoms kicked in: he could not look at his mirror image as he had done previously. The look of the bosses would constitute a form of the ego ideal, the point from which he was looked at and for which his ideal ego would come into focus. Without this look, his link to his actual body image was affected.

This is one of the reasons why depressive states are often a good sign in therapy. They mean that the work has challenged and put in question the internalised ego ideal of the patient, and this will always have effects of sadness and depletion. When this happens, it would obviously be counterproductive to try to 'cure' the depression, as this is the sign that something has changed, and must be respected for what it is. There are of course many other instances where a depressive episode is simply a legitimate response to what the person has gone through and is processing, and we see this frequently with mournings.

When we take the time to engage in a proper dialogue with someone complaining of depression, we often find that there is a mourning that has been blocked or arrested in some way. To link this to the question of the loss of a loved one, however, may only be part of the story, since beyond the question of whom and what we have lost is that of what we were for them. When Joan Didion's husband died, she describes how she had to mourn him, but also the image of who she had been for him, an identity that she no longer had.[4] She had to give up the image of the woman she imagined she had been for him, just as Queen Victoria, after her mother's death, had to give up the image of who she imagined she had been for the latter: always believing herself to have been detested, she now found that her mother had kept every memento of her precious daughter.

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The position of the therapist

I'd like to conclude with a few words about the position of the therapist in relation to depressive states. First of all, we have an ethical responsibility not to accept the term itself as a given. If someone says they are depressed, we have to find out exactly what this means for them, rather than assuming we understand and know how to treat them. Secondly, we can try to distinguish between those cases where a depressive episode requires intervention and interpretation and those where it simply requires recognition by a third party. In some cases of mourning, the person may just seek a third party to sanction their loss, to authenticate it as a loss. Thirdly, we can try in each case to see what function depressive states might have: are they the sign that something has been understood unconsciously, that an ideal has been collapsed, or, on the contrary, might they be a protection against something far worse?

Thinking about these questions will have an effect on how, when and if one intervenes. And finally, we can remember that no psychical difficulty or distress can be abstracted from its lived context. There is no such thing as 'depression' as such, as an abstract and immutable entity. Each person's symptoms are different and have different routes that have led to them. Looking for this difference, elaborating it and, with the patient, articulating it, is in itself a therapeutic endeavour. ■

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